STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A360	A. BUILDING _____ B. WING _____	12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENN MAR HEALTHCARE CENTER	3938 COGSWELL ROAD EL MONTE, CA 91732

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during a Recertification Survey conducted on 12/5/2023 to 12/8/2023. Representing the Department of Public Health: Health Facilities Evaluator Nurse #27785 Health Facilities Evaluator Nurse #14330 Health Facilities Evaluator Nurse #40913 Total Census - 45 Sample Size - 12 Closed Records - 2 Highest Scope and Severity: E The following reflects the findings of the California Department of Public Health during the investigation of two Facility Reported Incidents (FRI) and one complaint during the Recertification Survey conducted on 12/5/2023 to 12/8/2023. Facility Reported Incident numbers: CA00872996 and CA00874021 Complaint number: CA00873895 No deficiencies were issued for Facility Reported Incident numbers: CA00872996 and CA00874021 No deficiencies were issued for complaint number: CA00873895.	F 000	**Preparation and/or execution of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. This plan of correction is prepared and/or executed solely because it is required by provisions of 42 CFR 483, et seq., and Health Safety Code Section 1280. In response to the Department's findings, we submit the following Plan of Correction which constitute Penn Mar Therapeutic Center's credible allegation of compliance.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Gary Gurevich, Administrator	1/08/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the choice to shower was respected for one of 12 sampled residents (Resident 147). This deficient practice had the potential to violate Resident 147's right to make choices about her	F 561	• **How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The Administrator in-serviced staff on 1/04/2024 about the importance of making every effort to assist each resident in exercising his/her rights to assure that the resident is always treated with respect, kindness, and dignity. A shower bath is given to the residents to provide cleanliness, comfort and to prevent body odors. Residents are offered a shower at a minimum of once weekly and given per resident request. (exhibits 1, 2). • **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** The Administrator in-serviced Social Workers on 1/04/2024 to include issue of showering in the wellness questioner for wellness sessions (exhibit 3). • **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:**	

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F 561	Continued From page 2 life in the facility including interests and preferences that were important to her and could have a negative effect on Resident 147's well-being. Findings: During a review of Resident 147's Admission Record, the Admission Record indicated the facility admitted the resident on 11/16/23, with diagnoses that included schizoaffective disorder, bipolar type (a mental health disorder marked by a combination of schizophrenia [affects person's ability to think, feel and behave clearly] symptoms such as hallucinations [false perception of objects or events], delusions [false belief], and mood disorder symptoms, such as depression or mania [abnormally elevated and extreme mood]) and epilepsy (disease of the brain characterized by recurrent seizures [brief episodes of involuntary movement that may involve a part of the body or the entire body]). During a review of Resident 147's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 11/22/23, the MDS indicated the resident had no cognitive impairment and was independent with all activities of daily living (ADL's). During an observation on 12/7/23 at 8:52 a.m., Resident 147 asked Certified Nursing Assistant 2 (CNA 2) to open her locked cabinet so Resident 147 could grab clean clothes for changing after the shower. During an interview on 12/7/23 at 8:53 a.m. with CNA 2, CNA 2 stated the shower room was usually closed between 8:50 a.m. to 9 a.m. The	F 561	The facility will make showers available to residents per their request. The CNAs will help residents to have access to showers at their convenience (exhibit 2). • **How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system:** The Administrator instructed Social Workers (exhibit 3) and Nursing Staff (exhibit 2) to keep the shower log updated. A review of the shower log will be included in the monthly QA meetings report.	

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F 561	Continued From page 3	F 561		

shower room would open in the afternoon between 3:15 to 4:15 p.m. for male residents.

During an interview on 12/7/23 at 2:46 p.m. with Resident 147, Resident 147 stated she wanted to take a shower. Resident 147 stated, the shower room was available but the staff in the shower room told Resident 147 that the shower room was already closed. Resident 147 stated, it had been two days since her last shower. Resident 147 stated, it was her right and her hygiene. Resident 147 stated, she felt dirty and a little discomfort, and she wanted to wash her body.

During an interview on 12/7/23 at 2:50 p.m. with the Administrator (Admin), Admin stated the facility did not have a policy and procedure (P&P) on activities of daily living. Admin stated, there was no P&P on showers because all the residents were independent with ADL's and showers.

During an interview on 12/7/23 at 3:02 p.m. with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated if the residents could not shower on the scheduled time, the facility could extend the shower schedule if staff was available, since the CNAs had other schedules such as medication pass attendants, hallway monitoring, headcount, and other responsibilities.

During an interview on 12/8/23 at 6:14 a.m. with the Director of Nursing (DON), DON stated if the resident missed the schedule for a shower, the resident had to wait for the next schedule. DON stated, the residents at the facility needed a structured environment so the residents needed to follow the shower schedule.

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F 561	Continued From page 4 During a review of the facility's Daily Program/ADL's (undated), the Daily Program/ADL's indicated schedule for showers/personal grooming was from 8:15 to 9:00 a.m. and 3:45 to 4:30 p.m. During a review of the facility's policy and procedure (P&P) titled, "Resident Rights," (undated), the P&P indicated the facility will make every effort to assist each resident in exercising his/her rights to assure that the resident is always treated with respect, kindness, and dignity. The P&P indicated the residents were entitled to exercise their rights and privileges to the fullest extent possible.	F 561		
F 578 SS=B	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the	F 578	**F 578:** • **How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The social worker provided the resident's responsible party with the information about Advance Directive.	

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F 578	Continued From page 5 facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to inform and provide written information to the resident and the resident representative regarding the right to formulate an Advance Directive (a written instruction, such as a living will or durable power of attorney for health care, recognized under State law, relating to the provision of health care when the individual is incapacitated) for one of 12 sampled residents (Resident 15). This deficient practice had the potential for Resident 15 or Resident 15's representative to not be informed of their rights. Findings: During a review of Resident 15's Admission	F 578	• **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** The DON conducted an audit on 1/05/2024 of all current residents' charts. No other residents were identified as affected. • **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** At the time of admission, Admission Staff or designee will inquire about the existence of an Advance Directive, including whether the resident has requested or is in possession of an aid-in-dying drug. The Admission Staff will inform and provide written information to residents concerning the right to accept or refuse medical treatment. (exhibit 4). The Administrator provided in-service to Admission Coordinator and Social Workers on 1/04/2024 on the importance to obtain Advance Directive (exhibit 5). • **How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for**	

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F 578	Continued From page 6 Record, the Admission Record indicated the facility admitted the resident on 10/5/23, with diagnoses that included schizophrenia (a mental disorder that affects a person's ability to think, feel, and behave clearly). During a review of Resident 15's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 10/11/23, the MDS indicated the resident had no cognitive impairment and was independent with all activities of daily living. During a concurrent interview and record review on 12/8/23 at 4:01 p.m. with the Medical Records Director (MRD), Resident 15's Advance Directive Acknowledgement and Consent form was reviewed. Resident 15's Advance Directive Acknowledgement and Consent form indicated no signature by Resident 15 nor by Resident 15's representative. MRD stated, there was no signature on the form. During an interview on 12/8/23 at 4:01 p.m. with Social Worker 1 (SW 1), SW 1 stated there was no documentation on the computer that Advance Directive information was provided to Resident 15 or Resident 15's representative. SW 1 stated, the Advance Directive Acknowledgement and Consent form was not signed to acknowledge receipt of the information regarding resident's right to formulate an Advance Directive. During a review of the facility's policy and procedure (P&P) titled, "Advance Directive," dated 2/28/18, the P&P indicated at the time of admission, admission staff will inform and provide written information to all adult residents concerning the right to accept or refuse medical treatment. The P&P indicated each resident is	F 578	**ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system:** The Administrator instructed the Admission Staff and Social Workers to inquire about the existence of an Advance Directive, including whether the resident has requested or is in possession of an aid-in-dying drug. A review of the Advance Directive Audit will be included in the monthly QA meetings report.	

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F 578	Continued From page 7 informed that it is their choice to complete the Advance Directive. If the resident is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an Advance Directive, the facility may give Advance Directive information to the individual's resident representative in accordance with state law.	F 578		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to administer medications as scheduled and as ordered by the physician for two of 12 sampled residents (Resident 18 and 148). 1. For Resident 18, Licensed Psychiatric Technician 1 (LPT 1) failed to administer Risperdal (Risperidone, a medication used to treat symptoms of schizophrenia [a mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions]) 2 milligrams (mg, unit of measurement) as scheduled during the 9 a.m. medication administration. 2. For Resident 148, LPT 1 failed to administer	F 684	**F 684:** • **How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The Facility will follow-up with the pharmacy prior to the last dose given to the residents in order to procure enough supply to provide the residents with medications prescribed by the physician. The facility will provide Metformin oral tablet with the food. • **How the facility will identify other residents having the potential to be affected by the**	

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F 684	Continued From page 8 Metformin (a medication used to control high blood sugar levels) 850 mg with food as ordered by the physician. These deficient practices had the potential to cause uncontrolled behavioral symptoms for Resident 18 and unwanted side effects for Resident 148. Findings: 1. During a review of Resident 18's Admission Record, the Admission Record indicated the facility admitted Resident 18 on 12/8/22, with diagnoses that included impulse disorder (a condition in which a person has trouble controlling emotions or behaviors), cerebral palsy (group of lifelong conditions that affect movement and co-ordination), and hypothyroidism (a condition in which the thyroid gland does not make enough hormones that regulate the body's metabolic rate, growth and development, to meet the body's needs). During a review of Resident 18's care plan for suicide risk for self-inflicted, life-threatening injury, dated 9/5/23, the interventions indicated to provide medication and treatment as needed to control suicidal thoughts or voices telling resident to kill herself. During a review of Resident 18's Minimum Data Set (MDS, a standardized assessment and care panning tool), dated 9/16/23, the MDS indicated Resident 18 had the ability to make self understood and understand others. The MDS indicated Resident 18 had hallucinations (sensing things such as visions, sounds, or smells that seem real but are not) and delusions (fixed	F 684	**same deficient practice and what corrective action will be taken:** The Medical Records Coordinator conducted an audit on 1/05/2024 of all current residents' charts and interviews medication nurses. No other residents were identified as affected. • **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** The Administrator provided in-service to medication nurses on 1/04/2024 about the importance to follow-up with the pharmacy prior to the last dose given to the residents in order to procure enough supply to provide the residents with medications prescribed by the physician *(exhibit 6)*. The Administrator provided in-service to medication nurses on 1/04/2024 about the importance of Metformin oral tablet to be given with food with the food (ex 6). • **How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the**	

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F 684	Continued From page 9 beliefs about something that are not based in reality). During a review of Resident 18's Physician Order Summary Report for 12/2023, the Physician Order Summary Report indicated an order dated 8/8/23, to give Risperidone 2 mg by mouth in the morning for impulse control disorder manifested by paranoia. During a medication administration observation on 12/7/23 at 7:35 a.m. with LPT 1, LPT 1 was observed pre-pouring the medications for the 9 a.m. medication administration. LPT 1 was not able to pre-pour Resident 18's Risperdal 2 mg tablet because it was not available in the medication cart or any other place in the facility. During an interview on 12/7/23 at 8:10 a.m. with LPT 1, LPT 1 verified that Resident 18's Risperdal 2 mg disintegrating oral tablet was not available in the medication cart. LPT 1 stated, the facility's practice was that pharmacy would send the facility the medication monthly. LPT 1 stated, the medication nurse should have called the facility's pharmacy to order the medication when the medication was running low and before the medication ran out. LPT 1 stated, the facility did not have Risperdal in the facility's emergency medication Kit (E-kit). During an interview on 12/7/23 at 8:20 a.m. with LPT 2, LPT 2 stated that the pharmacy delivered 28 days cycle (monthly supply) of the medication and the facility usually received the supply a few days before the end of the month. LPT 2 stated, she did not follow up with the pharmacy when she gave the last remaining dose of Risperdal on 12/6/23. LPT 2 stated, she should have followed	F 684	**corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system:** The Administrator instructed DON to audit medication cart on a daily basis. The audit of the medication cart will be included in the monthly QA meetings report.	

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F 684	Continued From page 10	F 684		

up with the pharmacy.

During an observation of the 9 a.m. medication administration on 12/7/23 with LPT 1, LPT 1 was observed administering Resident 18's medications at her bedside at 10:15 a.m. Risperdal 2 mg was not available and was not among the medication administered to Resident 18.

During a review of Resident 18's Medication Administration Record (MAR) for 12/2023, the MAR indicated Risperidone 2 mg disintegrating oral tablet was scheduled to be given during the 9 a.m. medication pass. The MAR indicated on 12/7/23, during the 9 a.m. medication administration, the Risperidone 2 mg disintegrating tablet was not given because it was not available.

During a review of Resident 18's Progress Notes dated 12/7/23 at 10:49 a.m., the Progress Notes indicated that the Risperidone 2 mg disintegrating tablet was not available from pharmacy.

During a review of the facility's policy and procedure (P&P) titled "Medication - Administration," revised on 2/1/17, the P&P indicated that medications will be administered by a licensed nurse per the order of an attending physician or licensed independent practitioner. The policy indicated that medications may be administered one hour before or after the scheduled medication administration time.

2. During a review of Resident 148's Admission Record, the Admission Record indicated the facility admitted Resident 148 on 9/1/23, with diagnoses that included schizophrenia (a serious

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F 684	Continued From page 11	F 684		

mental illness that affects how a person thinks, feels, and behaves) and Type II Diabetes Mellitus (a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel) with hyperglycemia (high blood sugar).

During a review of Resident 148's care plan for diabetes mellitus, dated 9/2/23, the care plan interventions indicated to administer Resident 148's medication as ordered.

During a review of Resident 148's Minimum Data Set (MDS, a standardized assessment and care panning tool), dated 9/7/23, the MDS indicated Resident 148 had the ability to make self understood and understand others. The MDS indicated Resident 18 had hallucinations and delusions.

During a review of Resident 148's Physician Order Summary Report for 12/2023, the Physician Order Summary Report indicated an order dated 9/7/23, to give Metformin oral tablet 850 mg by mouth two times a day for diabetes mellitus. The order indicated to give the Metformin with food.

During an observation of the medication administration on 12/7/23 at 9:15 a.m. with LPT 1, LPT 1 administered Metformin 850 mg to Resident 148. Metformin 850 mg was administered to Resident 148 without food.

During an interview on 12/7/23 at 9:50 a.m. with LPT 1, LPT 1 stated that the Metformin should have been given with breakfast. LPT 1 stated, breakfast was served at 7:15 a.m. and she did not know why Metformin was scheduled at 9 a.m.

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F 684	Continued From page 12 During an interview on 12/7/23 at 11:17 a.m. with the Director of Nursing (DON), DON stated Metformin should have been given with food. DON stated, the Metformin was being given during breakfast previously but by the time the nurse got the medication ready, the resident had already finished eating, so the doctor changed the administration time to 9 a.m. DON stated the staff can offer food/snacks with the medication. During a review of the facility's policy and procedure (P&P) titled, "Medication Administration," revised on 2/1/17, the P&P indicated medications will be administered by a licensed nurse per the order of an attending physician or licensed independent practitioner. The P&P indicated that medications may be administered one hour before or after the scheduled medication administration time. Cross reference F759	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility	F 688	**F 688:** • **How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The facility will review resident's admission records for pre-existing conditions and perform physical examination for the new admission in order to identify and provide residents with treatment according to their conditions and prescribed by the physician.	

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F 688	Continued From page 13 receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide range of motion exercises (ROM) for one of two sampled residents (Resident 19). Resident 19 was not receiving ROM exercises for contractures (fixed tightening of muscle, tendons, ligaments, or skin) of right and left hands since 11/6/23. This deficient practice placed Resident 19 at risk for further development of contractures of both hands. Findings: During a review of Resident 19's Admission Record, the Admission Record indicated the facility admitted Resident 19 on 11/6/23, with diagnoses that included schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly). During a review of Resident 19's Nursing Admission Assessment dated 11/6/23, the Nursing Admission Assessment indicated Resident 19 was admitted with contracted upper extremities and amputated left index finger. During a review of Resident 19's Care Plan dated 11/6/23, the Care Plan indicated Resident 19 had impaired physical mobility related to contractures of left hand and pinky finger right hand. The Care Plan interventions indicated for the certified nursing assistant to provide gentle ROM	F 688	• **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** The DON conducted a physical evaluation on 1/052024 of current residents. No other residents were identified as affected. • **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** The Administrator provided in-service to licensed nurses on 1/04/2024 about the importance of reviewing admission documentation and performing physical evaluation to new residents upon admission (ex 7). The DON provided in-service to licensed nurses and CNAs on 1/04/2024 about the importance of follow-up with the physician orders on ROM exercises. (ex 7). • **How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for**	

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F 688	Continued From page 14 exercises to Resident 19's both hands as tolerated with daily care. During a concurrent observation and interview on 12/5/23 at 10:23 a.m., Resident 19 was observed walking in his room with contracted hands and amputated left index finger. Resident 19 demonstrated that he was unable to move his right arm sideways and raise the right arm to touch his head. Resident 19 stated, he was not getting ROM exercises from the staff and his hands were contracted before admission to the facility. During an interview on 12/7/23 at 9:56 a.m. with the Certified Nursing Assistant 1 (CNA 1), CNA 1 stated she was the caregiver of Resident 19. CNA 1 stated, she did not provide the ROM exercises to Resident 19's hands because nobody told her. CNA 1 stated, she did not check and/or read Resident 19's plan of care interventions for the resident's contracted hands. During a concurrent interview and record review on 12/7/23 at 11:09 a.m. with the Director of Nursing (DON), Resident 19's medical record was reviewed. DON stated, there was no documented evidence in Resident 19's medical record that range of motion exercises were provided to Resident 19's both hands since 11/6/23. DON stated, ROM exercises were important to prevent further development of contractures and to maintain the functional mobility of Resident 19's hands.	F 688	**its effectiveness. The POC is integrated into the quality assurance system:** The Administrator instructed DON to audit admission records, physical evaluation reports and physician orders on a daily basis. This audit will be included in the monthly QA meetings report.	
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration.	F 692	**F 692:** • **How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**	

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F 692	Continued From page 15 (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to follow up and act upon a recommendation by the Registered Dietician (RD) to consider a speech therapist (ST, an individual who provides professional services in the areas of communication and swallowing) consultation for one of one resident on pureed diet in a total sample of 12 residents (Resident 4). This deficient practice had the potential to result in further weight loss for Resident 4. Findings: During a review of Resident 4's Admission Record, the Admission Record indicated the facility admitted the resident on 3/22/23, with	F 692	The facility will serve blended diet as separate food items, not blended together. The facility will follow-up with RD recommendation of Speech Therapist consult to possibly advance diet texture to minced and moist, bite-sized. • **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** The Medical Records Coordinator conducted a diet audit on 1/05/2024 of current residents. No other residents were identified as affected. • **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** The Kitchen Supervisor provided in-service to cooks and assistants on 12/13/2023 about the importance of processing blended food separately. (exhibit 8). The Administrator provided in-service to licensed nurses on 1/04/2024 to notify the physician about the RD recommendation and follow-up with the physician about	

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F 692	Continued From page 16 diagnoses that included schizoaffective disorder (a mental health disorder where the person experiences psychosis [disconnection from reality] as well as mood symptoms). During an interview on 12/5/23 at 10:19 a.m. with Resident 4, Resident 4 stated he lost weight because he walked a lot. Resident 4 stated, he was on a pureed diet. During an observation on 12/7/23 at 11:31 a.m., inside the kitchen, Cook 1 put a slice of chicken, one scoop of broccoli bake, and one scoop of pasta in a blender then pureed the food items together and placed the contents in a bowl for Resident 4. During an observation on 12/7/23 at 11:55 a.m., inside the dining room, Resident 4's lunch was served in a bowl, with chocolate pudding, milk, and juice on the resident's tray. Resident 4 was eating his lunch independently and finished 60% of his lunch. During an interview on 12/8/23 at 6:08 p.m. with Resident 4, Resident 4 stated it would be "okay" to be on a different diet. During a concurrent interview and record review on 12/8/23 at 6:11 p.m. with the Director of Nursing (DON), Resident 4's Significant Weight Change Form dated 6/23/23 was reviewed. The Significant Weight Change Form indicated a recommendation by RD to consider speech therapist consultation to possibly advance (diet) texture to minced and moist, bite-sized, et cetera (etc.). DON stated the Dietary Services Supervisor (DSS) would be the one to follow up with RD regarding Resident 4's diet. DON stated,	F 692	implementation and documenting of non-implementation. (exhibit 9). • **How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system:** The Administrator instructed DON to audit admission records, physical evaluation reports and physician orders on a daily basis. This audit will be included in the monthly QA meetings report.	

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F 692	Continued From page 17 he did not know if the ST consultation was completed. During a review of the facility's policy and procedure (P&P) titled, "Residents' Weights," (undated), the P&P indicated the licensed nurse will notify the physician of the dietitian's recommendations, and if the physician does not implement the dietitian's recommendations, the rationale for non-implementation will be documented in the medical record.	F 692		
F 732 SS=D	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors.	F 732	**F 732:** • **How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The facility will post the nurse staffing data on a daily basis at the beginning of each shift. • **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:**	

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F 732	Continued From page 18 §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to post accurate nurse staffing information on 12/5/23 and 12/6/23, that included resident census and actual hours worked by the licensed and unlicensed nursing staff directly responsible for resident care per shift every day. This deficient practice of posting inaccurate nurse staffing information had the potential to mislead the residents and visitors and could result in inappropriate nursing care. Findings: During an observation on 12/5/23 at 9:02 a.m. and 12/6/23 at 8:15 a.m., the nurse staffing information was posted on the wall in front of the nurses' station. The nurse staffing information did not include the resident census and actual hours worked by the licensed and unlicensed nursing staff directly responsible for resident care per shift every day.	F 732	DON conducted an audit on 12/12/2023 of current staffing. No other residents were identified as affected. • **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** The charge nurse is posting appropriate nurse staffing information before the beginning of each shift as of 12/06/2023. (exhibit 10). • **How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system:** The Administrator instructed DSD to audit posting of nurse staffing information on daily bases. This audit will be included in the monthly QA meetings report.	

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F 732	Continued From page 19 During a concurrent interview and record review on 12/6/23 at 3:05 p.m. with Licensed Vocational Nurse (LVN) 1, the facility's nurse staffing information dated 12/5/23 and 12/6/23 were reviewed. LVN 1 stated, the charge nurse was responsible for posting the nurse staffing information before the beginning of each shift. LVN 1 stated, he was the charge nurse. LVN 1 stated, he did not know that the nurse staffing information had to include the resident census and actual hours worked by the staff providing direct care before he posted the information. During an interview on 12/6/23 at 3:43 p.m. with the Assistant Staff Developer (ASD), ASD stated she was responsible for the completion of the nurse staffing information to be posted for each shift by the charge nurse. ASD stated, she did not know that the resident census and actual hours worked by the licensed and unlicensed nursing staff must be included on the nurse staffing information form. ASD stated, it was important to post the complete nurse staffing information for the resident and/or visitor to know if the facility had enough staff to meet the resident's needs. During a review of the facility's policy and procedure (P&P) titled, "Staffing, Scheduling & Postings," dated 2/1/17, the P&P indicated the facility will post the following information on a daily basis: facility name, current date, resident census, and the total and actual hours worked by the licensed and unlicensed nursing staff directly responsible for resident care per shift.	F 732		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services	F 755	**F 755:** • **How corrective action(s) will be accomplished for those residents**	

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F 755	Continued From page 20 The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that medication was available and in stock in the facility for one of 12 sampled resident (Resident 18). Resident 18's routine medication, Risperdal (medicine that helps with symptoms of some mental health conditions) 2 mg disintegrating oral tablet, was	F 755	**found to have been affected by the deficient practice:** The facility will notify the pharmacy consultant prior to the last dose given to the residents in order to procure enough supply to provide the residents with medications prescribed by the physician. • **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** The DON conducted an audit on 12/12/23 of all current residents' charts and interviews medication nurses. No other residents were identified as affected. • **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** The Administrator provided in-service to medication nurses on 1/04/2024 about the importance to follow-up with the pharmacy consultant prior to the last dose given to the residents in order to procure enough supply to provide the residents with medications prescribed by the physician. (exhibit 6).	

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F 755	Continued From page 21 not available during the 9 a.m. medication administration and was not in stock in the facility. This had the potential to result in an increase of behavior symptoms for Resident 18. Findings: During a review of Resident 18's Admission Record, the Admission Record indicated the facility admitted Resident 18 on 12/8/22, with diagnoses that included impulse disorder (a condition in which a person has trouble controlling emotions or behaviors), cerebral palsy (group of lifelong conditions that affect movement and co-ordination), and hypothyroidism (a condition in which the thyroid gland does not make enough hormones that regulate the body's metabolic rate, growth and development, to meet the body's needs). During a review of Resident 18's Minimum Data Set (MDS, a standardized assessment and care panning tool), dated 9/16/23, the MDS indicated Resident 18 had the ability to make self understood and understand others. The MDS indicated Resident 18 had hallucinations (sensing things such as visions, sounds, or smells that seem real but are not) and delusions (fixed beliefs about something that are not based in reality). During a review of Resident 18's care plan for suicide risk for self-inflicted, life- threatening injury, dated 9/5/23, the interventions indicated to provide medication and treatment as needed to control suicidal thoughts or voices telling resident to kill herself.	F 755	• **How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system:** The Administrator instructed DON to audit medication cart on a daily basis. The audit of the medication cart will be included in the monthly QA meetings report. The pharmacy consultant will be part of quarterly QAA meetings.	

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F 755	Continued From page 22	F 755		

During a review of Resident 18's Physician Order Summary Report for 12/2023, the Physician Order Summary Report indicated an order dated 8/8/2023, to give Risperidone 2 mg by mouth in the morning for impulse control disorder manifested by paranoia.

During a medication administration observation on 12/7/23 at 7:35 a.m. with Licensed Psychiatric Technician 1 (LPT 1), LPT 1 was observed pre-pouring the medications for the 9 a.m. medication administration. LPT 1 was not able to pre-pour Resident 18's Risperdal 2 mg tablet because it was not available in the medication cart or any other place in the facility.

During an interview on 12/7/23 at 8:10 a.m. with LPT 1, LPT 1 verified that Resident 18's Risperdal 2 mg disintegrating oral tablet was not available in the medication cart. LPT 1 stated, the facility's practice was that pharmacy would send the facility the medication monthly. LPT 1 stated, the medication nurse should have called the facility's pharmacy to order the medication when the medication was running low and before the medication ran out. LPT 1 stated, the facility did not have the Risperdal in the facility's emergency medication Kit (E-kit).

During an interview on 12/7/23 at 8:20 a.m. with LPT 2, LPT 2 stated that the pharmacy delivered 28 days cycle (supply) of the medication and the facility usually received the supply a few days before the end of the month. LPT 2 stated, she did not follow up with the pharmacy when she gave the last remaining dose of Risperdal on 12/6/23. LPT 2 stated, she should have followed up with the pharmacy.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 23 During a review of the facility's policy and procedure (P&P) titled, "Ordering and Reordering Medications," revised on 7/2023, the P&P indicated that solid oral dosage form medications that administered on a regular (scheduled) basis are filled on a monthly (cycle) basis in punch cards. The P&P indicated that cycle medications are filled, checked, and delivered by the pharmacy on time to start the first day of the cycle. Cross reference F684.	F 755		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced	F 757	**F 757:** • **How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Macrobid was discontinued at the time of discovery. The physician was notified of the issues. • **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** The Medical Records Coordinator conducted an audit on 12/12/2023 of all current residents' charts. No other residents were identified as affected.	

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F 757	Continued From page 24 by: Based on observation, interview, and record review, the facility failed to ensure each resident was free from unnecessary drug for one of two sampled residents (Resident 27). Resident 27 was given Macrobid (antibiotic, medication used to fight infections caused by bacteria) for seven days without an adequate indication for its use. The McGeer Criteria (used to conduct infection surveillance for tracking appropriateness of antibiotic prescribing in nursing homes) was not met before the use of antibiotic drug for Resident 27. This deficient practice placed Resident 27 at risk for antibiotic drug resistance (happens when bacteria change and resist the effects of an antibiotic; resistant bacteria may continue to grow and multiply). Findings: During a review of Resident 27's Admission Record, the Admission Record indicated the facility admitted the resident on 3/9/23, with diagnoses that included paranoid schizophrenia (a person feels distrustful and suspicious of other people and acts accordingly). During a review of Resident 27's Physician's Orders dated 9/11/23, the Physician's Orders indicated to give Macrobid 100 milligram ([mg]unit of measurement) by mouth twice a day for seven days for diagnosis of acute cystitis (infection of the bladder). During an observation on 12/5/23 at 3:40 p.m., Resident 27 was observed walking in the hallway alert and coherent. Resident 27 stated she had	F 757	• **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** The Administrator provided in-service to medication nurses on 1/04/2024 about the importance of reviewing medical records for information that the resident had signs and symptoms of UTI and using McGeer criteria to ensure the criteria were met before starting the antibiotic drug. (exhibit 11). • **How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system:** The Administrator instructed DON to monitor physician orders on a daily basis. The Administrator instructed the Medical Records Coordinator to audit eMAR on a daily basis. These audits will be included in the monthly QA meetings report. The pharmacy consultant will be notified of the issues and will be part of quarterly QAA meetings.	

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F 757	Continued From page 25 no symptoms of urinary tract infection (UTI, infection in any part of the urinary system), and she did not remember when she received an antibiotic drug for urine infection. During a concurrent interview and record review on 12/7/23 at 11:30 a.m. with the Director of Nursing (DON), Resident 27's medical record was reviewed. DON stated, Resident 27's medical record did not contain information that the resident had signs and symptoms of acute cystitis before the antibiotic drug (Macrobid) was given to Resident 27. The McGeer criteria for cystitis was not met when Macrobid drug was ordered for Resident 27 on 9/11/23. DON stated, the facility's licensed staff were using the McGeer criteria to ensure the criterias were met before starting the antibiotic drug to prevent unnecessary use that could result in antibiotic drug resistance.	F 757		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the medication administration error rate was not greater than 5%. The facility had 2 medication administration errors out of 28 medication opportunities for error observed, to yield a medication administration error rate of 7.14%. The medication errors were as follows:	F 759	**F 759:** • **How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The facility will follow-up with the pharmacy prior to the last dose given to the residents in order to procure enough supply to provide the residents with medications prescribed by the physician. The facility will provide Metformin oral tablet with the food.	

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F 759	Continued From page 26 1. For Resident 18, Licensed Psychiatric Technician 1 (LPT 1) failed to administer Risperdal (Risperidone, a medication used to treat symptoms of schizophrenia [a mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions]) 2 milligrams (mg, unit of measurement) as scheduled during the 9 a.m. medication administration. 2. For Resident 148, LPT 1 failed to administer Metformin (a medication used to control high blood sugar levels) 850 mg with food as ordered by the physician. These deficient practices had the potential for Resident 18 and 148 to have adverse effects for not administering medications as scheduled and as ordered by the physician. Findings: 1. During the medication administration observation on 12/7/23 at 7:35 a.m. with LPT 1, LPT 1 was observed pre-pouring the medications for the 9 a.m. medication administration. LPT 1 was not able to pre-pour Resident 18's Risperdal 2 mg tablet because the medication was not available in the medication cart or any other place in the facility. During an interview on 12/7/23 at 8:10 a.m. with LPT 1, LPT 1 verified that Resident 18's Risperdal 2 mg disintegrating oral tablet was not available in the medication cart. LPT 1 stated, the facility's practice was that pharmacy would send the facility the medication monthly. LPT 1 stated, the medication nurse should have called the facility's pharmacy to order the medication when	F 759	• **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** The DON conducted an audit on 12/12/2023 of all current residents' charts and interviews medication nurses. No other residents were identified as affected. • **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** The Administrator provided in-service to medication nurses on 1/04/2024 about the importance to follow-up with the pharmacy prior to the last dose given to the residents in order to procure enough supply to provide the residents with medications prescribed by the physician. (exhibit 6). The Administrator provided in-service to medication nurses on 1/04/2024 about the importance of Metformin oral tablet to be given with food with the food. (exhibit 6). • **How the facility plans to monitor its performance to make sure that solutions are sustained. The**	

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F 759	Continued From page 27 the medication was running low and before the medication ran out. LPT 1 stated, the facility did not have the Risperdal medication in the facility's emergency medication Kit (E-kit). During an observation of the 9 a.m. medication administration on 12/7/23 with LPT 1, LPT 1 was observed administering Resident 18's medications at her bedside at 10:15 a.m. Risperdal 2 mg was not available and was not among the medication administered to Resident 18. During a review of Resident 18's Physician Order Summary Report for 12/2023, the Physician Order Summary Report indicated an order dated 8/8/23, to give Risperidone 2 mg by mouth in the morning for impulse control disorder manifested by paranoia. During a review of the facility's policy and procedure (P&P) titled, "Medication Administration," revised on 2/1/17, the P&P indicated medications will be administered by a licensed nurse per the order of an attending physician or licensed independent practitioner. The P&P indicated that medications may be administered one hour before or after the scheduled medication administration time. During a review of the facility's policy and procedure titled, "Ordering and Reordering Medications," revised in 7/2023, the P&P indicated solid oral medications that administered on a regular (scheduled) basis are filled on a monthly (cycle) basis in punch cards. The P&P indicated that cycle medications are filled, checked, and delivered by the pharmacy on time to start the first day of the cycle.	F 759	**facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system:** The Administrator instructed DON to audit medication cart on daily basis. The audit of the medication cart will be included in the monthly QA meetings report. The pharmacy consultant will be notified of the issues and will be part of quarterly QAA meetings.	

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F 759	Continued From page 28	F 759		

2. During an observation of the medication administration on 12/7/23 at 9:15 a.m. with LPT 1, LPT 1 administered Metformin 850 mg to Resident 148. Metformin 850 mg was administered to Resident 148 without food.

During a review of Resident 148's Physicians Order Summary Report for 12/2023, the Physician Order Summary Report indicated an order dated 9/7/23, to give Resident 148 Metformin oral tablet 850 mg by mouth two times a day for diabetes mellitus (a condition that happens when the blood sugar is too high). The order indicated to give the Metformin with food.

During an interview on 12/7/23 at 9:50 a.m. with LPT 1, LPT 1 stated that the Metformin should have been given with breakfast. LPT 1 stated, breakfast was served at 7:15 a.m. and she did not know why Metformin was scheduled at 9 a.m.

During an interview on 12/7/23 at 11:17 a.m. with the Director of Nursing (DON), DON stated Metformin should have been given with food. DON stated, the Metformin was being given during breakfast previously but by the time the nurse got the medication ready, the resident had already finished eating, so the doctor changed the administration time to 9 a.m. DON stated, the staff can offer food/snacks with the medication.

During a review of the facility's policy and procedure (P&P) titled, "Medication Administration," revised on 2/1/17, the P&P indicated medications will be administered by a licensed nurse per the order of an attending physician or licensed independent practitioner.

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F 805 SS=E	Continued From page 29 Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure pureed food was not mixed together for one of one resident (Resident 4) on pureed diet in a total of 12 sampled residents. This deficient practice had the potential for Resident 4 to not be provided with palatable, attractive, and appetizing food. Findings: During an observation on 12/7/23 at 11:31 a.m., Cook 1 put one scoop of broccoli, one piece of chicken, one scoop of pasta into a blender and pureed the food items together. During a concurrent observation and review of the facility's Fall Menu on 12/7/23 at 11:55 a.m., the menu for lunch indicated Italian chicken, herb pasta, broccoli bake, breadstick, and chocolate pudding. Resident 4's tray had a bowl that contained pureed food, chocolate pudding, water, and juice. Resident 4 was eating independently and ate 60% of his lunch. During an interview on 12/7/23 at 11:57 a.m. with Cook 1, Cook 1 stated she mixed the food together and forgot to puree the breadstick. Cook	F 805 F 805	**F 805:** • **How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The cook will puree food by blending separately according to the menu, with the consistency desired of that mashed potato or pudding like consistency, pureed foods are not to be mixed together and must be seasoned according to diet and be pleasantly acceptable and be garnished. The facility will follow-up with RD recommendation of Speech Therapist consult to possibly advance diet texture to minced and moist, bite-sized. • **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** The Medical Records Coordinator conducted a diet audit on 1/05/2024 of current residents. No other residents were identified as affected. • **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:**	

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F 805	Continued From page 30 1 stated, she was supposed to puree each food separately. During a review of the facility's policy and procedure (P&P) titled, "Food Service Management," dated 2017, the P&P indicated pureed foods are not to be mixed together.	F 805	The Kitchen Supervisor provided in-service to cooks and assistants on 12/13/2023 about checking the indicated texture/consistency on the resident's tray card. To check the resident's tray card whether the resident is on pureed consistency and give the corresponding correct texture of the food item. (exhibit 8). The Administrator provided in-service to licensed nurses on 1/04/2024 to notify the physician about the RD recommendation and follow-up with the physician about implementation and documenting of non-implementation. (exhibit 9). • **How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system:** The facility will do an in-service on the same subject annually for continuing education for the current staff and also for the education of newly hired kitchen staff. The facility will post a poster in the kitchen for the staff to look at showing the correct	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety by failing to ensure: 1. Opened food items in the dry storage area and	F 812		

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F 812	Continued From page 31 refrigerator had a written or labeled use-by-date. 2. Expired food items were removed from the dry storage area and refrigerator. 3. An insecticide spray was not inside the kitchen in an open shelf. 4. A high concentration of chemical sanitizing solution was not used for the dishwasher. These deficient practices had the potential to result in foodborne illnesses and chemical food contaminants. Findings: 1. During a concurrent kitchen observation and interview on 12/5/23 from 8:25 a.m. to 8:50 a.m. with the Dietary Services Supervisor (DSS), the following items were opened and had no open date and use-by-date: One bottle of opened black pepper had no open date and no use-by-date. The DSS checked the bottle and stated, there was no expiration date on the bottle, just the manufacturing date of 8/25/22. One bottle of garlic powder had no open date and no use-by-date, the expiration date indicated 5/1/25. One bottle of paprika powder had no open date and no use-by date. The DSS checked the bottle and stated, there was no expiration date on the bottle, just the manufacturing date of 4/15/22. One bottle of onion powder had no open date and no use-by-date, the expiration date indicated 3/19/25. One bottle of cumin powder had no open date	F 812	consistency of a pureed diet. The dietary supervisor will check the meal tray of the residents on pureed diet before the start of the meal service and remind the cook to also check the "Daily Cook's Menu" spreadsheet before meal service starts. The Administrator instructed DON to audit admission records, physical evaluation reports and physician orders on a daily basis. This audit will be included in the monthly QA meetings report. **F 812:** • **How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Expired and unlabeled items were discarded upon discovery. Chemical insecticide was removed from the kitchen area upon discovery. The service was requested from the service provider to have dishwasher recalibrated. • **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:**	

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F 812	Continued From page 32 and no use-by-date, the DSS checked the bottle and stated, there was no expiration date on the bottle, just the manufacturing date of 5/11/21. One bottle of tarragon leaves had no open date and no use-by date, the expiration date indicated 12/8/24. One bottle of ground ginger had no open date and no use-by-date, the expiration date indicated 12/6/24. One bottle of dill weed had no open date and no use-by-date, the DSS checked the bottle and stated, there was no expiration date on the bottle, just the manufacturing date of 9/16/22. During an interview on 12/5/23 at 8:50 a.m. with DSS, DSS stated the use-by-date was not the same as the expiration date because once the food item was opened, the food item could go through oxidation (a chain reaction that occurs in the presence of oxygen, responsible for deterioration in the quality of food products). DSS stated, he will dispose the expired items right away and the other items that had no open and use-by-dates. During a review of the facility's policy and procedure (P&P) titled, "Food Service Management," dated 1/1/17, the P&P indicated all open food items will have an open date and use-by-date per manufacturer's guidelines. The P&P indicated ground spices had a recommended storage time of 6 months and whole spices had a recommended storage time of 1-2 years. 2. During a concurrent kitchen observation and	F 812	The DSS conducted an audit on 12/13/2023 of current items in the kitchen, storage and dishwasher. No other residents were identified as affected. • **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** The DSS provided in-service to cooks and assistants on 12/13/2023 about the importance of labeling food items and discarding items nearing the expiration date. (exhibit 12). An In-service is given to all kitchen staff that will cover dating and labeling in all food items being use and to make sure that there will be two dates labeled on the food item, one date will be the open date and the other will be the use by or discard by date. All the kitchen staff required to date labeled any open item with use by date according to the manufacturer's recommendation and or facilities storage guidelines. All kitchen staff is required to check every item's use by date before using and to discard the item immediately if it is already passed by the use by date. The facility will provide an in-service on the same subject annually for the current staff continuing education and for the education of newly hired kitchen staff. The facility will post a large poster in every storage area like refrigerator, freezer and dry storage area of Storage	

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F 812	Continued From page 33 interview on 12/5/23 from 8:25 a.m. to 8:56 a.m. with DSS, the following expired food items were observed: One bottle of dill pickles had no open date and no use-by-date, the expiration date indicated 11/25/23. One bottle of basil leaves had no open date and no use-by-date, the expiration date indicated 11/1/23. One container containing multiple packets of soy sauce packet had a best-before-date of 10/21/22. One bottle of red dye had an expiration date of 12/1/23. Four bottles of green dye had no expiration date on the bottle and no written or labeled open date or use-by-date. One bottle of mayonnaise opened on 10/30/22 and a written use-by-date of 11/30/23, the expiration date indicated 9/8/24. One bottle of golden Italian dressing opened on 10/12/23 and a written use-by-date of 11/12/23, the expiration date indicated 8/30/24. DSS stated, he missed the expired items. DSS stated, he would throw away the expired items immediately. During a review of the facility's P&P titled, "Food Service Management," dated 1/1/17, the P&P indicated practices to maintain safe refrigerated storage include ...labeling, dating, and monitoring refrigerated food, including, but not limited to	F 812	Guidelines of food items being stored in that particular area of how long it should be kept and when it should be discarded. The DSS provided in-service to cooks and assistants on 12/13/2023 about the importance of not storing chemical insecticide in the kitchen area. (exhibit 12). Requiring all kitchen staff not to store any pesticides and other toxic substances in the kitchen area or storerooms for food or food preparation equipment and utensils. The facility will do an in-service on the same subject annually for the current staff continuing education and for the education of newly hired kitchen staff. Requesting Ecolab technician to have the Dish Machine Chlorine dispenser be calibrated to correct PPM. Chlorine PPM should be 50 to 100 ppm. Ecolab Technician came on the same day 12/5/23 make the necessary calibration and was able to adjust the ppm to 100. All dishwashers will be required to do visual inspection on the dish machine setup aside from checking and logging the temperature and testing chlorine level for all three meals and to record the temperature and chlorine level to the Dish Machine Log Form. The facility will do an in-service on the same subject annually for the current staff continuing education and for the education of newly hired kitchen staff.	

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F 812	Continued From page 34 leftovers, so it is used by its use-by-date, or frozen (where applicable) or discarded. 3. During a concurrent observation of the kitchen and interview on 12/5/23 at 8:52 a.m. with DSS, there was a chemical insecticide inside the kitchen placed on an open shelf below a work desk. DSS stated, the insecticide spray should not be inside the kitchen where there was food preparation. During a review of the facility's P&P titled, "Food Service Management," dated 1/1/17, the P&P indicated pesticides and other toxic substances and drugs shall not be stored in the kitchen area or in storerooms for food or food preparation equipment and utensils. 4. During a concurrent observation of the kitchen and interview on 12/5/23 at 8:55 a.m. with DSS, the dishwashing temperature was 150 degrees Fahrenheit on the thermometer. During a random check of the chlorine (chemical sanitizing solution) level using the chlorine test strip, DSS stated, the chlorine level was 150. DSS stated, the water was too chlorinated. DSS stated, he would have the dishwasher recalibrated. During a review of the facility's log titled, "Dish Machine Temperature Log," dated 12/2023, the log indicated the following instructions: please record wash and rinse temperatures and chlorine parts per million (ppm, measurement system) before each meal. Run empty racks through machine until proper temperatures and chlorine level are reached. Wash and rinse temperatures must be at least 120 Fahrenheit (F). Chlorine should be 50 to 100 ppm. The log indicated chlorine ppm from 12/1/23 to 12/4/23 at	F 812	• **How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system:** The Administrator instructed DSS to audit food items on a daily basis. The Dietary Supervisor will check every food item stored for date labeled every day incorporating it on dietary supervisor's daily kitchen inspection. The Administrator instructed DSS to review the kitchen for presence of chemical insecticide on a daily basis. The Dietary Supervisor will check for any pesticides and other toxic substances on a daily basis incorporating it on dietary supervisor's daily kitchen inspection. The Administrator instructed DSS to audit dish machine Maintenance Log on schedule basis and "Dish Machine Temperature Log" before each meal. This audit will be included in the monthly QA meetings report. The Dietary Supervisor will check Dish Machine Log Form for recording and conduct visual inspection	

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F 812	Continued From page 35 breakfast, lunch, and dinner and 12/5/23 at breakfast time were between 95-100 ppm.	F 812	and separate chlorine testing incorporating it on dietary supervisor's daily kitchen inspection.	
F 911 SS=B	Bedroom Number of Residents CFR(s): 483.90(e)(1)(i) §483.90 (e)(1) Bedrooms must §483.90(e)(1)(i) Accommodate no more than four residents. For facilities that receive approval of construction or reconstruction plans by State and local authorities or are newly certified after November 28, 2016, bedrooms must accommodate no more than two residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure five out of 11 resident bedrooms accommodated no more than four residents in each room. Rooms 25, 27, 29, 31, and 33 had more than four residents as indicated in the facility's Client Accommodation Analysis (form indicating square footage measurement and number of residents for each room in the facility), signed and dated by the Administrator (Admin) on 12/6/23. This deficient practice had the potential to result in inadequate space for residents' mobility and staff provision of care to the residents in these rooms. Findings: A review of the facility's Client Accommodation Analysis (CAA) form dated 12/6/23, submitted by Admin on 12/7/23 at 2:57 p.m., the CAA form indicated that each of the following rooms were occupied by five residents:	F 911	**F 911:** • **How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The Room Waiver Request Letter has been submitted to CDPH. • **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** The Administrator conducted an audit on 12/06/2023 of all resident's rooms in the facility. There were adequate spaces available for the residents' use and movement. There were no adverse effects as to the adequacy of the spaces for nursing care, comfort, and privacy to the residents. There were no residents who expressed any concerns about the room sizes. No other residents were identified as affected. • **What measures will be put into place or what systemic changes the facility will make to ensure**	

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F 911	Continued From page 36	F 911	**that the deficient practice does not recur:**	

Room No.	No. of Beds	Room Square Footage
25	5	464.96 square feet (sq ft)
27	5	464.96 sq ft
29	5	464.96 sq ft
31	5	464.96 sq ft
33	5	464.96 sq ft

During a review of the facility's Room Waiver Request Letter (RWRL) dated 12/6/23, submitted by Admin on 12/7/23 at 2:57 p.m., the RWRL indicated that the facility is requesting for a room waiver for Rooms 25, 27, 29, 31, and 33 which had five beds in each room. The RWRL indicated that each of these rooms had ample space to accommodate wheelchairs and other medical equipment, as well as space for mobility and movement of ambulatory residents. The RWRL indicated that there was adequate space for nursing care, and the health and safety of residents occupying these rooms were not in jeopardy.

During an interview on 12/7/23 at 2:57 p.m. with Admin, Admin verified that Rooms 25, 27, 29, 31, and 33 were occupied by five residents in each room. Admin stated, these rooms were in accordance with the special needs of the residents and had adequate space to provide care for each resident and will not adversely affect the residents' health and safety.

During an observation of the five resident bedrooms for which a waiver was requested (Rooms 25, 27, 29, 31, and 33) on 12/7/23 at 3:13 p.m., there were adequate spaces available for the residents' use and movement. There were no adverse effects as to the adequacy of the

The Administrator submitted the Room Waiver Request Letter to CDPH on 12/07/2023.

- **How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system:**

The Administrator will continue submitting the Room Waiver Request Letter to CDPH on annual bases.

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F 911	Continued From page 37 spaces for nursing care, comfort, and privacy to the residents. There were no residents who expressed any concerns about the room sizes.	F 911		
F 919 SS=E	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to have a properly functioning call light system for 11 of 11 rooms (Room 23, 24, 25, 26, 27, 28 ,29, 30, 31, 32, and 33). This deficient practice had the potential to negatively affect the residents' well-being when the residents are unable to call staff for assistance. Findings: During the resident council meeting on 12/6/23 at 1:17 p.m., 11 out of 13 residents stated their rooms did not have a working call system. Resident 41 stated, some residents had to scream or yell to call the staff for assistance. Resident 38 stated, residents could wait for the	F 919	**F 919:** • **How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** All room call lights were repaired the same day. • **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** The Administrator conducted an audit on 12/12/2023 of all room lights in the facility. No other residents were identified as affected.	

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F 919	Continued From page 38 staff assigned to conduct the headcount to communicate their needs, but some residents had to scream or yell to call the staff for help. During an observation on 12/6/23 at 1:58 p.m. with Social Worker 1 (SW 1), there was a call button located close to each resident's bed in each room. Rooms 24, 25, 26, 27, 28, 29, 30, 31, 32, and Room 33 did not have an audible sound when the call system was pressed from one of the beds inside the room. Rooms 27, 28, 30, and 32 had a very faint light visible outside the room. During an interview on 12/6/23 at 2:30 p.m. with the Maintenance Supervisor (MS), MS stated his monthly maintenance included checking fire door latch, all doors, emergency exit lighting inspection, and generator run log. The MS stated, he completed a random check of the call system in Room 25 and Room 27 last week but did not document the inspection. During an interview on 12/6/23 at 2:35 p.m. with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated if the residents needed help, they could approach the staff during the headcount which was being conducted every 15 minutes. CNA 1 stated, during emergency situations which could happen anytime, the resident and/or staff could not wait 15 minutes to get help. CNA 1 stated, examples of emergencies would be if a resident was aggressive inside the room, if a staff needed help inside the room, and if a resident had a hard time breathing or had a heart attack. CNA 1 stated, it was important for the light outside the resident's room to be visible when the resident activated the call light so the staff could see which resident room needed help and staff could go in the room and check on the resident.	F 919	• **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** The MS will include call lights monitoring in his monthly maintenance procedure. • **How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system:** The Administrator will perform random call lights function check. The MS will include call lights function check in QA meetings report.	

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F 919	Continued From page 39	F 919		

During an interview on 12/7/23 at 10:53 a.m. with Resident 38, Resident 38 stated he had not used the call system because he knew the call system was not working.

During an interview on 12/7/23 at 11:01 a.m. with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated he did not notice that the sound of the call light system was not working. LVN 1 stated, it was important to have a functioning call system so the residents could use it to call for help.

During an observation on 12/7/23 at 3:29 p.m., the following rooms call system were checked:

Room 23 call system was pressed, lights turned on outside the room, but no sound activated at the nurse's station.

Room 24 call system was pressed, lights outside the room was faint and not visible, and no sound activated at the nurse's station.

Room 25 call system was pressed, lights outside the room was faint and barely visible, and no sound activated at the nurse's station.

Room 26 call system was pressed, lights outside was faint and barely visible, and no sound activated at the nurse's station.

Room 27 call system was pressed, no lights outside the room and no sound activated at the nurse's station.

Room 28 call system was pressed, lights turned on outside the room, but no sound activated at the nurse's station.

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F 919	Continued From page 40	F 919		

Room 29 call system was pressed, lights turned on outside the room, but no sound activated at the nurse's station.

Room 30 call system was pressed, lights tuned on outside the room, but no sound activated at the nurse's station.

Room 31 call system was pressed, lights turned on outside the room, but no sound activated at the nurse's station.

Room 32 call system was pressed, lights outside the room was very faint and no sound activated at the nurse's station.

Room 33 call system was pressed, lights outside the room was very faint and no sound activated at the nurse's station.

During an interview on 12/7/23 at 3:46 p.m. with the MS, MS stated he needed to change the bulb for the call light system to work properly.

During an interview on 12/7/23 at 3:51 p.m. with the Administrator (Admin), Admin stated he did not want the audible alarms on because he did not want to trigger any resident behavior. Admin stated, any abrupt sound and light could trigger behavioral symptoms. Admin stated, the facility did not have non-ambulatory residents and the residents could get the staff if the residents needed assistance.

During an interview on 12/7/23 at 4:16 p.m. with the Admin, Admin stated the facility did not have a policy and procedure on the call system. Admin stated, the facility only had the document titled

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F 919	Continued From page 41 "Operation of Resident Basic Unit," which indicated each resident room was equipped with two call lights/buttons and one next to the door as you enter the room. During a review of the facility's document titled "Operation of Resident Basic Unit," (undated), indicated each resident was equipped with two call lights/buttons. One is in the bathroom and one next to the door as you enter the room.	F 919		
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide a safe and sanitary environment for residents, staff, and the public by failing to ensure: 1. Staff immediately wipe clean Resident 5's saliva on the floor due to excessive drooling (saliva flowing out of the mouth uncontrollably) to prevent risk of slip and fall of resident, staff, and the public. 2. Staff monitor Resident 5's excessive drooling and dripping of saliva on the floor to prevent incident of slip and fall in the facility. As a result, on 12/7/23 at 9:32 a.m., Health Facilities Evaluator Nurse (HFEN) 1 slipped and fell on the floor in the hallway. HFEN 1 complained of pain and difficulty walking on the	F 921	**F 921:** • **How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** 1. Staff will immediately wipe clean Resident's saliva from the floor. 2. Staff will monitor Resident's excessive drooling and dripping of saliva on the floor. • **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** The DON conducted an audit on 12/12/2023 of all residents in the facility. No other residents were identified as affected.	

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F 921	Continued From page 42 left foot and sustained skin redness and discoloration on both knees and skin redness on the left foot. Findings: During a review of Resident 5's Admission Record, the Admission Record indicated the facility admitted Resident 5 on 12/13/22, with diagnoses that included schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly). During a review of Resident 5's Physician Order dated 8/9/23, the Physician Order indicated to give Glycopyrrolate (used to treat chronic, severe drooling) tablet 4 milligrams (mg, unit of measurement) by mouth two times a day for extrapyramidal symptoms (EPS, serious side effects that can develop after taking certain antipsychotic [drug for mental disorder] medication). During a concurrent observation and interview on 12/7/23 at 9:32 a.m. with the Director of Nursing (DON), Resident 5 and other residents were lined up in the hallway to receive their medications from the medication nurse in the medication pass room located in the utility room. Four staff (unidentified) were standing on the opposite side while watching the residents walk towards the utility room. HFEN 1 was walking beside the DON in the hallway when HFEN 1 suddenly stepped on slippery liquid then slipped and fell to the floor. DON assisted HFEN 1 to get up from the floor and then DON wiped the wet skid marks on the floor with paper towels. There were trails of several drops of clear liquid on the floor along the side where residents were lined up. Resident 5's	F 921	• **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** The physician discontinued Clozaril and reduced dose of Haldol regimen that caused excessive drooling. Patient is no longer drooling. • **How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system:** The DON will perform an audit of residents, receiving anti-psychotic medications to identify possible EPS. This audit will be included in the monthly QA meetings report.	

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F 921	Continued From page 43	F 921	**The Facility will be in substantial compliance no later than January 8, 2024**	

saliva was observed dripping on the floor as he walked towards the utility room to get his medications. DON stated, staff were aware of Resident 5's excessive drooling. DON stated, the slippery liquid was from Resident 5's excessive drooling that dripped on the floor that caused HFEN to slip and fall to the floor.

During a concurrent interview and record review on 12/7/23 at 2:35 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated he was walking by when he saw HFEN 1 slipped and fell to the floor in the hallway where Resident 5 and other residents were lined up for medication pass. LVN 1 stated, Resident 5 had been on Glycopyrrolate for excessive drooling of saliva. LVN 1 stated, staff were aware that Resident 5's saliva was dripping uncontrollably from his mouth to the floor whenever Resident 5 walked in the room or hallway. LVN 1 stated, staff who were watching the residents for medication pass did not wipe clean Resident 5's saliva on the floor, knowing Resident 5 was excessively drooling and Resident 5's saliva was dripping on the hallway floor. LVN 1 stated, staff should immediately wipe clean Resident 5's saliva on the floor to prevent slip and fall of resident, staff, and the public.

During a concurrent interview and record review on 12/7/23 at 3:51 p.m. with the DON, DON stated Resident 5's care plan for excessive drooling did not indicate nursing measures on how to provide a safe and sanitary environment from Resident 5's uncontrollable and excessive drooling and dripping of saliva on the floor to prevent the risk of slip and fall of resident, staff, and the public. DON stated, slip and fall incidents could be avoided if staff were to monitor Resident 5 in the room and hallway to immediately wipe

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F 921	Continued From page 44 clean Resident 5's saliva on the floor.	F 921		