STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555852	A. Building B. Wing	05/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Avenue Healthcare & Wellness Center	1550 North Park Avenue Pomona, CA 91768

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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** 36290 Based on observation, interview, and record review, the facility failed to ensure adequate bed linen for one of two sampled residents (Resident 359) as indicated on the facility policy. Resident 359's mattress did not have a fitted sheet and the Resident was laying on a bare mattress. This deficient practice resulted with Resident 359 feeling uncomfortable and had the potential to negatively impact the resident's psychosocial well-being. Findings: A review of the Face Sheet (Admission Record) indicated Resident 359 was admitted to the facility on [DATE]. Resident 359's diagnoses included type 2 diabetes (persistently high levels of sugar in the blood), muscle weakness, shortness of breath, and sepsis (life threatening complication of an infection). During an observation and concurrent interview on 5/17/21 at 10:21 am, Resident 359 was lying in bed and a flat sheet was placed on the top portion of the mattress. The mattress was bare from Resident 359's shoulders down to his foot. One of Resident 359's two pillows located on top of the bed did not have a pillowcase. Resident 359 stated, he did not like his bed that way and the situation made him feel bad. During an interview on 5/19/21, at 9:05 am, Certified Nursing Assistant 6 (CNA 6) stated, the previous shift (night) should have placed a fitted sheet on Resident 359's mattress. CNA 6 stated, it was his fault because he should have checked the linen as well and made sure the pillows had pillowcases. A review of the facility policy and procedure titled, Resident Rights - Quality of Life, revised March 2017 indicated each resident shall be cared for in a manner that promotes and enhances the quality of life, dignity, respect, individuality and receives services in a person-centered manner.

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38108 Based on interview and record review, the facility failed to inform one of 37 sampled Residents (Resident 40) total health status and medical condition in a language Resident can fully understand. This failure violated Resident 40's right to be informed and had the potential for the resident not to make choices regarding her medical condition. Findings: During a review of an Admission Record, it indicated Resident 40 was admitted to the facility on [DATE]. Resident 40's diagnoses included paraplegia (paralysis of the legs or lower body) and osteoarthritis (degeneration of joint cartilage and the underlying bone). During a record review of a History and Physical (H&P), dated 10/9/20, H&P indicated Resident 40 had the capacity to understand and make decisions. During a review of a Minimum Data Set (MDS, a resident assessment and care-screening tool), dated 2/15/21, indicated Resident 40 had clear speech, was understood (ability to express ideas and wants) and had the ability to understand others. The MDS also indicated Resident 40 needed extensive assistance (staff provide weight-bearing support) with one-person assist with bed mobility (moves to and from laying position), transfers (moved between bed to chair), dressing, and toilet use (cleanses self after elimination). During an interview and concurrent record review, on 5/20/21 at 10:14 am, Resident 40 stated, she received a letter from her neurosurgeon (physician who treats disorders of the brain and nervous system), but was unable to understand the content due to the medical terms in the letter. Resident 40 stated, she informed and asked for assistance from the Social Services Director (SSD) to help her understand the medical terms written in the letter. Resident 40 stated the SSD simply read the letter, but did not explain or enlist any assistance to help the resident understand what the medical terms meant. During an interview on 5/21/21, at 11:15 am, the SSD stated on 5/18/21, Resident 40 asked for her assistance to read the letter she received from her visit with the neurosurgeon. During an interview on 5/21/21 at 11:37 am, at Resident 40's bedside, DSD confirmed and stated she read the letter to Resident 40, but did not understand the medical terms written within the letter. DSD stated she should have asked a medical person to read and explain what the terms meant to Resident 40. DSD further stated, it was important because the residents needed to know their medical conditions. A record review titled Social Services Coordinator - Job Description, indicated the principle responsibilities of a social services coordinator was to ensure the residents' psychosocial and concrete needs are identified and met in accordance with federal, state and company requirements. To communicate needs and plan of care to resident, families, responsible parties and appropriate staff.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28074 Based on observation, interview and record review, the facility failed to ensure oxygen was not self-administered for one of two sampled residents (Resident 16). Resident 16 had an inhaler (also known as a puffer, pump or allergy spray, which is a medical device used for delivering medicines into the lungs through the work of a person's breathing) and oxygen concentrator at bedside. This deficient practice had the potential for Resident 16 to administer the oxygen inaccurately, unauthorized access to the oxygen and complications due to inadequate or excessive oxygen intake. Findings: A review of the Admission Record indicated Resident 16 was admitted to the facility on [DATE]. Resident 16's diagnoses included diabetes mellitus (high sugar content in the blood), chronic obstructive pulmonary disease (COPD, an ongoing, progressive disease of the lower respiratory tract in the lungs creating difficulty with breathing that slowly gets worse over time) and hypertension (high blood pressure). A review of the Minimum Data Set (MDS, a standardized assessment tool), dated 2/7/21, indicated Resident 16 was able to understand others and make herself understood. Resident 16 had a BIMS (Brief Interview for Mental Status -a screening used to assist with identifying a resident's current cognition and to help determine if any interventions need to occur) score of 15. (A BIMS score of 13-15 indicated a person was cognitively [mental] intact). Resident 16 required supervision from staff in performing activities of daily living. During an observation and interview on 5/17/21, at 9:30 am, Resident 16 had an inhaler at her bedside and an oxygen concentrator next to the head of the bed. Resident 16 stated, the inhaler was her own supply and she had been administering it by herself when she had shortness of breath (SOB). The inhaler was not labeled with the drug name, resident's name, expiration date and direction on how to administer the inhaler. Resident 16 also stated, she was able to administer her own oxygen when she needed it. Resident 16 stated, she never informed the nursing staff about the inhaler and the oxygen use. A review of Resident 16's physician's telephone order, dated 4/23/21, indicated to discontinue albuterol inhaler (used to prevent and treat wheezing, difficulty breathing, chest tightness, and coughing caused by lung diseases). Another physician's order dated 2/10/20, indicated, may have oxygen two liters via nasal cannula as needed for SOB. During an interview with Licensed Vocational Nurse 2 (LVN 2) on 6/18/21, at 10 am, after reviewing the medication administration record (MAR) indicated that Resident 16 did not have any albuterol order. There was also no indication for usage of oxygen. During an interview on 5/19/21, at 10 am, LVN 3 confirmed Resident 16's albuterol was discontinued on 4/23/21. LVN 3 stated she was not aware Resident 16 was using her oxygen on her own. LVN 3 stated she will call the physician and clarify the order. LVN 3 also stated she will assess and speak with the resident regarding keeping the medication at her bedside. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Cross reference: F 636, F655, F695, F689

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38108 Based on observation, interview and record review, the facility failed to promote care that maintains the resident's dignity for one of 37 sampled residents (Resident 75). During a dining observation, Certified Nurse Assistant 4 (CNA 4) was observed standing while feeding Resident 75. This deficient practice had the potential to violate Resident 75's right to be treated with respect and dignity. Findings: During a dining observation on 5/18/2021 at 8:52 am, Resident 75 was in bed, fed by CNA 4. CNA 4 was standing next to the resident. During an interview on 5/18/2021 at 8:53 am, CNA 4 stated she was supposed to be sitting down while feeding Resident 75 but she did not know why she should be sitting down while feeding residents. During an interview on 5/18/2021 at 2:48 pm, the Director of Staff Development (DSD) stated staff who assist residents while eating should be seated to respect the resident's dignity and ensure the resident is comfortable A review of Resident 75's Facesheet indicated the resident was admitted to the facility on [DATE] with diagnoses that included dysphagia (difficulty swallowing) and dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning). A review of Resident 75's Minimum Data Set (MDS, a resident assessment and care-screening tool,) dated 12/15/2020, indicated the resident was totally dependent (full staff performance every time) with one-person assist with bed mobility (how resident move to and from lying position), eating and toilet use. A review of Resident 75's History and Physical, dated 5/21/2020, indicated the resident had the capacity to understand and make decisions. A review of Resident 75's Physician's Orders indicated an order for the resident to receive mechanical soft diet with fortified (foods to which extra nutrients have been added) food with honey thick liquids. A review of a facility list titled Green Zone Feeders, dated 5/24/2021, indicated Resident 75 needed assistance with his meals. During an interview on 5/24/2021 at 11:28 am, the Administrator (ADM) stated the facility did not have a policy on dignity but the policy for resident's rights will cover dignity per facility consultant. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/24/2021 at 11:49 am, the DSD stated staff feeding the residents should be sitting down as discussed in the facility's in-service education. A review of the facility's Policy and Procedure, titled Resident Rights, revised 1/1/12, indicated employees are to treat all residents with kindness, respect and dignity and honor the exercise of resident rights.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27785 Based on observation, interview and record review, the facility failed to ensure one of 1 sampled residents (Resident 11) needs are met by making sure resident's call light is within reach. Resident 11's call light was observed on the floor behind the resident's bed and out of Resident 11's reach. This deficient practice had the potential for Resident 11 to not be able to call staff for help or assistance when needed. Findings: A review of Resident 11's face sheet (admission record) indicated Resident 11 was admitted to the facility on [DATE], with diagnoses that included acute and chronic Respiratory Failure (condition that develops when the lungs can not get enough oxygen into the blood), unspecified abnormalities of gait and mobility (when a person is unable to walk in the usual way), and anxiety disorder (intense, excessive and persistent worry and fear about everyday situations) among others. A review of Resident 11's minimum data set (MDS, a standardized assessment and care planning tool), dated 4/28/2021, indicated Resident 11 has the ability to make self understood and understand others. The MDS indicated Resident 11 required limited assistance with one person physical assistance from staff for bed mobility, transfer to and from bed, chair, or wheelchair, walk in the room, walk in the corridor, dressing, toilet use, and personal hygiene. The MDS also indicated resident is continent of bowel and bladder. During observations on 5/18/2021 at 9:05 AM, and 5/20/2021 at 10:28 AM, Resident 11 was in bed asleep. Call light was not seen anywhere near the resident and was on the floor behind the resident's head of the bed. During an observation and concurrent interview with Licensed Vocational Nurse 8 (LVN 8) on 5/20/2021 at 11:16 AM, Resident 11's call light was observed on the floor behind the resident's head of the bed. LVN 8 stated call light was not within reach of the resident. LVN 8 stated that the call light should have been within the resident's reach to be able to call for assistance.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38108 Based on interview and record review, the facility failed to report an allegation of abuse and mistreatment to the authorized agencies by no less than 2 hours, in accordance to state law for one of one sampled resident (Resident 40) who alleged Certified Nurse Assistant 6 (CNA 6) did not change her and left a scratch on her. This deficient practices violated the Resident 6's right and had the potential to place the resident's safety at risk. Findings: A review of Resident 40's Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included paraplegia (paralysis of the legs or lower body) and osteoarthritis (degeneration of joint cartilage and the underlying bone). A record review of the History and Physical, dated 10/9/20, indicated Resident 40 had the capacity to understand and make decisions. A review of a Minimum Data Set (MDS, a resident assessment and care-screening tool), dated 2/15/21, indicated Resident 40 had clear speech, was understood (ability to express ideas and wants) and had the ability to understand others. The MDS also indicated Resident 40 needed extensive assistance (staff provide weight-bearing support) with one-person assist with bed mobility (moves to and from laying position), transfers (moved between bed to chair), dressing, and toilet use (cleanses self after eliminations). During an interview on 5/20/21 at 10:14 am, Resident 40 stated on 5/15/21, early in the morning before shift change, CNA 6 had dug her fingers and scratched her on her perineal (region between the tights bounded by the anus and the opening of the vagina). Resident 40 stated she scratched me down there and it hurt. During an interview on 5/20/21 at 2:26 pm, Certified Nurse Assistant 7 (CNA 7) stated on 5/15/21, Resident 40 reported CNA 6 hurt her on her bottom area. CNA 7 stated he immediately reported the abuse allegation to Licensed Vocational Nurse 10 (LVN 10) and Licensed Vocational Nurse 7 (LVN 7). CNA 6 further stated he witnessed LVN 7 and LVN 10 speak to Resident 40 regarding the alleged abuse. A review of the Department Notes, dated 5/16/21 at 8:20 am, indicated on 5/16/21 at 6:30 am, Resident 40 reported a certified nurse assistant cleaned her peri area and dug deep in her butt and scratched her. The Department Notes indicated the Certified Nurse Assistant hurt her. A review of the Departmental Notes dated 5/16/21 at 3:15 pm, indicated Resident 40 informed Licensed Vocational Nurse 7 (LVN 7) that she was upset due to a certified nurse assistant from the previous shift not cleaning her right. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/20/21 at 2:58 pm, the Administrator (ADM) stated the first time she was informed of the allegation of abuse from Resident 40 was on 5/19/21 from a letter sent by Resident 40's insurance company. The ADM stated reporting abuse was important because it was illegal; it is hurting something or someone. Abuse needs to be reported right away. A review of the facility's policy and procedure titled Abuse - Reporting & Investigations, revised on 3/2018, indicated the facility will report all allegations of abuse and criminal activity as required by law and regulations to the appropriate agencies. Allegations of abuse, neglect, mistreatment, exploitation or reasonable suspicion of a crime to be reported to the Administrator or designated representative immediately. Notification or Outside Agencies or Allegations of Abuse with or with no serious bodily injury; the Administrator or designed representative will also notify the Ombudsman, California Department of Public Health and Law Enforcement within two hours by telephone or in writing.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28074 Based on observation, interview and record review, the facility failed to assess one of 2 sampled residents (Resident 16) to determine the resident's capacity for safe use of oxygen. Staff did not aware that Resident 16 administered the oxygen on her own. This deficient practice resulted in Resident 16 not receiving enough oxygen and placed the resident at risk for respiratory distress. Findings: A review of Resident 16's admission face indicated the resident was admitted to the facility on [DATE], with diagnoses that included diabetes mellitus (high sugar content in the blood), chronic obstructed pulmonary disease (COPD-an ongoing, progressive disease of the lower respiratory tract in the lungs creating difficulty with breathing that slowly gets worse over time) and hypertension (high blood pressure). A review of the Minimum Data Set (MDS), a standardized assessment tool, dated 2/7/21, indicated the resident was able to understand others and make herself understood, and required supervision from staff in performing activities of daily living. Resident 16 had a BIMS (Brief Interview for Mental Status -a screening used to assist with identifying a resident's current cognition and to help determine if any interventions need to occur) score of 15. The MDS also indicated the resident was cognitively (mental) intact. The MDS under section O for special treatments procedures and programs indicated Resident 16 did not reciceive oxygen therapy within the last 14 days while the rsident was in the facility. The box for oxygen therapy was left blank. A review of Resident 16's clinical records indicated a physician's telephone order dated 4/23/21, to discontinue albuterol inhaler. Another physician's order dated 2/10/20, indicated, May have oxygen (O2) 2 L (liters) nasal canula (n/c) prn (as needed) for SOB (shortness of breath) During a concurrent observation and interview on 5/17/21, at 9:30 am, an oxygen concentrator with nasal canula tubing attached was stored next to the head of the bed. Resident 16 stated that she uses the O2 when she needed it without informing the nursing staff. When asked how she was able to operate the oxygen concentrator, Resident 16 stated that she usually just turn on the knob to 2. During an interview with LVN 2 on 5/17/21, at 10 am, she stated that she was not aware that resident 16 can apply her own O2. The MAR was reviewed and there was no documentation that O2 was used. Cross reference to F655 and F695

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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** 30258 Based on interview and record review, the facility staff failed to accurately document the Pre-Admission Screening And Resident Review (PASARR- federal requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are not inappropriately placed in nursing homes for long term care) for one of 37 sampled residents (Resident 19). This failure had the potential for Resident 19 not to be screened or receive services related to mental illness. Findings: A review of Resident 19's admission face sheet indicated the resident was admitted to the facility on [DATE] with diagnoses that included anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety/fear strong enough to interfere with one's daily activities) and unspecified psychosis (severe mental disorder in which thought and emotions are so impaired that contact is lost with external reality) not due to a substance or known physiological condition and schizoaffective disorder (a mental condition that causes both a loss of contact with reality (psychosis) and mood problems) unspecified. A review of Resident 19's PASRR Level 1 Screening Document, dated 5/9/2021, indicated under Section V-Mental Illness: Does the resident have a diagnosed mental disorder such as Schizophrenia/Schizoaffective Disorder, Psychotic/Psychosis, Delusional, Depression, Mood Disorder, Bipolar, or Panic/Anxiety, the answer was marked No. During an interview on 5/21/2021 at 2:25 pm, the Minimum Data Set Coordinator 2 (MDS 2) stated the question on the PASRR Level 1 Screening Document pertaining to Resident 19's diagnoses was answered incorrectly. According to MDS 2, the admitting nurse is responsible for completing the PASRR and should have the resident's history and physical, active diagnoses and list of medications available in order to complete the screening. MDS 2 stated if the question had been answered correctly, Resident 19 may have had further screening (Level 2) by Mental Health and possibly offered additional services if needed. A review of the facility's policy titled Pre-Admission Screening Resident Review (PASRR) revised 7/2018, indicated the purpose of the policy is to ensure that all facility applicants are screened or mental illness and intellectual disability or a related condition prior to admission. The facility MDS Coordinator will be responsible to access and ensure updates to the PASRR is done per MDS guidelines.

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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** 28074 Based on observation, interview and record review, the facility failed to establish care areas into the comprehensive care plan for 4 of 37 sampled residents (Residents 106, 148, 259, and 103) 1. For Resident 106, there was no care plan for the use of Ambien (medication for sleep). This deficient practice placed Resident 106 at risk for staff not to provide specific care to the resident while using Ambien. 2. For Resident 148, there was no care plan for Eliquis (medication to prevent blood clot formation). This deficient practice placed Resident 148 at risk for staff not to provide specific care to the resident while using Eliquis. 3. For Resident 259, a newly admitted resident, the facility failed to ensure a care plan was initiated in a timely manner, regarding the use of urinary catheter (a tube placed in the body to drain and collect urine from the bladder). This deficient practice placed Resident 259 at risk for not receiving the appropriate care and treatment and potentially result in bladder infection. 4. For Resident 103, there was no comprehensive care plan developed to address the resident's brain implant (a piece of tissue, prosthetic device, or other object implanted in the brain) for tremors (an involuntary quivering movement). This deficient practice placed Resident 103 at risk of adverse (harmful) consequences if the medical team was unaware of the implant and there were no interventions in place to ensure the resident's safety. These deficient practices had the potential for staff not to provide individualized care to Residents 106, 148, 259, and 103. Findings: 1. A review of Resident 106's Facesheet (Admission Record) indicated the resident was admitted to the facility on [DATE], with diagnoses that included paraplegia (paralysis of the legs and lower body), hypertension (high blood pressure), diabetes mellitus (high sugar content in the blood) and schizophrenia (serious mental illness that affects how a person thinks, feels, and behaves). A review of Resident 106's Minimum Data Set (MDS), a standardized assessment tool, dated 3/26/2021, indicated the resident was able to understand others and make himself understood and required supervision from staff in performing activities of daily living. The MDS also indicated Resident 106 had intact cognition (process of acquiring knowledge and understanding). A review of Resident 106's clinical record indicated a physician's order dated 5/7/2021, for staff to administer Ambien 5 milligrams (mg- unit of measurement) every hour of sleep (qhs) for inability to sleep for 30 days. (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 concurrent record review and interview with Licensed Vocational Nurse 2 (LVN 2) on 5/18/2021, at 10 am, she stated there was no care plan developed to address Resident 106's use of Ambien, including monitoring of effectiveness and side effects of the medication. 2. A review of Resident 148's Facesheet indicated the resident was admitted to the facility on [DATE], with diagnosis that included chronic obstructed pulmonary disease (COPD- type of obstructive lung disease characterized by long-term poor airflow), diabetes mellitus, end stage renal disease (medical condition in which a person's kidneys cease functioning on a permanent basis and dependence on renal dialysis (treatment for kidney failure that removes unwanted toxins, waste products and excess fluids by filtering the blood). A review of Resident 148's Minimum Data Set (MDS), a standardized assessment tool, dated 4/19/2021, indicated the resident was able to understand others and make himself understood and required supervision from staff in performing activities of daily living. A review of Resident 148's clinical record indicated a physician's order dated 8/14/2020, for staff to administer Eliquis 2.5 milligrams (mg) one tablet by mouth twice (2 x) a day for deep vein thrombosis (DVT or blood clot). During a concurrent interview and record review with LVN 1 on 5/19/2021, at 2:30 pm, she stated there should have been a care plan for Resident 148 to address the possible side effects of the Eliquis. 3. A review of Resident 259's Facesheet indicated the resident was admitted to the facility on [DATE], with diagnosis that included benign prostatic hyperplasia (a condition in men in which the prostate gland is enlarged but not cancerous), pneumonia (infection of the lungs), alcohol abuse and unspecified protein-calorie malnutrition (not enough intake of food rich in important nutrients). There was no MDS (minimum data set) assessment completed at the time of the recertification survey. During an observation on 5/17/2021, at 10 am, Resident 259 was lying in bed with urinary catheter and the catheter drainage bag was hung on the side of the bed. During a concurrent interview, Resident 259 stated, the tube is needed because I am unable to pass urine on my own. A review of Resident 259's clinical record indicated there was no care plan developed to address the use of urinary catheter. During an interview with LVN 1 on 5/18/2021, at 2:20 pm, she stated there was no care plan developed for Resident 259's use of a urinary catheter. LVN 1 stated, a care plan is important for the staff to be aware of the care and services needed to provide for the resident's specific needs. 37897 4. A review of Resident 103's Facesheet indicated the resident was admitted to the facility on [DATE], with diagnoses that included schizophrenia (mental disorder characterized by abnormal social behavior and failure to understand what is real) and personal history of traumatic brain injury (a form of acquired brain injury when a sudden trauma causes damage to the brain). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 103's Minimum Data Set (MDS- standardized assessment and care screening tool), dated 4/16/2021, indicated the resident had mild cognitive impairment (mental action or process of acquiring knowledge and understanding) for daily decision making, with short and long term memory problems. Resident 103 required supervision with one person physical assist for bed mobility, transfer and walking in the room. During an observation on 5/17/2021 at 10:30 am, Resident 103 stated he has an implant in his brain that was surgically placed to help relieve tremors . Resident 103 stated the implant required to be charged and he had not charged it since he was admitted at the facility. During a telephone interview with Resident 103's Nurse Practitioner (NP) on 5/20/2021 at 11:27 am, the NP stated she was not aware Resident 103 had a brain implant for tremors. The NP stated she examined Resident 103 on 4/11/2021 and she failed to assess Resident 103 for the implant. NP stated it is important to document the implant in the resident's medical record so that there will be a follow up. During an observation and concurrent interview of Resident 103 with the Minimum Data Set Nurse 1 (MDS 1) on 5/20/2021 at 11:30 am, Resident 103 stated he did not have the charger for the implant at the facility, he had it at home and his home was very far from the facility. Resident 103 stated he notified the staff about his charger but could not state the name of the nurse he had informed about it. Resident 103 stated he was waiting to schedule an appointment with a neurologist (medical doctor with specialized training in diagnosing, treating, and managing disorders of the brain) to have the implant assessed. During a concurrent observation with MDS 1, Resident 103 lifted up his shirt and a raised square shaped could be seen under the resident's skin on the chest and a scar was observed right above it. During an interview with Licensed Vocational Nurse 4 (LVN 4) on 5/20/2021 at 11:35 am, he stated Resident 103 mentioned to him about an implant so he texted the resident's doctor about it but did not receive any response from the physician. LVN 4 stated he did not document the incident in the nurses notes. During an interview on 5/20/2021 at 12 pm, MDS 1 stated if a resident has an implant in their body, a care plan should be developed to address it. MDS 1 stated the care plan should indicate the type of implant, when it should be charged and the date the resident will be seen by the specialist doctor. MDS 1 stated for a resident with tremors, there should be a care plan intervention to make sure the resident's needs are addressed. A review of Resident 103's clinical record did not indicate that a care plan was developed to address brain implant for tremors. A review of the Facility's Policy and Procedures titled Comprehensive Person-Centered Care Planning revised November 2018, indicated the baseline care plan must include minimum healthcare information necessary to properly care for each resident immediately upon their admission. It should address resident specific health and safety concerns to prevent decline or injury.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30258 Based on interview and record review the facility failed to provide assistance with activities of daily living (ADL's) for one of 37 sampled residents (Resident 139). This failure had the potential for Resident 139 not to receive necessary care and services needed. Findings: A review of Resident 139's Facesheet indicated the resident was admitted to the facility on [DATE] with diagnoses that included muscle weakness and lack of coordination. A review of Resident 139's Minimum Data Set (MDS, a comprehensive standardized assessment and care screening tool) dated 4/16/2021 indicated the resident was able to make herself understood, able to understand others and intact cognition (process of acquiring knowledge and understanding). The MDS indicated Resident 139 required extensive assistance from staff with one person physical assist for activities of daily living (ADL's) including dressing, eating, toileting and personal hygiene. A review of Resident 139's Care Plan dated 10/18/2020 indicated the resident requires assistance with ADL's and nursing interventions included to encourage exercises during daily care and maintain a consistent schedule with a daily routine. During an interview on 5/18/2021 at 8:08 am, Resident 139 stated she needed assistance from staff with ADL's especially with toileting. According to Resident 139 she often asks for assistance to get to the restroom and is often left waiting which ended up causing her discomfort and sometimes pain. Resident 139 stated she was left by staff sitting on the toilet and had to yell for help several times because she could not get up on her own. During an interview on 5/18/2021 at 3:32 pm, Certified Nursing Assistant 6 (CNA 6) stated Resident 139 was alert and can do things for herself but was unsteady when ambulating and required assistance from staff getting out of bed. CNA 6 stated, residents requiring assistance should be attended to as soon as possible. During an observation on 5/19/2021 at 10:27 am, Resident 139 asked Licensed Vocational Nurse 3 (LVN 3) for assistance to the restroom. LVN 3 asked a CNA to assist the resident. The CNA stated she was on her way to assist another resident and would return when she was done. LVN 3 stated to Resident 139 that she would assist her to the restroom herself after she completed administering medications to her. Resident 139 stated, OK, because I really need to go. LVN 3 administered medications to Resident 139 on 5/19/2021 at 10:27 am and proceeded to prepare medications for the next resident in Bed B and administered the medications on 5/19/2021 at 10:39 am without assisting Resident 139 to the restroom. LVN 3 completed giving medication to the resident in Bed B on 5/19/2021 at 11:06 am. During an interview on 5/19/2021 at 2:37 pm, LVN 3 stated all staff are responsible for assisting residents, when needed, in a timely manner.

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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** 30258 Based on observation, interview and record review, the facility staff failed to follow physician's orders for three of 37 sampled residents (Residents 10, 57, and 85). 1. For Resident 10, the facility staff failed to follow physician's order to check the residents's respiratory rate (number of breaths in a minute) and apical pulse (point of maximal impulse and is located at the apex [the base] of the heart) as ordered. 2. For Resident 57, the facility staff failed to follow physician's order to pad the resident's bed side rails. 3. For Resident 85, the facility staff failed to follow physician's orders to pad the resident's bed side rails. These failures had the potential to result in harm or injury to Residents 10, 57 and 85. Findings: 1. A review of Resident 10's Facesheet indicated Resident 10 was admitted to the facility on [DATE] with diagnoses that included congestive heart failure (a chronic condition in which the heart cannot pump blood as it should) and presence of implanted pacemaker (device that is placed under the skin in the chest to help control one's heartbeat). A review of Resident 10's Minimum Data Set (MDS, a comprehensive standardized assessment and care screening tool) dated 5/3/2021 indicated the resident was rarely understood, rarely ever able to understand others and impaired cognition (process of acquiring knowledge and understanding). A review of Resident 10's Physician's Order dated 10/16/2019, indicated for staff to monitor apical pulse every shift and notify physician if apical pulse is less than 60 beats per minute (BPM) or greater than 100 BPM for pacemaker use. A review of another Physician's Order for Resident 10 dated 2/27/2021 indicated to monitor heart rate, temperature, respiratory rate (RR) and oxygen saturation (O2 sat) every shift. During an observation of medication administration for Resident 10 on 5/19/2021 at 10:39 am, Licensed Vocational Nurse 3 (LVN 3) failed to obtain an apical pulse for Resident 10. LVN 3 did not check Resident 10's respiratory rate. During an interview on 5/19/2021 at 2:37 pm, LVN 3 stated she did not obtain Resident 10's respiratory rate because there was no place to document it on the Medication Administration Record (MAR). LVN 3 stated she did not realize there was an order to obtain an apical pulse until after she was done with the medication administration and reviewed the MAR. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy titled Physician Orders dated 8/21/2020 indicated the licensed nurse will confirm that physician's orders are clear, complete and accurate. Whenever possible the licensed nurse receiving the order will be responsible for documenting and carrying out the order. 27785 2. A review of Resident 57's Facesheet indicated the resident was admitted to the facility on [DATE] with diagnoses that included hemiplegia (paralysis of one side of the body), epilepsy (a common condition that affects the brain and causes frequent seizures), encephalopathy (a brain disease, damage, or malfunction that affects the function or structure of the brain), and psoriasis (a skin disorder that causes skin cells to multiply up to 10 times faster than normal). A review of Resident 57's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 3/5/2021, indicated Resident 57 rarely had the ability to make self understood and understand others. The MDS indicated Resident 57 was totally dependent on staff for transfer to and from bed or wheelchair, dressing, toilet use, and personal hygiene, and has range of motion impairment on one side of resident's upper and lower extremity. The MDS indicated Resident 57 had a seizure disorder or epilepsy. A review of Resident 57's Physician's Order dated 8/31/2020 indicated an order for bilateral half (1/2) side rails to aid in turning, repositioning, bed mobility to promote highest level of function. A review of Resident 57's Physician's Order dated 8/31/2020, indicated 1/2 bilateral padded side rails to minimize injury due to seizure disorder. During an observation on 5/17/2021 at 11:51 am Resident 57 was in bed, awake, moving a lot trying to rub his back from the mattress and was scratching his side and leg. Resident 57's bed was in the lowest position and bilateral 1/2 side rails were up. The side rails were not padded. During another observation on 5/24/21 at 12:11 pm, Resident 57 was in bed asleep on a low bed with bilateral 1/2 side rails up. The side rails were not padded. During a concurrent observation and interview with Certified Assistant 9 (CNA 9) on 5/24/2021 at 12:23 pm, CNA 9 stated the bilateral 1/2 side rails of Resident 57's bed were not padded. CNA 9 stated she is from a staffing registry and is assigned to Resident 57 but did not know if the resident's side rails needed to be padded. CNA 9 stated she was not told that Resident 57's side rails needed to be padded. During an interview with Director for Staff Developer (DSD) on 5/24/2021 at 12:29 pm, DSD stated CNA 9 was from a staffing registry. DSD stated staff from registry were supposed to get resident care update from the charge nurse assigned to the resident. DSD stated it is important for Resident 57 to have padded side rails as ordered, to prevent injury because the resident had a seizure disorder. A review of the facilities Policy and Procedure titled Bed Rails, revised on 12/4/2020, under Section III. Safety, indicated the use of padded bed rails to prevent injury for resident with uncontrolled movement disorders. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	37897 3. A review of Resident 85's Facesheet indicated the resident was admitted to the facility on [DATE] with diagnoses that included schizophrenia (mental disorder characterized by abnormal social behavior and failure to understand what is real) and seizures (episodes of disturbed brain activity that cause changes in attention or behavior). A review of Resident 85's History and Physical (H&P) dated 12/9/2020, indicated Resident 85 does not have the capacity to understand and make decisions. A review of Resident 85's Minimum Data Set (MDS- standardized assessment and care screening tool), dated 3/22/21, indicated the resident was severely impaired with cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making, with short and long term memory problems. Resident 85 required extensive assistance with one person physical assist for bed mobility, transfers, walking in the room and in the corridor. Resident 85 was totally dependent with one person physical assist for eating. A review of Resident 85's Physician's Orders dated 12/9/2020, indicated padded side rails (bed rails) for seizure precautions. A review of Resident 85's Care Plan for risk for seizure disorder, dated 5/17/2021, indicated for Resident 85 not to experience serious injury if seizures occur. The care plan interventions included to maintain a safe environment for the resident. The care plan did not indicate for the resident to have padded side rails. During an observation of Resident 85 with Licensed Vocational Nurse 4 (LVN 4) on 5/17/2021 at 1:06 pm, the resident was in bed. Resident 85's left side rail was padded but the right side rail was not padded. During an interview with Certified Nurse Assistant 4 (CNA 4) on 5/21/2021 at 2:21 pm, CNA 4 stated Resident 85's side rails were not fully padded since the right side rail was not padded and the left side rail had a small pad that did not cover all the sides rail. CNA 4 stated the side rails had to be padded to prevent injuries during seizure episodes. A review of the facility's Policy and Procedure titled Physician's Orders- Medical Record Manual revised 8/21/2020, indicated the licensed nurse will confirm that physician orders are clear, complete and accurate.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42307 Based on observation, interview and record review, the facility failed to provide treatment consistent with professional standards of practice and in accordance with the facility's policy and procedure by failing to ensure the low air loss mattress (LAL, special type of mattress used for both the prevention and treatment of pressure ulcer) was set according to resident's weight for one of four sampled residents (Resident 559). This deficient practice had the potential to result in delayed healing of Resident 559's existing pressure ulcer (injury to the skin and/or underlying tissue resulting from prolonged pressure) and risk of developing new pressure ulcers. Findings: A review of Resident 559's Facesheet indicated the resident was admitted to the facility on [DATE] with diagnoses that included respiratory failure (a condition when the lungs cannot get enough oxygen into the blood) and pressure ulcer of sacral (area above the tailbone) region, unspecified stage. A review of Resident 559's Minimum Data Sheet (MDS), a resident assessment and care-screening tool, dated 5/10/2021 indicated, the resident had no impairment with cognitive skills (process of acquiring knowledge and understanding), was at risk of developing pressure ulcers/injuries, and had unhealed pressure ulcer. During an observation on 5/17/2021 at 12:54 pm and on 5/18/21 at 8:48 am, the control dial of the LAL mattress for Resident 559 was set at the SOFT level. During a concurrent interview on 5/17/2021 at 1:05 pm with Licensed Vocational Nurse 6 (LVN 6) and Registered Nurse 1 (RN1), LVN 6 stated low air loss mattress should be set according to resident's weight or closest to the resident's weight due to their pressure ulcer. RN 1 stated, Resident 559's low air loss mattress should be set up at least on the second bar. Each bar corresponds to 50 pounds and Resident 559 weighed 118 pounds. RN 1 stated it is important to set the LAL mattress accurately to prevent worsening of wound. A review of Resident 559's Face Sheet indicated the resident had an admission weight of 118 pounds taken on 5/3/2021. During an interview on 5/19/2021, at 2:15 pm with Resident 559, she stated she wanted the mattress soft, but was not informed about the importance of setting the low air loss mattress based on her weight. During a concurrent interview and record review on 5/20/2021, at 2:39 pm., RN 6 stated, there was no documented evidence that teaching about LAL mattress was provided to Resident 559. RN 6 stated it is important to teach the resident so that the resident will be more compliant. RN 6 stated since there was no documentation about teaching Resident 559 regarding the LAL mattress, it can't be verified that it was done. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility did not have the manufacture's guidelines for the use of the Low Airloss Mattress. A review of the facility's Policy and Procedure (P&P) titled, Mattresses, revised 1/1/12, indicated, alternating air mattresses are used to relieve pressure as indicated by the resident's physical condition. The P&P indicated to explain the purpose of the mattress to the resident.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 37897 Based on observation, interview, and record review, the facility failed to put measures in place to ensure safety and supervise residents who were diagnosed with dementia (a decline in mental ability severe enough to interfere with daily life) from wandering out, placing residents who reside in the locked unit (locked, secured, or alarmed units) at risk from elopement (occurs when a resident leaves the premises or a safe area without authorization) by failing to: 1. Ensure Resident 138 who was diagnosed with dementia and assessed as a high risk for elopement by the facility, did not walk out of the facility's locked unit unsupervised. 2. Implement Resident 138's plan of care who had a history of walking out of the facility, by placing a monitoring device (continuously keeps track) on the resident to monitor the resident's whereabouts. 3. Ensure CNA (Certified Nursing Assistant 2 [CNA 2]), was able to identify Resident 138, who walked out of the facility unsupervised, was a current resident residing in the facility. On 5/18/2021 at 1 pm, Resident 138 was observed walking alone outside on a main street approximately 0.2 miles (1056 feet) away from the facility. Resident 138 was unable to state name or place of residence. The resident was not wearing an identification band (ID bands, used to confirm the resident's identity or a monitoring device to track the resident's whereabouts). 4. Ensure Resident 459, who was diagnosed with dementia and was assessed by the facility as a high risk for elopement, did not walk out of the facility toward the parking lot unsupervised on 5/18/2021 at 3:12 pm. These deficient practices caused Resident 138 and Resident 459 to leave the facility unsupervised and placed the residents at risk for serious injuries or death, and had the potential for the 28 remaining residents in the locked unit to elope. Findings: A review of Resident 138's Face Sheet (admission record) indicated the facility admitted Resident 138 on 4/9/2021, with diagnoses of dementia and schizoaffective disorder (a mental illness that affects moods and thoughts, characterized by loss of contact with reality and the environment, abnormal social behavior and failure to understand what is real). A review of Resident 138's Elopement Risk Tool dated 4/9/2021, indicated Resident 138 was at risk for elopement. A review of Resident 138's Department Notes dated 4/10/2021 timed at 1:42 pm, indicated Resident 138 was confused and tried to exit the door (unspecified door). The resident stated she wanted to go home. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of Resident 138's History and Physical dated 4/11/2021, indicated Resident 138 did not have the capacity to understand and make decisions. A review of Resident 138's Department Notes dated 4/11/2021, and timed at 9:53 am, indicated a late entry from 4/10/2021, at 10 am, indicated Resident 138 was restless. The resident ran out of the facility and stood in the middle of the street. The notes indicated the staff brought the resident back to the facility. There was no evidence the facility that interventions were provided for the resident to prevent walking out of the facility from 4/11/2021 to 4/15/2021. A review of Resident 138's Minimum Data Set (MDS, standardized assessment and care screening tool), dated 4/16/2021, indicated Resident 138 was severely impaired with cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making, with short and long term memory problems. The MDS indicated Resident 138 was assessed requiring supervision with walking. A review of Resident 138's Care Plan titled Wandering: Unsafe situations, dated 4/16/2021, indicated to place a monitoring device on Resident 138 that sounded alarms when resident left the building. The care plan indicated to designate staff (unspecified) to account for the resident's whereabouts throughout the day, monitor, and document target behaviors. The care plan indicated to note which exits Resident 138 favored for elopement from the facility, and to alert staff. The care plan indicated if Resident 138 wandered away from the unit, staff were to stay with the resident, converse and gently persuade to walk back to designated area with the resident. A review of Resident 138's Physician's Telephone Orders dated 4/23/2021, at 1:30 pm, indicated an order to move the resident to the locked unit of the facility due to the resident being an elopement risk. A review of Resident 138's Department Notes dated 4/23/2021, and at 2:45 pm, indicated Resident 138 was not in her room and the resident was out of the facility's premises and was brought back by staff (unidentified). A review of Resident 138's medical record indicated no documented evidence of a care plan for the resident's monitoring device or a monitoring system of the resident's whereabouts as indicated on the resident's wandering care plan from 4/16/21-5/18/21. During an observation on 5/18/2021 at 1 pm, two surveyors observed Resident 138 walking alone outside on a main street approximately 0.2 miles from the facility. The surveyors intervened and attempted to speak to the resident. The resident was unable to identify name or place of location. On 5/18/21, at 1:14pm an observation and interview, in the street, the facility's Director of Social Services (SSD) arrived to walk with Resident 138 back to the facility. Resident 138 recognized SSD, and stated, She is my friend and I know she will make sure I am safe. While walking back to the facility's premises with Resident 138, the SSD confirmed Resident 138 was not wearing a monitoring device and did not have an ID band. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 5/18/2021 at 1:36 pm, Certified Nursing Assistant 2 (CNA 2) stated she observed Resident 138 in the facility's parking lot on 5/18/2021 before 1 pm. CNA 2 stated she asked Resident 138 if she was a resident of the facility but Resident 138 waved at her and left. CNA 2 stated did not know Resident 138 was a resident from the facility and did not know the resident was at risk for elopement. CNA 2 stated she should have called for help immediately but that she did not call for help. During an interview on 5/18/21 at1:48 pm, Licensed Vocational Nurse 4 (LVN 4) stated he worked in the locked unit and stated he was the only licensed nurse working in the unit. It was impossible to monitor all the residents including Resident 138 in the locked unit. LVN 4 stated that he did not check if all the residents, including Resident 138 wore an ID band on 5/18/2021 because he was busy administering medications to all 29 residents in the locked unit. LVN 4 stated he did not know who was responsible for checking if residents wore an ID band. LVN 4 stated on 5/18/2021 before 1 pm, he did not have time to monitor the exit doors. LVN 4 stated that staff in Station 3 did not know Resident 138 had eloped until the facility called a code green, which was a code that a resident had eloped from the facility. During an interview on 5/18/021 at 2:46 pm, CNA 3 stated that on 5/18/2021 during lunch time (before 1pm), medical records staff 1 (MR 1) asked her to open the emergency door located in the locked unit for her. CNA 3 stated the emergency door was not to be used as an entrance, and should be used for emergencies only but because MR 1 asked her to open the door for her, she opened it and let her in. CNA 3 stated that there was no alarm on that door, once a code was entered, this emergency door lead to the parking lot. During an interview on 5/20/2021 at 3:08 pm, DON stated the locked unit was a secured unit to prevent the 29 residents from getting out of the unit unsupervised and prevent them from getting injured outside the facility. DON stated residents in the locked unit such as Resident 138, required close supervision to ensure that they did not injured themselves and ensure their safety. 42914 A review of Resident 459's Face Sheet indicated the facility admitted Resident 459 on 5/6/2021 with diagnoses of dementia and anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). A review of Resident 459's Department Notes dated 5/6/2021 indicated the resident was at risk for wandering and had exhibited elopement tendency during the resident's stay at the facility. During observation on 5/18/2021 at 3:12 pm in the facility's yellow zone (area where residents with symptomatic or suspected with Corona Virus 19 [COVID-19], a respiratory illness that can spread from person to person] are placed for quarantine) Resident 459 was observed walking down the hallway leaving the yellow zone through the entrance/exit door of the facility and walking toward the back parking lot of the facility. There were no staff seen with the resident as the resident exited the building. A surveyor observed the resident leaving the yellow zone walking towards the parking lot. The surveyor intervened and alerted the staff to the incident. Two staff (unidentified) responded after being told by the surveyor that the resident had walked out of the building who was heading towards the back-parking lot. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 5/18/2021 at 3:18 pm, LVN 1 stated Resident 459 had the tendency to elope requiring a one-to-one supervision (supervise at all times). LVN 1 stated Resident 459 attempted to elope the facility three or four times on 5/18/2021. LVN 1 stated she did not notice Resident 459 eloped through the exit door in the yellow zone because it did not alarm and stated staff (unidentified) forgot to enter the code on the way out so it didn't alarm when the resident walked out. During an interview on 5/18/21 at 3:20 pm LVN 7 stated she did not see the resident walk out of the yellow zone until the surveyor informed her the resident eloped the facility. During an observation on 5/18/2021 at 6:15 pm and an interview LVN 1 stated Resident 459 did not have an ID band. A review of the facility's policy and procedure titled Elopement Risk Reduction Approaches, with a revised date of November 2012, indicated to establish a resident identification file and to accompany wandering residents on their journeys when supervision was required to ensure safety or encourage a meaningful alternate activity. A review of the Facility's Policy and Procedures titled: Wandering and Elopement, with a revised date of July 2017, indicated that if facility staff observed a resident leaving the premises without having followed proper procedures, the staff could try to prevent the departure in a courteous manner, get help from other facility staff in the immediate vicinity, if necessary; if the resident exited the facility despite efforts to stop the resident, a staff member would accompany or follow the resident to ensure the resident's safety until assistance arrived. A review of the Facility's Policy and Procedures titled: Elopement Risk Reduction Approaches, with a revised date of November 2012, indicated to ensure the residents were monitored and remain safe, account for each resident on a regular basis, establish a resident identification file with recent photographs and former addresses, plan to provide searches with a description of clothing worn and other relevant information. The policy indicated the facility staff needed to know the consequences of unsafe wandering, the protocols to follow to minimize successful exiting and the procedures to follow when a resident is lost.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 38108 Based on observation, interview, and record review, the facility failed to ensure 3 of 5 sampled residents (Resident 8, 259, and 106) with an indwelling urinary catheter (a flexible tube inserted into the bladder to provide continuous urinary drainage to a collection bag) received appropriate treatments and services by: 1. For Resident 8, the facility failed to assess and document evidence for the presence of sediment (cells, debris and other solid matter) in the urine. 2. For Resident 106, the facility failed to secure the urinary catheter device to prevent accidental pulling or dislodgement that can cause pain. 3. For Resident 259, the facility failed to obtain a physician's order for the urinary catheter; failure to measure the urinary output in volume. Accurate urine output measurement essential in evaluating both fluid status and renal perfusion (flow of the urine). These deficient practices had the potential to result in catheter related complications such as a urinary tract infections (UTI, an infection in any part of the kidneys, bladder or urethra) or worsening of an existing UTI. Findings: 1. A review of Resident 8's Face Sheet indicated the facility admitted the resident on 4/26/2020 with diagnoses of overactive bladder (a problem with bladder function that causes the sudden need to urinate). A review of Resident 8's Minimum Data Set (MDS, a standardize assessment and care screening tool), dated 5/1/2021, indicated Resident 8 had unclear speech (slurred/mumbled), sometimes understood (ability is limited to making requests) and had the ability to sometimes understood others and required extensive assistance with one person assist for bed mobility. A review of Resident 8's care plan Supra Pubic Catheter for the diagnosis of neuromuscular dysfunction (a problem in which a person lack bladder control) of the bladder, with a start date of 3/5/2021, indicated the goal for the resident would show no signs or symptoms of UTI. The care plan indicated the interventions included to observe for signs and symptoms of infection. During an observation on 5/17/2021 at 9:17 am, Resident 8's F/C was observed draining yellow colored urine with cloudy sediment. During an observation and interview on 5/17/2021 at 10:38 am, Licensed Vocational Nurse 7 (LVN 7) stated Resident 8's F/C had cloudy sediment. LVN 7 stated sediment present in Resident 8's urine was an indication of an infection. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and record review of Resident 8's medical record, LVN 7 stated there was no indication in the medical record the resident's physician was notified of Resident 8's cloudy urine. During an interview on 5/21/2021 at 1:31 pm, Registered Nurse 4 (RN 4) stated physicians needed to be informed for interventions to stop and protect the resident from a possible infection. A review of the facility's policy and procedure titled Catheter- Care of, with a revised date on 1/1/2012, indicated to assess urinary drainage for signs and symptoms of infection, noting cloudiness, color, sediment, blood or odor and amount of urine and to inform he attending physician of any signs and symptoms of infection for clinical interventions. 28074 2. A review of Resident 106's Face Sheet indicated the facility admitted the resident on 7/1/2020, with diagnoses of paraplegia (paralysis of the legs and lower body), hypertension (high blood pressure), diabetes mellitus (high sugar content in the blood) and schizophrenia (serious mental illness that affects how a person thinks, feels, and behaves). During an observation on 5/17/2021 at 10:30 am, Resident 106 was awake lying in bed with a urinary catheter connected to a urine collection bag with yellow colored urine and the urinary catheter tube was unsecured. A review of Resident 106's MDS dated [DATE], indicated the resident was able to understand others and make herself understood, and required supervision from staff in performing activities of daily living. The MDS also indicated Resident 106 was cognitively (mental) intact. During an interview on 5/19/2021 at 10 am, Licensed Vocational Nurse 3 (LVN 3), stated the resident's urinary catheter should have been anchored (clipped) securely to the resident's upper leg or abdomen to ensure proper positioning of the catheter inside the bladder for proper drainage of urine and to prevent accidental dislodgement. A review of Resident 259's Face Sheet indicated the facility admitted the resident on 5/8/2021 with diagnoses of benign prostatic hyperplasia (a condition in men in which the prostate gland is enlarged and not cancerous), pneumonia (infection of the lungs), alcohol abuse and unspecified protein-calorie malnutrition (not enough intake of food rich in important nutrients). A review of Resident 259's clinical record indicated there was no physician's order for the urinary catheter. During the initial tour observation and interview on 5/17/2021 at 10 am, Resident 259 was lying in bed with a urinary catheter hung on the side of the bed and the resident stated the tube is needed because I am unable to pass urine on my own. A review of the facility's Care of Catheter policy and procedure, with a revised date of 1/1/2012, indicated the Attending Physician would conduct a comprehensive assessment that addressed the factors that predispose the resident to the development of urinary incontinence and the need for an indwelling (urinary) catheter.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 28074 Based on observation, interview and record review, the facility failed to perform nutritional evaluation one of 5 sampled residents (Resident 259). For Resident 259, the facility failed to assess Resident 259's height and weight and possible nutritional problems related to the diseases and conditions. The facility also failed to perform an initial dietary evaluation that included food preferences upon the resident's admission to the facility These deficient practices had the potential of not meeting Resident 259's nutritional needs. Findings: A review of Resident 259's Face Sheet indicated the facility admitted the resident on5/8/2021, with diagnoses of benign prostatic hyperplasia (a condition in men in which the prostate gland is enlarged and not cancerous), pneumonia (infection of the lungs), alcohol abuse and unspecified protein-calorie malnutrition (not enough intake of food rich in important nutrients). A review of Resident 259's physicians order dated 5/8/2021, indicated to provide regular diet with thin liquids. A review of Resident 259's nursing admission assessment, height and weight were not included in the assessment. Further review of Resident 259's clinical records indicated there was no dietary assessment for the resident's food preferences. During a dining observation on 5/17/2021 at 12 pm, Resident 259's meal tray had a diet card (diet information that contained the type of diet as prescribed by a doctor to aid the patient in healing or with discomfort during digestion or swallowing) that indicated regular diet, thin liquids (examples are water, coffee, milk, soda, broth, and soup). During a concurrent interview, Resident 259, stated that the food was ok, and preferred not to answer any further questions. During an interview on 5/18/2021 at 10 am, the dietary supervisor (DS) stated Resident 259's height and weights should have been recorded by the nursing staff and stated the resident's food preferences should have been done 72 hours after admission. A review of the facility's Nutritional Assessment policy and procedure, with a revised date of 8/20, indicated a registered dietitian would complete a nutritional assessment, initiated by Dietary Manager upon admission for Residents. A review of the facility's Resident Preference Interview policy and procedure, dated 4/1/14, indicated the Dietary Manager or designee would meet with the resident within 72 hours of admission.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27785 Based on observation, interview, and record review, the facility failed to ensure two of 4 sampled residents (Resident 137 and 559) receiving enteral tube feeding (nutrition taken through the mouth or through a tube that goes directly to the stomach or small intestine) received appropriate care and services. 1. For Resident 137, the facility failed to ensure the resident received the total dose of feeding formula ordered by the physician. 2. For Resident 559, the facility failed to ensure the feeding formula and tubing were changed every 24-48 hours in accordance with the physician's order and facility's policy and procedures. These deficient practices had the potential to result in complications of the enteral feeding such as infection and inadequate nutrition. Findings: 1.A review of Resident 137's Face Sheet (admission record) indicated the facility admitted Resident 137 on 8/25/2020 with diagnoses of Emphysema (a condition in which the air sacs of the lungs are damaged and enlarged, causing breathlessness), generalized muscle weakness, and Gastro-Esophageal Reflux (when stomach acid frequently flows back into the esophagus [a tube connecting the mouth and stomach]). A review of Resident 137's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 4/13/2021, indicated Resident 137 sometimes had the ability to make self-understood and understand others. The MDS indicated Resident 137 required extensive assistance from staff for bed mobility, transfer to and from bed, chair, or wheelchair, and total dependence on staff for dressing, eating toilet use and personal hygiene. The MDS indicated Resident 137 had a feeding tube and did not have any weight loss. A review of Resident 137's physician orders dated 8/25/2020, for the resident to receive Jevity 1.2 (an enteral feeding formula) to run at 65 cubic centimeter per hour (cc/hr), for 18 hours (hr) via Gastric Tube (GT, a tube that goes directly to the stomach or small intestine used administer nutrition and/or medications) to provide 1170 milliliters (ml)/1404 kilocalorie (kcal) in 24 hours. The order indicated to start the feeding pump (a device used to deliver the feeding formula through the GT) at 2 pm and run until 8 am or until dose limit is met. A review of Resident 137's care plan for Nutritional Status, dated 4/1/2021, indicated a goal for the resident to have no significant weight changes in 90 days and the interventions listed on the plan of care were to provide enteral feeding to resident as ordered. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observation and concurrent interview on 5/20/2021 at 11:10 am, Licensed Vocational Nurse 8 (LVN 8), stated Resident 137 was in bed sleeping and the resident's feeding pump was turned off. LVN 8 stated the feeding would start at 2 pm and would be off at 8 am. LVN 8 stated the total formula amount infused was 1115 cc and it was turned off at 8 am. LVN stated she was not sure what the total dose ordered was. During an interview on 5/20/2021 at 4:19 pm, the facility's Director of Nursing (DON) stated Resident 137's feeding pump should be off when the total dose ordered was met even if it was after or before 8 am. 42307 2. A review of Resident 559's Face Sheet indicated, the facility admitted Resident 559 was admitted on [DATE] with diagnoses of Respiratory Failure (a serious condition that develops when the lungs can't get enough oxygen into the blood), and Gastrostomy (GT, an opening into the stomach from the abdominal wall, made surgically for the introduction of food) status. During a review of Resident 559's Physician Orders dated May 2021, indicated, to change the GT feeding administration set every 24 hours. During an observation on 5/18/2021, at 8:48 am, Resident 559's feeding bag that was infusing had a label dated 5/15/2021, with a time of 2 pm. During an interview on 5/18/2021 at 1:02 pm, with LVN 5 stated, Resident 559's tube feeding bag should be replaced after two days (48 hours) after opening. During an interview on 5/18/2021, at 1:10 pm, with Registered Nurse 1 (RN 1) stated Resident 559's tube feeding bag should be changed at least 24 hours. A review of the facility's policy and procedure (P&P) titled, Enteral Feeding-Closed, with a revised date of 1/1/2012, indicated the formula may hang for 24-48 hours, depending on manufacturer guidelines. The P&P further indicated to change the feeding formula and tubing every 24-48 hours or as required by manufacturer guidelines.

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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** 28074 Based on observation, interview, and record review, the facility failed to ensure two of two sampled residents (Resident 16 and 70) received appropriate respiratory care services. 1. For Resident 16, the facility failed to document the resident's respiratory status that included assessment and treatment prior to discontinuing albuterol (medication used to prevent and treat difficulty breathing, wheezing, shortness of breath, coughing, and chest tightness caused by lung diseases such as asthma and other lung and airway diseases). 2. For Resident 70, the facility failed to ensure the oxygen tubbing was labeled. These deficient practices had the potential to result in an ineffective respiratory treatment, respiratory distress and decline in resident's health condition. Findings: 1. A review of Resident 16's Face Sheet indicated the facility admitted the resident to the facility on [DATE], with diagnoses of diabetes mellitus (high sugar content in the blood), chronic obstructed pulmonary disease (COPD-is an ongoing, progressive disease of the lower respiratory tract in the lungs creating difficulty with breathing that slowly gets worse over time) and hypertension (high blood pressure). A review of Resident 16's Minimum Data Set (MDS, a standardized assessment tool), dated 2/7/2021, indicated the resident was able to understand others and make herself understood, and required supervision from staff in performing activities of daily living. A review of Resident 16's physician's telephone order dated 4/23/2021, indicated to discontinue the albuterol inhaler. During an initial tour observation and interview on 5/17/2021 at 9:30 am, Resident 16 was lying in bed and stated she was using the albuterol when she had shortness of breath (SOB) and the inhaler was not labeled with the drug name, resident's name, expiration date and direction on how to administer the medication. Resident 16 stated that the inhaler was her own supply and could not state where she got it from. During an interview on 6/18/2021 at 10 am, Licensed Vocational Nurse 2 (LVN 2) stated Resident 16's Medication Administration Record (MAR) indicated Resident 16 did not have any albuterol order. During an interview on 5/19/2021 at 10 am, with LVN 3 stated Resident 16's albuterol was discontinued on 4/23/2021 and no respiratory assessment. 36290 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. A review of Resident 70's Face Sheet indicated the facility admitted Resident 70 to the facility on [DATE] with diagnoses of respiratory failure, epilepsy (neurological disorder marked by sudden recurrent episodes of sensory disturbance, loss of consciousness, or convulsions, associated with abnormal electrical activity in the brain), and dysphagia (difficulty swallowing). A review of Resident 70's physician order dated 3/8/21 indicates oxygen 4 liters via nasal cannula (oxygen tubbing) as needed for shortness of breath. A review of Resident 70's MDS dated [DATE] indicated Resident 70 was nonverbal and rarely/never understood and rarely/never was understood by others. During an observation on 5/17/2021 at 9:46 am, Resident 70 was lying in bed asleep and oxygen was on via nasal cannula (flexible plastic tubing used to deliver oxygen through nostrils and the tubing is fitted over the patient's ears), the oxygen tubbing was not labeled. During an observation and interview on 5/19/2021 at 8:03 am, the facility's Infection Preventionist (IP, nurse who helps prevent and identify the spread of infectious agents like bacteria and viruses in a healthcare environment), stated Resident 70's oxygen tubbing was not labeled and stated the oxygen tubbing should be labeled and dated. A review of the facility's Oxygen Therapy policy and procedure with a revised date of November 2017 indicated oxygen tubing, mask, and cannulas would be changed no more than every seven days and as needed and would be dated each time they were changed.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 37897 Based on observation, interview, and record review, the facility failed to ensure one of 37 sampled residents (Resident 85) was assessed for bed rails (are adjustable metal or rigid plastic bars that attach to the bed) entrapment (is an event in which a resident is caught, trapped, or entangled in the space in or about the bed rail). This deficient practice resulted in Resident 85 getting her left leg caught in the bed rails and had the potential for injury and death. Findings: A review of Resident 85's Face sheet (Admission Record) indicated the facility admitted the resident on 12/8/2020 with diagnoses of schizophrenia (Schizophrenia is a serious mental illness that affects how a person thinks, feels, and behave, is characterized by delusions, unusual thoughts or beliefs, hallucinations, hearing, seeing, smelling or feeling things that aren't there) and seizures (a burst of uncontrolled electrical activity between brain cells that causes temporary abnormalities in muscle tone or movements (stiffness, twitching or limpness). A review of Resident 85's History and Physical (H&P) dated 12/9/2020, indicated Resident 85 did not have the capacity to understand and make decisions. A review of Resident 85's Physicians Orders dated 12/9/2020, indicated for Resident 85 to have padded side rails (bed rails) for seizure precautions. A review of Resident 85's Minimum Data Set (MDS, a comprehensive standardized assessment and care screening tool), dated 3/22/2021, indicated Resident 85 was severely impaired with cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making, with short and long term memory problems. The MDS indicated Resident 85 required extensive assistance with one person physical assist for bed mobility, transfers- how the resident moves between surfaces including to and from bed, chair, standing position), walking in the room and in the corridor and was total dependent with one person physical assist for eating. A review of Resident 85's Side Rail Evaluation, dated 3/22/2021, indicated that prior to side rails being placed on the bed, mattress and side rails must meet Federal Drug Administration (FDA) measurement standards to reduce the risk of entrapment which may cause serious injury death. The Side Rail Evaluation Form indicated the risks/benefits of side rails had not been explained to the resident/surrogate which included the risk of entrapment from the side rails which may result in the possibility of serious injury including death. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 5/17/2021 at 1:06 pm, Licensed Vocational Nurse 4 (LVN 4) stated Resident 85 was lying in bed with her body across the bed her head close to the right side bed rails. During the concurrent observation, the resident attempted to get up and was nonverbal, the resident's left side rail was padded, the right side rail was not padded, was loose from the lower side. LVN 4 stated the resident's right side rail was broken and that it could be a risk for accidents for Resident 85 and entrapment. During an observation and concurrent interview on 5/19/21 at 9:51 am, Certified Nursing Assistant 4 (CNA 4), stated Resident 85 was restless in bed. CNA 4 observed supporting Resident 85's head with her hands to prevent the resident from injuring her head on the wall. CNA 4 stated that she had other residents to monitor but that if she left Resident 85 alone, the resident could have an accident. During an observation and interview on 5/24/2021 at 12:55 pm, Registered Nurse 2 (RN 2) stated Resident 85 was sitting up in bed with her left lower leg caught between the unpadded left bed rails, the resident had an open skin with red discoloration on the left shin. RN 2 started assisting the resident as surveyor called for help. Two non-licensed staff and one licensed staff came in the room to assist releasing Resident 85's leg from the bed rail. During an interview and a review of Resident 85's medical record on 5/24/2021 at 2:05 pm, the Medical Record Director (MRD) stated a care plan for the use of bed rails was not developed for Resident 85. During an interview and concurrent review of Resident 85's medical record on 5/24/2021 at 2:24 pm, MRD stated that there was no bed rail risk screen on file for Resident 85. During an interview and concurrent review of Resident 85's medical record on 5/24/2021 at 2:24 pm, RN 2 stated Resident 85's Side Rail Evaluation form did not indicate if Resident 85 was at risk of entrapment or not, and the form did not indicate if the alternatives to the use of bed rails were effective or not and that it should indicate if it was or not. During an interview on 5/24/2021 at 2:30 pm, , RN 2 stated that when Resident 85 got her leg trapped with the bed rail, the resident was restless in bed and was attempting to get out of bed and there was no nurse supervising the resident. RN 2 stated that it was important to assess the resident for bed rails entrapment to prevent injuries that could include death to Resident 85 if the resident's head was to get caught between the bed rails. A review of the Facility's Policy and Procedures titled Bed Rails, with a revised date of 12/4/2020, indicated that prior to installation of bed rails, assess the Resident's risk of entrapment with bed rails, confirmed that the bed's dimensions are appropriate for the Resident's size and weight. The policy indicated to evaluate the Resident's need for bed rails included that the licensed nurse would complete the Bed Rail Risk Screen Form upon admission, prior to the use and/or installation of any bed rail and when any mattress is replaced. The policy indicated the licensed nurse would initiate a care plan about the use of bed rails.

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. 28074 Based on observation, interview, and record review, the facility failed to obtain physician orders for the use of indwelling urinary catheter (tube inserted into the bladder to drain urine), for 1 of 5 sampled residents (Resident 259) with indwelling urinary catheters. This deficient practice had the potential for injury for Resident 259 and had the potential for unnecessary use of the catheter. Findings: A review of Resident 259's Face Sheet indicated the facility admitted the resident on 5/8/2021 with diagnoses of benign prostatic hyperplasia (a condition in men in which the prostate gland is enlarged and not cancerous), pneumonia (infection of the lungs), alcohol abuse and unspecified protein-calorie malnutrition (not enough intake of food rich in important nutrients). During a tour observation on 5/17/2021 at 10 am, Resident 259 was lying in bed with an indwelling urinary catheter hung on the side of the bed. During an interview and record review on 5/19/2021 Licensed Vocational Nurse 1 (LVN 1) stated Resident 259's physician's order did not indicate an order for the urinary catheter until 5/19/21. A review of the facility's Care of Catheter policy and procedure, with a revised date of 1/1/2012, indicated the Attending Physician would conduct a comprehensive assessment that addressed the factors that predispose the resident to the development of urinary incontinence and the need for an indwelling (urinary) catheter.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30258 Based on observation and interview the facility failed to provide adequate staff to provide necessary care and services for 5 of 37 sampled residents (Residents 64, 139, 46, 11, and 16). 1. Residents 64 and 139 stated the facility did not have enough staff to provide assistance when needed. 2. During a group meeting Residents 46, 111, and 16, stated the facility did not have sufficient staff to assist with activities of daily living (ADL's) when requested. Findings: 1. A review of Resident 64's Face Sheet indicated the facility admitted the resident on 10/23/2019 with diagnoses of quadriplegia (paralysis of all four limbs), and dependent on a ventilator (machine that blows air into the airways and lungs) for breathing. A review of Resident 64's Minimum Data Set (MDS, a comprehensive standardized assessment and care screening tool) dated 3/11/2021, indicated Resident 64 was able to make himself understood, able to understand others and cognitively intact, and was total dependent on staff with one person physical assist for activities of daily living (ADL's) including dressing, eating, toileting and personal hygiene. During an observation and interview on 5/17/2021 at 10:52 am, Resident 64 was inside his room awake and stated there was not enough staff to provide care. Resident 64 stated due to his condition he needed assistance with all ADL's but often there was only one certified nursing assistant (CNA) for all the residents in the subacute unit (unit for individuals with complex care). During a concurrent interview CNA 8 stated she needed assistance with providing care to her assigned residents (11 total residents) in the subacute unit. CNA 8 stated her residents were totally dependent and she could not provide the care they needed without help. A review of Resident 139's Face Sheet indicated the facility admitted the resident on 4/10/2021 with diagnoses of muscle weakness and lack of coordination. A review of Resident 139's MDS dated [DATE] indicated Resident 139 was able to make herself understood, able to understand others and cognitively intact. The MDS indicated Resident 139 required extensive assistance from staff with one person physical assist for ADL's including dressing, eating, toileting and personal hygiene. During an interview on 5/18/2021 at 8:08 am, Resident 139 stated she required assistance from staff with ADL's especially with toileting. Resident 139 stated she often asked for assistance to get to the restroom and was often left waiting which ended up causing discomfort and sometimes pain. Resident 139 stated she was left by staff sitting on the toilet and had to yell for help several times because she could not get up on her own. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a resident council meeting on 5/18/2021 at 10:12 am, Residents 46, 111 and 16 stated the facility did not have sufficient staff to provide ADL's when needed. Resident 46 stated the staff stated they would move him but nothing was done. Resident 111 stated call lights were an issue due to shortage of staff. Resident 16 stated her roommate had dementia (group of conditions characterized by impairment in brain functions such as memory loss or judgement) and could ask for help. Resident 16 stated she often asked staff to provide adult brief changes to her roommate and often during the late shift her roommate's adult brief would only be changed once during the shift. During an interview on 5/18/2021 at 3 pm, the Director of Staff Development (DSD), stated staffing was depending on the facility's census and the licensed nurses made adjustments to the schedule based on the resident's acuity (number of hours needed for nursing staff to care for physical and mental health needs).

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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. 42914 Based on observation, interview, and record review, the facility failed to ensure all controlled medications (generally a drug or chemical whose manufacture, possession, or use is regulated by a government, such as illicitly used drugs or prescription medications that are designated by law) were properly accounted for when several dates had no signature to verify staff had counted the controlled drugs with another staff. This deficient practice had the potential to cause a discrepancy in medication management in the facility and account for residents' medications accurately. Findings: During an observation and interview on 05/18/2021 at 11:15 am, Registered Nurse 1 (RN 1) stated the Medication cart 1 in station 4, the Narcotic Count Signature Sheet had missing signatures to verify that two staff had verified the amount of Narcotics in the medication carts were accounted for on 2/3/2021, 2/22/2021, 2/23/2021, 2/29/2021, 3/16/2021, 3/24/2021, 3/25/2021, 3/31/2021 incoming 7AM shift, 3/31/2021, 5/7/2021, and 5/12/2021. During an interview on 5/18/2021 at 12:04 pm, RN 1 stated two licensed nurses must sign to indicate all narcotics were accounted for in the Narcotic Count Sheet. RN 1 state there should be a signature for all shifts. RN 1 stated if there were missing signatures, indicated that the nurses did not count the controlled medications together. During an interview and record review on 5/18/2021 at 2:22 pm, Licensed Vocational Nurse 4 (LVN 4) stated at station 3 med cart 1 of the Narcotics Count Signature Sheet; the following dates did not have signatures: 5/5/2021, 5/9/2021, and 5/16/2021. LVN 1 stated that two signatures were needed to verify that medications have been accounted for and if there was a signature missing, it is could mean the controlled medications had not been counted or verified. During an interview and record review on 5/18/2021 at 3:43 pm, LVN 1 stated the Shift Count Narcotics Verification Form, indicated the following dates had no signatures: 5/4/2021, 5/6/2021, 5/9/2021, 5/10/2021, 5/11/2021, 5/14/2021, and 5/16/21. During an interview on 5/18/2021 at 4:33 pm, RN5 stated there should always be two signatures to verify that all narcotics were accounted for and she did not know the reason why there had been so many missing signatures. RN 5 stated the missing signatures could the licensed nurses did not count the medication. During an interview on 5/19/2021 at 11:39 am, the facility's Director of Nursing (DON), stated two licensed nurses should count the narcotics and must sing the narcotics count sheet. DON stated if there were no signatures it could indicate the licensed staff did not count the medication narcotics. The DON stated it was important to properly count the narcotics and to have a signature to ensure they are accounted for. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's undated policy and procedure titled Policy and Procedures for Pharmaceutical Services 'Controlled Drugs, it indicated that drugs with high abuse potential would be subject to special handling, storage, disposal, and record keeping through the following: PRN Controlled Drug Records were maintained at each change of shift for all Schedules (Drugs, substances, and certain chemicals used to make drugs were classified into five distinct categories or schedules depending upon the drug's acceptable medical use and the drug's abuse or dependency potential) II, III, IV, and V drugs. The policy indicated these controlled drug records were physically counted at the change of each shift (on-coming nurse to count, off-going nurse to review the records for accuracy), and the records are retained for a least one year.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28074 Based on interview, and record review, the facility failed to provide documented evidence the monthly medication review (MMR) for three of 37 residents (Resident 29, 106, and 148) was reviewed by a licensed pharmacist at least once a month This deficient practice had potential to cause adverse consequences related to the medications that could affect the resident's quality of life. Findings: a. A review of Resident 29's Face Sheet indicated the facility admitted the resident on 8/31/2018, with diagnoses of schizophrenia, respiratory failure (a serious condition that develops when the lungs can't get enough oxygen into the blood), gastrostomy (GT-a surgical operation for making an opening in the stomach for introduction of food and medication) and dependence on respirator ventilator (a breathing machine that blows air into lungs and removes carbon dioxide out of your lungs). A review of Resident 29's physician order dated 8/31/2018, indicated for the resident to receive Abilify 30 mg daily via GT for schizophrenia m/b visual hallucination as evidenced by (aeb) stating she saw ghost that want to hurt her. A review of Resident 29's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 2/16/2021, indicated the resident had short and long-term memory problems, was severely impaired in cognitive skills for daily decision-making, sometimes able to understand others and sometimes made herself understood, and required total assistance from the staff for most activities of daily living. A review of Resident 29's Monthly Psychoactive Drug Management dated from 3/1/2021 to 4/30/2021, indicated Resident 29 had various number of behavioral episodes, the comparisons between each month was unknown. During an initial tour observation on 5/17/2021, at 10 am, Resident 29 was asleep in bed and had a tracheostomy (a medical procedure that involves creating an opening in the neck to place a tube into a person's windpipe) attached to the ventilator and gastrostomy feeding. During an interview on 5/18/2021, at 10 am, Registered Nurse (RN) 1 stated Resident 29 did not exhibit any behaviors of seeing a ghost. RN 1 stated there had been no GDR attempted since Abilify was ordered. RN 1 stated the facility did not conduct an MMR for Resident 29. b. A review of Resident 106's Face Sheet indicated the facility admitted the resident on 7/1/2020, with diagnoses of paraplegia (paralysis of the legs and lower body), hypertension (high blood pressure), diabetes mellitus (high sugar content in the blood) and schizophrenia. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 106's MDS dated [DATE], indicated the resident was able to understand others and make herself understood, and required supervision from staff in performing activities of daily living. The MDS also indicated Resident 106 was cognitively (mental) intact. A review of Resident 106's Telephone Physician Orders dated 4/23/2021, indicated for the resident to receive Lexapro 20 mg one tablet by mouth every day for depression manifested by verbalization of sadness. On 5/7/21, a telephone order indicated to administer Ambien (sleeping pill) 5 mg every hour of sleep as needed (prn) for inability to sleep for 30 days. A review of Resident 106's Medication Administration Record for the Monthly Psychoactive Drug Management for Lexapro dated from 1/1/2021 to 3/31/2021, indicated a total of 23 episodes. A review of Resident 106's care plan dated 7/1/2020, indicated the resident was using Risperdal for schizoaffective disorder and one of the nursing interventions included for gradual dose reduction as indicated and referred by Behavioral Management Committee. A review of Resident 106's care plan dated 7/2/2020, did not include a nursing interventions for gradual dose reduction. A review of Resident 106's psychiatrist (specializes in mental health, including substance use disorders) notes dated 4/22/2021, indicated, per staff, stable, no increase in meds for a while. A review of Resident 106's Medication Administration Record (MAR) dated from 5/1/2021 to 5/19/2021, indicated the resident had zero (0) behaviors. During an interview on 5/18/2021 at 10 am, Licensed Vocational Nurse 2 (LVN 2) stated there had been no increase in Resident 106's behavioral episodes and the gradual dose reduction had not been attempted. LVN 2 stated that there was no MMR in the clinical records and stated both Escitalopram and Risperdal did not have a pharmacy recommendation for a gradual dose reduction. LVN 2 stated the order of Ambien exceeded the beyond 14 days, and should have documentation of rationale for the extended its extended use. c. A review of Resident 148's Face Sheet indicated the facility admitted the resident on 8/14/2020 with diagnosis of chronic obstructed pulmonary disease (COPD, an ongoing, progressive disease of the lower respiratory tract in the lungs creating difficulty with breathing that slowly gets worse over time), end stage renal disease, diabetes mellitus and dependence on renal dialysis (treatment for kidney failure that rids your body of unwanted toxins, waste products and excess fluids by filtering your blood). A review of Resident 148's physician's order dated 8/14/2020, indicated to administer Eliquis 2.5 milligrams (mg, a unit of measurement) one tablet by mouth twice a day for deep vein thrombosis (DVT, condition that occurs when a blood clot forms in a deep vein). A review of Resident 148's Minimum Data Set (MDS, a standardized assessment tool), dated 4/19/2021, indicated the resident was able to understand others and make himself understood, and required supervision from staff in performing activities of daily living. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and record review on 5/19/2021 at 2:30 pm, Licensed Vocational Nurse 1 (LVN 1), stated Resident 148's clinical record indicated there was no documented evidence Resident 148 was monitored for adverse consequences for the use of anticoagulant Eliquis. A Review of the facility's undated policy and procedure, titled Drug regimen Review, indicated, indicated thee consultant pharmacist was to provide an in-depth clinical drug regimen review on all of the center's resident at least once a month.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 28074 Based on interview, and record review the facility failed to adequately monitor signs and symptoms of bleeding for one of 37 sampled residents (Resident 148) who was taking Eliquis (medication that reduces or prevent blood from clotting) This deficient practice had the potential for Resident 1 to not receive adequate monitoring while taking Eliquis. Findings: A review of Resident 148's Face Sheet indicated the facility admitted the resident on 8/14/2020 with diagnosis of chronic obstructed pulmonary disease (COPD, an ongoing, progressive disease of the lower respiratory tract in the lungs creating difficulty with breathing that slowly gets worse over time), end stage renal disease, diabetes mellitus and dependence on renal dialysis (treatment for kidney failure that rids your body of unwanted toxins, waste products and excess fluids by filtering your blood). A review of Resident 148's physician's order dated 8/14/2020, indicated to administer Eliquis 2.5 milligrams (mg, a unit of measurement) one tablet by mouth twice a day for deep vein thrombosis (DVT, condition that occurs when a blood clot forms in a deep vein). A review of Resident 148's Minimum Data Set (MDS, a standardized assessment tool), dated 4/19/2021, indicated the resident was able to understand others and make himself understood, and required supervision from staff in performing activities of daily living. During an interview and record review on 5/19/2021 at 2:30 pm, Licensed Vocational Nurse 1 (LVN 1), stated Resident 148's clinical record indicated there was no documented evidence Resident 148 was monitored for adverse consequences for the use of anticoagulant Eliquis.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28074 Based on observation, interview and record review, the facility failed to administer psychotropic medications (any medication capable of affecting the mind, emotions, and behavior), without documented indication, attempt for Gradual Dose Reduction (GDR, is the stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued), and as ordered by the physician for three of 37 sampled residents (Residents 29, 106, and 67). 1. For Resident 29, there was no documented evidence that a GDR was attempted for the use Abilify (medication used to treat certain mental/mood disorders) 30 milligrams (mg, a unit of measurement), daily for schizophrenia (a long-term mental disorder involving a breakdown in the relation between thought, emotion, and behavior, leading to faulty perception, inappropriate actions and feelings, withdrawal from reality and personal relationships), since 8/31/2018. 2. For Resident 106, there was no adequate indication for the increase of Lexapro (antidepressant) from 10 mg to 20 mg daily for depression (a constant feeling of sadness and loss of interest), manifested by (m/b) verbalization of sadness, and there was no indication that a GDR for the use of Risperdal had been performed since 7/1/2020. 3. For Resident 67, the facility failed to follow the resident's physician orders prior to use of Seroquel (antipsychotic medication used to treat severe mental disorders). These deficient practices had the potential to result in significant adverse consequences from possible excessive doses and prolonged use of psychotropic medications. Findings: 1. A review of Resident 29's Face Sheet indicated the facility admitted the resident on 8/31/2018, with diagnoses of schizophrenia, respiratory failure (a serious condition that develops when the lungs can't get enough oxygen into the blood), gastrostomy (GT-a surgical operation for making an opening in the stomach for introduction of food and medication) and dependence on respirator ventilator (a breathing machine that blows air into lungs and removes carbon dioxide out of your lungs). A review of Resident 29's physician order dated 8/31/2018, indicated for the resident to receive Abilify 30 mg daily via GT for schizophrenia m/b visual hallucination as evidenced by (aeb) stating she saw ghost that want to hurt her. A review of Resident 29's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 2/16/2021, indicated the resident had short and long-term memory problems, was severely impaired in cognitive skills for daily decision-making, sometimes able to understand others and sometimes made herself understood, and required total assistance from the staff for most activities of daily living. (continued on next page)

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	555852	A. Building B. Wing	05/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Avenue Healthcare & Wellness Center	1550 North Park Avenue Pomona, CA 91768

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 29's Monthly Psychoactive Drug Management dated from 3/1/2021 to 4/30/2021, indicated Resident 29 had various number of behavioral episodes, the comparisons between each month was unknown. During an initial tour observation on 5/17/2021, at 10 am, Resident 29 was asleep in bed and had a tracheostomy (a medical procedure that involves creating an opening in the neck to place a tube into a person's windpipe) attached to the ventilator and gastrostomy feeding. During an interview on 5/18/2021, at 10 am, Registered Nurse (RN) 1 stated Resident 29 did not exhibit any behaviors of seeing a ghost. RN 1 stated there had been no GDR attempted since Abilify was ordered. During an interview with the certified nurse assistant (CNA) 1 on 5/20/2021, at 3:10 p.m., she stated Resident 29 did not manifest any behavioral symptoms. 2. A review of Resident 106's Face Sheet indicated the facility admitted the resident on 7/1/2020, with diagnoses of paraplegia (paralysis of the legs and lower body), hypertension (high blood pressure), diabetes mellitus (high sugar content in the blood) and schizophrenia. A review of Resident 106's MDS dated [DATE], indicated the resident was able to understand others and make herself understood, and required supervision from staff in performing activities of daily living. The MDS also indicated Resident 106 was cognitively (mental) intact. A review of Resident 106's Telephone Physician Orders dated 4/23/2021, indicated for the resident to receive Lexapro 20 mg one tablet by mouth every day for depression manifested by verbalization of sadness. A review of Resident 106's Medication Administration Record for the Monthly Psychoactive Drug Management for Lexapro dated from 1/1/2021 to 3/31/2021, indicated a total of 23 episodes. A review of Resident 106's care plan dated 7/1/2020, indicated the resident was using Risperdal for schizoaffective disorder and one of the nursing interventions included for gradual dose reduction as indicated and referred by Behavioral Management Committee. A review of Resident 106's care plan dated 7/2/2020, did not include a nursing interventions for gradual dose reduction. A review of Resident 106's psychiatrist (specializes in mental health, including substance use disorders) notes dated 4/22/2021, indicated, per staff, stable, no increase in meds for a while. A review of Resident 106's Medication Administration Record (MAR) dated from 5/1/2021 to 5/19/2021, indicated the resident had zero (0) behaviors. During an interview on 5/18/2021 at 10 am, Licensed Vocational Nurse 2 (LVN 2) stated there had been no increase in Resident 106's behavioral episodes and the gradual dose reduction had not been attempted. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Behavior/Psychoactive Drug Management policy and procedure, with a revised date of 1/16/2020, indicated any psychoactive medication ordered on as needed (PRN) basis, must be ordered not to exceed 14 days. The policy indicated if the physician felt the medication needed to be continued, he/she must document the reason/s for the continued usage, and write the order for the medication not to exceed the 14 day time frame. 37897 A review of Resident 67's Face Sheet indicated the facility admitted Resident 67 on 3/9/2020 with diagnoses included unspecified psychosis (conditions that affect the mind, where there has been some loss of contact with reality, during a period of psychosis, a person's thoughts and perceptions are disturbed and the individual may have difficulty understanding what is real and what is not, symptoms of psychosis include delusions (false beliefs) and hallucinations (seeing or hearing things that others do not see or hear) and unspecified dementia without behavioral disturbance (a mental disorder in which a person loses the ability to think, remember, learn, make decisions, and solve problems). A review of Resident 67's History and Physical dated 3/9/2021, indicated Resident 67 did not have the capacity to understand and make decisions. A review of Resident 67's MDS, dated [DATE] indicated Resident 67 was severely impaired with cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making, with short and long term memory problems and required supervision with set up help only for bed mobility, transfers, and walking. During a review of Resident 67's medical records and an interview on 5/24/2021 at 12:20 pm, Registered Nurse 2 (RN 2), stated Resident 67's physicians orders dated 12/17/2020, indicated for the resident to receive Seroquel 50 milligrams (mg) by mouth at bed time for psychosis manifested by delusion regarding her living situation, the resident believed that she lived in [NAME]. RN 2 stated Resident 67's Medical Administration Record (MAR) indicated Resident 67 received Seroquel 50 mg by mouth at 9 am and at 9 pm. RN 2 stated nurses must verify the physicians orders prior to administering medications but failed to do verify Resident 67's orders. RN 2 stated residents with diagnosis of dementia could have episodes of delusions, they could think they were at one place that they were not and the nurses had to reorient them. RN 2 stated that in his experience, residents with dementia without other psychiatric diagnosis were not automatically placed on antipsychotic medications. A review of the Facility's Policy and Procedures titled Physician's Orders- Medical Record Manual, with a revised date of 8/21/20 indicated the licensed nurses would confirm that the physician orders were clear, complete, and accurate. The facility did not provide a policy on following physician's orders. A review of the Facility's Policy and Procedures titled Behavior/psychoactive Drugs Management, with a revised November 2018, indicated psychoactive drug interventions included to ensure the dosage was appropriate for the resident and was not in excess of the suggested daily maximum dosage, unless specifically documented by the Attending Physician.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30258 Based on observation, interview, and record review the facility failed to ensure to have a medication error rate of less than five percent during medication administration. Twelve medication errors were observed out of twenty-five opportunities which resulted in a medication error rate of 48%. 1. For 4 of 4 sampled residents (Residents 82, 153, 139 and 10), medications were administered late. 2. For 1 of 4 sampled residents (Resident 10) no apical pulse (is the vibration of blood as the heart pumps can be found in the left center of the chest, just below the nipple), or respiratory rate were taken. These deficient practices had the potential to result in harm to the residents. Findings: 1. A review of the Face Sheet (admission record) indicated the facility admitted Resident 82 to the facility on [DATE] with diagnoses of epilepsy (neurological disorder marked by sudden recurrent episodes of sensory disturbance, loss of consciousness, or convulsions, associated with abnormal electrical activity in the brain), psychosis (disconnection from reality), schizoaffective disorder (a mental health condition including schizophrenia and mood disorder symptoms) dementia (a decline in mental ability), and glaucoma (a group of eye conditions that can cause blindness). A review of Resident 82's physician orders dated 9/2/2020 indicated the following medications to be administered to Resident 82: a. Namenda (medication for dementia) 10 milligrams (mg) one tablet by mouth twice a day for dementia. b. Depakene (valproic acid, medication for epilepsy) 250 mg one capsule by mouth three times day for seizure disorder. c. alphagan ophalmic (eye drops for glaucoma) 0.15% one drop on both eyes three times per day for glaucoma, wait five minutes between eye application. A review of Resident 82's physician orders dated 9/3/2020 indicated for the resident to receive risperidone (medication to treat certain types of mental illnesses) 1 mg, one tablet by mouth every morning for schizoaffective disorder manifested by rambling speech. A review of Resident 82's Medication Administration Record for the month of May 2021 indicated the following schedule for Resident 82's medication administration: a. Namenda 10 mg at 9 am and 5 pm. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Depakene 250 mg at 9 am, 1 pm, and 5 pm. c. alphagan ophalmic 0.15% one drop to each eye at 7am, 12 pm, and 5 pm. d. risperidone 1mg one tablet at 9 am. During an observation and interview on 5/17/2021 at 7:59 am, Resident 82 was in his room sitting on the edge of his bed and stated he was waiting for his medications to be administered. During a medication pass observation on 5/18/2021 at 8:18 am, Licensed Vocational Nurse 4 (LVN 4) administered: 1 capsule of Depakene 250 mg, 1 tablet of Namenda 10 mg, and one drop of alphagan ophalmic solution to the left eye. Resident 82 refused 1 tablet of risperidone mg. All medications were given by mouth. At 8:27 am, LVN 4 administered 1 drop of alphagan ophalmic solution to the left eye and Resident 82 accepted the 1 tablet risperidone During an interview on 5/20/2021 at 9:27 am, LVN 4 stated the alphagan eye drops have a scheduled administration time of 7 am, I have to give them an hour before to an hour after the scheduled time. LVN 4 stated that he administered Resident 82's medications late. A review of Resident 153's Face Sheet indicated the facility admitted Resident 153 to the facility on [DATE] with diagnoses of cerebral infarction (also known as a stroke, refers to damage to tissues in the brain due to a loss of oxygen to the area), occlusion and stenosis of right carotid artery (narrowing of a large artery), hypertension, and acute embolism and thrombus (blood clots). A review of Resident 153's physician orders dated 10/19/2020 indicated the following medications for Resident 153: a. Aspirin (medication to prevent clotting) 81 mg tablet via G-tube (gastrostomy tube, feeding tube) daily for CVA (cardiovascular accident) prophylaxis (prevention). b. Clopidogrel (Plavix, medication to prevent clotting) 75 mg one tablet via G-tube daily for CVA prophylaxis. c. Propranolol (medication to lower blood pressure) 10 mg via G-tube daily for hypertension, to hold the medication if SBP (systolic blood pressure, top number measures the force your heart exerts on the walls of your arteries each time it beats) less than 110 or a heart rate less than 60 (normal parameters 60 to 100 beats per minute). d. Lovenox (medication to prevent clotting) 0.4 milliliters (mL) to be administered subcutaneous (SQ, under the skin) every 12 hours for CVA prophylaxis, sites to be rotated. A review of Resident 153's Medication Administration Record for the month of May 2021 indicated the following schedule for Resident 153's medication administration: aspirin 81mg tablet, clopidogrel 75 mg one tablet, propranolol 10 mg, and lovenox 0.4 mL all to be administered at 9 am. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a medication pass observation on 5/18/2021 at 10:24 am, LVN 5 administered the following medications to Resident 153: aspirin 81 mg one tablet via, clopidogrel one tablet 75 mg, and propranolol one tablet 10 mg. all medications were administered via G-tube. At 10:33 am, LVN 5 administered lovenox 0. 4 mL (40 mg) SQ to the left upper quadrant of the abdomen. During an interview on 5/20/2021 at 9:24 am, the facility's Director of Nursing (DON) stated that it was the facility practice to administer medications one hour before to one hour after of scheduled time. A review of Resident 139's face sheet indicated the facility admitted Resident 139 on 4/20/2018 with diagnoses of anemia (a decrease in the total amount of red blood cells). A review of Resident 139's physician's order dated 4/21/2018 indicated to administer Aspirin 81 mg one tablet by mouth for prophylaxis stroke. Another physician's order dated 9/1/2020 indicated to administer Ferrous Sulfate 325 mg one tab by mouth daily for supplement. A review of Resident 139's Medication Administration Record (MAR), for the month of May 2021, indicated Ferrous Sulfate and Aspirin should be administered at 9 am. During a medication pass observation on 5/19/2021 at 10:27 am, LVN 3 administered Resident 139's medications. During an interview on 5/19/2021 at 10:27 am, LVN3 stated she normally did treatments but was asked to pass medications that morning. LVN 3 stated, I got held up, I'm running late. A review of Resident 10's Face Sheet indicated the facility admitted the resident on 11/13/2017 with diagnoses of congestive heart failure (a chronic condition in which the heart cannot pump blood as it should which can potentially lead to heart failure) and presence of implanted pacemaker (a small device that is placed under the skin in the chest to help control one's heartbeat). A review of Resident 10's physician's order dated 11/13/2018, indicated to administer Namenda 5 mg one tablet by mouth twice a day for dementia (group of conditions characterized by impairment of at least two brain functions such as memory loss and judgement). Another physician's order dated 5/8/2021, indicated to administer Megace 400 mg by mouth every day for one month for appetite stimulant. A review of Resident 10's MAR for the month of May 2021, indicated Namenda and Megace should be administered at 9 am. During an interview on 5/19/2021 at 10:27 am, LVN3 stated she normally did treatments but was asked to pass medications that morning. LVN 3 stated, I got held up, I'm running late. During a medication pass observation on 5/19/2021 at 10:47 am, LVN 3 administered Resident 10's medications. A review of the facility's Medication-Administration policy, dated 1/1/2012 indicated medications maybe administered one hour before or after the scheduled medication administration time. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. A review of Resident 10's Physician's Order dated 10/16/2019, indicated to monitor apical pulse every shift and notify physician if apical pulse was less than 60 beats per minute (BPM) or greater than 100 BPM. A review of another physician's order dated 2/27/2021, indicated to monitor heart rate, temperature, respiratory rate (RR) and oxygen saturation (amount of oxygen in the blood) every shift. During a medication pass observation on 5/19/2021 at 10:39 am, LVN 3 did not check Resident's apical pulse and respirations. During an interview on 5/19/2021 at 2:37 pm, LVN 3 stated she did not obtain Resident 10's respirations because there was nowhere to document it on the MAR. LVN 3 also stated she did not realize there was an order to obtain an apical pulse for Resident 10 until after she was done with the medication administration and reviewed the MAR. A review of the facility's policy, Medication-Administration, dated 1/1/2012, indicated when administration of the drug is dependent upon vital signs or testing, the vital signs/testing would be completed prior to administration of the medication and recorded in the medical record i.e. blood pressure (BP), finger stick blood glucose monitoring etc.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42914 Based on observation, interview, and record review, the facility failed to follow its Medication Storage policy and procedure by failing to: 1. Ensure Resident 111's reusable medication (eye drop) was properly labeled. 2. Ensure staff's belongings were not stored inside the medication cart. 3. Ensure to monitor the room temperatures were medications were stored. 4. Ensure Resident 67 did not have a medicine cup with six pills unlabeled and unattended on her bedside table. These deficient practices had the potential to alter the use, effectiveness, and potency of medications. Findings: 1. During an observation and interview on [DATE] at 9:12 am, Licensed Vocational Nurse (LVN 4) stated the medication cart 1 at station 1 had an unlabeled GeriCare Artificial Tears Lubricant Eye Drops that belonged to Resident 111. During an interview on [DATE] at 9:14 am, LVN 4 stated there was no open date labeled for the eye drops. LVN 4 stated that any reusable medication that was opened, such as Resident 111's eye drops should be labeled with the date it was opened because the open/reusable medications were considered expired after thirty days of the opened date. During an interview on [DATE] at 11:45 am, the facility's Director of Nursing (DON) stated medications such as eye drops that were for reuse, should be labeled with the proper date to ensure they were within the time frame of use and to ensure the medication was still effective. 2. During an observation and interview on [DATE] at 12:08 pm, Registered Nurse 1 (RN 1) stated medication cart 1 in station 4 had a staff's water bottle was stored in the medication cart. During an interview on [DATE] at 12:10 pm, RN 1 stated she knew which staff the water bottle belonged to LVN 5 and stated LVN 5 should not store personal items such as a water bottle in the medication cart. During an interview on [DATE] at 12:11 pm, LVN 5 stated he did not have a place to store his water bottle so he placed it in the medication cart but he was told not place personal items in the medication cart. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on [DATE] at 11:47 am, the DON stated staff was not supposed to store not personal items inside the medication cart and stated the medication carts were for the storage of residents' medications 3. During an observation and interview on [DATE] at 3:43 pm, LVN1 stated the refrigerator temperature log titled Medication Refrigerator Daily Temperature Record, did not have the temperature logs for the following dates [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and for [DATE]. During an interview on [DATE] at 4:38 pm RN 5 stated the temperature for the refrigerator should be logged to ensure the medications were stored at the correct temperature. During an interview on [DATE] 11:46 am, the DON stated the temperature in the refrigerator should be checked twice per day and should be logged in the temperature log. DON stated it was important to check the temperature and log it to ensure the medications that were stored in the refrigerator was stored at the proper temperature to prevent the medication from losing its potency or effectiveness. A review of the facility's policy and procedure titled Policy and Procedures for Med Pass Section IV. Medication Storage in the Facility, indicated medications and biologicals were stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier and medications requiring refrigeration, temperatures between 36 F and 46 F are kept in a refrigerator with a thermometer to allow temperature monitoring. The policy indicated outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy, if a current order exists. The policy indicated the medication storage areas were kept clean, well lit, and free of clutter and extreme temperatures. The facility's policy indicated medication storage conditions are monitored on a regular basis and corrective action taken if problems are identified. For refrigerators used to store biologicals and/or vaccines, the temperature should be monitored and recorded twice a day. 37897 4. A review of Resident 67's Face Sheet indicated the facility admitted Resident 67 on [DATE] with diagnoses unspecified psychosis (conditions that affect the mind, where there has been some loss of contact with reality), hallucinations (seeing or hearing things that others do not see or hear) and unspecified dementia without behavioral disturbance (a mental disorder in which a person loses the ability to think, remember, learn, make decisions, and solve problems). A review of Resident 67's History and Physical dated [DATE], indicated Resident 67 did not have the capacity to understand and make decisions. A review of Resident 67's Minimum Data Set (MDS- standardized assessment and care screening tool), dated [DATE], indicated Resident 67 was severely impaired with cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making, with short and long term memory problems. The MDS indicated Resident 67 required supervision with set up help only for bed mobility, transfers, and walking. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on [DATE] at 11:05 am, with Certified Nursing Assistant 5 (CNA 5) observed a medication cup with six pills, unlabeled and unattended on top of the Resident 67's bedside table. During an interview on [DATE] at 11:10 am, with the Minimum Data Set Nurse (MDS 2), MDS 2 stated Resident 67 did not have the capacity to administer her own medications and that leaving the medications unattended at the bed side had the risk that other residents could take her meds or the risk that the medications would not be taken on time and may interact with other medications that Resident 67 would take at a later time. A review of the Facility's Policy and Procedures titled Medication Administration- Nursing Manual General, with a revised date of [DATE], indicated the medications would be given to the resident by the licensed nurse preparing the medication.

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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. 28074 Based on observation and interview, the facility failed to ensure sanitary conditions were maintained in the kitchen. This deficient practice had the potential for unsanitary food practices. Findings: During the initial tour of the kitchen on 5/17/21, at 8:10 am, the following were observed: 1. The kitchen floor under the preparation (prep) table was littered with bits of food debris. The prep table had an undershelf where multiple chopping boards were stored. A staff (Staff 1) observed sweeping the floor with food particles and dust around and under the preparation table. 2. Four uncovered storage bins were utensils were stored with dust and food debris. 3. Food debris found inside a microwave. During an interview on 5/17/21 at 8:40 am, dietary supervisor stated the storage bins should always be cleaned and covered and the microwave should be cleaned after each use.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30258 Based on interview and record review the facility staff failed to accurately document medical records for two of 37 sampled residents (Resident 10 and 139). This deficient practice had the potential for an inaccurate record or lack of care being provided for the residents. Findings: a. A review of Resident 10's Face Sheet (admission record) indicated the facility admitted Resident 10 on 11/13/2017 with diagnoses of congestive heart failure (a chronic condition in which the heart cannot pump blood as it should which can potentially lead to heart failure) and presence of implanted pacemaker (a small device that is placed under the skin in the chest to help control one's heartbeat). A review of Resident 10's Minimum Data Set (MDS, a comprehensive standardized assessment and care screening tool) dated 5/3/2021 indicated Resident 10 was rarely understood, rarely ever able to understand others and cognitively impaired (when a person has trouble remembering, learning new things, concentrating or making decisions that affect their everyday life). A review of Resident 10's Monitoring Sheet: COVID 19 (Corona Virus-19, a respiratory illness that can spread from person to person), for the month of May 2021, indicated to monitor temperature, heart rate, and oxygen saturation (amount of oxygen in the blood) every shift and document. May 8, 9, and 16th during the 3-11pm shift were left blank. The monitoring sheet indicated to monitor for signs and symptoms including: chills, body aches, sore throat, change in smell or taste, cough, shortness of breath (SOB) and respirations every shift. May 8, 9, and 16th were left blank during the 3-11pm shift. A review of Resident 10's Medication Administration Sheet (MAR) for the month of May 2021, indicated to administer Megace (appetite stimulant) 400 milligrams (mg, a unit of measurement) by mouth every day for appetite stimulant. The MAR indicated May 11 and 18th were left blank. The MAR indicated to administer 4 ounces (oz) of a high protein supplement every day at breakfast, lunch and dinner as well as Namenda (medication to treat dementia [loss of memory and other mental abilities severe enough to interfere with daily life]), 5 mg by mouth twice a day for dementia. May 8th and 9th were left blank for both 5 pm doses. A review of Resident 10's Activities of Daily Living (ADL's) Flowsheet, for the month of May 2021, indicated to monitor meal percentages daily during breakfast lunch and dinner. Various dates and meals were left blank including May 1, 2, 3, 5, 6, 9, 10, 13, 14, 15, 17, and 18, 2021. b. A review of Resident 139's Face Sheet indicated Resident 139 the facility admitted the resident on 4/20/2018 with diagnosis of dementia. (continued on next page)

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	555852	A. Building B. Wing	05/24/2021

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 139's MDS dated [DATE] indicated Resident 139 was able to make herself understood, able to understand others and cognitively intact. A review of Resident 139's Monitoring Sheet: COVID 19, for the month of May 2021, indicated to monitor temperature, heart rate, and oxygen saturation every shift and document. May 8, 9, and 16th during the 3-11pm shift were left blank. In addition the monitoring sheet indicated to monitor for signs and symptoms including: chills, body aches, sore throat, change in smell or taste, cough, shortness of breath (SOB) and respirations every shift. May 8, 9, and 16th were left blank during the 3-11pm shift. A review of Resident 139's Medication Administration Sheet (MAR) for the month of May 2021, indicated to administer Aricept 5 mg by mouth at hour of sleep for dementia. May 8 and 9th were left blank. A review of Resident 139's ADL's Flowsheet, for the month of May 2021, indicated to monitor meal percentages daily during breakfast lunch and dinner. The flowsheet indicated various dates and meals were left blank including May 1, 5, 8, 9, 11, 13, 15, 16, 17, and 18, 2021. During an interview on 5/21/2012 at 9:36 am, the Director of Nursing (DON) stated accurate documentation was important to ensure care was being provided and resident needs were being met. The DON stated if it was not documented, meant that it was not done. A review of the facility's Completion and Correction policy, dated 1/1/2012, indicated information concerning pertinent observations, psychosocial and physical manifestations, incidents, unusual occurrences and abnormal behavior would be documented as soon as possible. The policy indicated any person(s) making observations or rendering direct services to the resident would document in the record.

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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** 36290 Based on observation, interview, and record review, the facility failed to follow infection control practices by failing to: 1. Ensure staff (Certified Nursing Assistant 6 [CNA 6]) donned (put on) personal protective equipment (PPE, protective clothing, gloves, face shields, goggles, facemasks and/or respirators or other equipment designed to protect the wearer from the spread of infection or illness), gown before entering Resident 359's room located in the yellow zone (area where residents under investigation are allocated). 2. Ensure two of five sampled residents (Resident 144 and 361) urinary catheter's (a flexible tube inserted into the body for removal of urine) bags did not touch the floor. 3. Ensure to have paper towels in the bathroom for room [ROOM NUMBER]C on 5/17/2021 and on 5/18/2021, and ensure the wall mounted alcohol-based hand sanitizer (ABHS) dispenser in room [ROOM NUMBER] was not empty. 4. Ensure the ice tray with ice was not left exposed and unattended in the hallway of the yellow zone. These deficient practices had the potential to spread infections. Findings: 1. A review of Resident 359's Face Sheet (admission record) indicated the facility admitted Resident 359 on 5/6/2021 with diagnoses of muscle weakness, shortness of breath, and sepsis (life threatening complication of an infection). A review of Resident 359's physician's order dated 5/6/2021 indicated Resident 359 was to be admitted to the yellow zone for a 14-day quarantine (separate someone exposed to infectious and contagious disease) and observation. During an observation on 5/17/2021 at 10:21 am, outside of Resident 359's room there was an isolation cart that contained yellow gowns. Resident 359 was awake and lying in bed, the resident pressed his call light (a device used by a patient to signal his or her need for assistance) and CNA 6 entered the resident's room and was not wearing a yellow gown. CNA 6 spoke to Resident 359 and left the room. During the concurrent observation at 10:35 am, CNA 6 entered Resident 359's room for a second time and was holding a yellow gown, CNA 6 was not wearing the gown. CNA 6 dropped the gown on the floor, picked it up and put on the gown while in Resident 359' room. During an interview on 5/19/2021 at 8:43 am, Licensed Vocational Nurse 9 (LVN 9) stated that in yellow zone, yellow gowns should be worn before entering resident rooms to prevent the spread of infections. (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 5/19/2021 at 9:05 am, CNA 6 stated that he was supposed to wear an isolation gown before he entered Resident 359's room located in the yellow zone. CNA 6 stated he entered Resident 359's room with no yellow gown because he thought it was an emergency. CNA 6 stated that if a gown falls on the floor, he should throw it away because the floor was dirty. CNA 6 stated he was supposed to wear gown before he entered the rooms in the yellow zone to protect the residents and others including himself to prevent the spread of infections. A review of the facility's Coronavirus-19 (COVID-19, a respiratory illness that can spread from person to person), Mitigation Plan (MP, a plan to reduce loss of life and impact of COVID-19 in the facility)with a revised 4/27/2021 indicated that in the facility's yellow area gowns should be worn and changed between resident encounters. 2. A review of Resident 144's Face Sheet indicated the facility admitted the resident on 7/14/2018 with diagnoses of respiratory failure, chronic obstructive pulmonary disease (a group of lung disease that block airflow and make it difficult to breath), tracheostomy (an incision in the windpipe made to relieve an obstruction to breathing), dependence on ventilator, and chronic (long term) kidney disease. A review of Resident 144's physician order dated 12/1/2019 indicated Resident 144's Foley (urinary) catheter was always to be connected to a drainage bag and positioned lower than the bladder. During an initial tour observation on 5/17/2021 at 9:53 am, inside Resident 144's room, Resident 144 was lying in bed asleep and the urinary catheter bag was inside a dignity bag (additional bag used to preserve a resident's dignity) and touched the floor. During an observation and concurrent interview on 5/19/2021 at 8:14 am, Resident 144's urinary catheter bag was inside the dignity bag and touching the floor. LVN 10 stated Resident 144's dignity bag was touching the floor and the floor was dirty. LVN 10 stated that bacteria could travel up and can go into Resident 144, and could result in a urinary tract infection or infection in the blood. LVN 10 stated the bag should not be touching the floor even though it's in the dignity bag and all staff was responsible for insuring catheter bags did not touch the floors. A review of Resident 361's Face Sheet indicated the facility admitted the resident on 5/12/2021 with diagnosis of leukemia (cancer of blood forming tissues). A review of Resident 361's physician order's dated 5/22/2021 indicated a urinary catheter to gravity for drainage for Resident 361. During an observation on 5/17/2021 at 10:16 am, Resident 361 was lying in bed asleep and the urinary catheter bag was inside the dignity bag touching the floor. During an interview on 5/20/2021 at 9:24 am, the facility's Director of Nursing (DON) stated urinary catheter bags should not be touching the floor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Indwelling Catheter policy and procedure revised 9/1/2014 indicated that the purpose of the policy was to relieve bladder distention to obtain a urine specimen for diagnosis testing and or maintain constant drainage. The resident's privacy and dignity would be protected by placing a cover over the drainage bag. This policy did not indicate that the dignity bag/indwelling catheter bag should not be touching the floor. A review of the facility's Infection Control - Policies and Procedures with a revised date of 1/2/2012 indicated the policies were intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections. 42307 3. During observations on 5/17/2021 at 10:25 am, and on 5/18/21, at 8:26 a.m., in room [ROOM NUMBER] the paper towel dispenser in the bathroom was empty. During a concurrent observation an interview on 5/17/2021 at 11:32 a.m., LVN 5 stated the ABHS dispenser in room [ROOM NUMBER] was empty. During an interview on 5/18/2021 at 1:02 pm, LVN 5 stated it was important for the ABHS dispenser not to be empty to continue hand hygiene, for infection prevention. During an interview on 5/18/2021 at 1:10 pm, Registered Nurse 1 (RN 1) stated, ABHS was needed for infection control. During an interview on 5/18/2021 at 2:35 pm, Housekeeping Supervisor (HKS) stated it was important that ABHS dispenser was not empty to sanitize the hands and prevent infection. During an interview on 5/19/2021 at 9:18 am Housekeeping (HK) stated it was important to have paper towels for the staff and the residents to dry their hands. During an interview on 5/19/2021 at 11:40 am, the IP nurse stated the importance of having the ABHS and paper towel dispenser of not being empty was for accessibility and for good practice for hand hygiene. A review of the facility's policy and procedure titled, Hand Hygiene, with a revised date of 9/1/2020, indicated the facility considered hand hygiene as the primary means to prevent the spread of infections. The policy indicated hand hygiene meant cleaning hands by handwashing, antiseptic hand wash or antiseptic hand rub i. e. alcohol-based hand rub (ABHR) including foam or gel. The policy indicated paper towels as one of the supplies necessary to perform hand hygiene. 42914 4. During an initial tour observation on 5/18/2021 at 3:27 pm in station 2 within the yellow zone, an ice storage chest filled with ice inside was observed in the hallway and residents seen walking around the area. (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 5/18/2021 at 3:27 pm LVN 10 stated the ice storage chest was utilized to store ice for the residents and residents and staff could freely access and touch the storage chest and ice inside, which can contaminate the ice. LVN 10 sated the ice storage chest was not assigned to any staff and was just placed in the hallway and anyone could access the ice and stated there was potential for contamination. During an interview on 5/18/2021 at 4:28 pm, the IP nurse stated the ice storage chest should be placed in the staff's break room and not at a high traffic area where residents or staff were able to easily access it and possibly contaminate it. The IP nurse stated the staff might have forgotten to place it in the break room after passing out drinks with ice during lunch or snack time. The IP nurse stated when not in use the ice storage chest should be kept out of reach of residents and monitored by immediate staff who would be handling the ice. A review of the facility's policy titled Ice Machine & Ice Storage Chests, with a revised date of 10/1/2014, indicate the facility staff were aware that ice-making machines, ice storage chests/containers, and ice could become contaminated by unsanitary manipulation by employees, residents, and visitors, Improper storage or handling of ice. The policy indicated to limit access to ice machines or ice storage chests/containers to employees only.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 42914 Based on interview, and record review, the facility failed to monitor the use of antibiotic (a medication used to treat bacterial infections), for residents on the Antibiotic Stewardship Program (refers to a set of commitments and actions designed to optimize the treatment of infections while reducing the adverse events associated with antibiotic). This deficient practice had the potential to cause unnecessary or inappropriate antibiotic use for the residents. Findings: During an interview on 5/20/2021 at 10:40 am, the facility's Infection Preventionist (IP, nurse who helps prevent and identify the spread of infectious agents like bacteria and viruses in a healthcare environment), stated if any resident was prescribed an antibiotic, the Surveillance Data Collection Form should be filled out prior and an updated care plan would be needed to address the need for the antibiotic. The IP nurse stated the form was incomplete for seven residents and did not indicate whether or not the antibiotic prescribed had been reviewed to determine if it was needed or effective. During an interview on 5/20/2021 3:27 pm, the IP nurse stated there was a process for review of clinical signs and symptoms and laboratory reports to determine if the antibiotic was indicated, which included her personal review of the Surveillance Data Form, to determine if the antibiotic met the criteria. The IP nurse stated she did not review the Surveillance Data Form to determine if the residents met the criteria for the antibiotic use because she might had missed it. During an interview on 5/24/2021 at 11:32 am the IP nurse stated the Surveillance Data Collection Forms helped guide the nurses and the IP nurse to determine whether the residents required antibiotic and the purpose of the antibiotic. The IP nurse stated if the form was not completed, it indicated antibiotic was not reviewed. During an interview on 5/24/2021 11:41 am, the facility's Director of Nursing (DON) stated if a resident was having symptoms of an infection or if a physician ordered an antibiotic for a resident, the nurse could start the process by filling out the Surveillance Data Collection Form. The DON stated if the form was not filled out it meant the IP nurse did not follow up to see if the resident had a true infection or if the antibiotic was needed. A review of the facility's policy and procedure titled, Antibiotic Stewardship, with a revised date of 7/25/2019, indicated the Antibiotic Stewardship Program (ASP) was put into place to ensure antibiotics were used appropriately. The procedure included: identifying an Infection Preventionist (IP) to oversee the ASP ensuring that policies regarding stewardship and monitored and enforced and the IP will collect and analyze infection surveillance data, coordinate data collection and monitor adherence to the infection control and policies and procedures.