STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555319	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunrise Post Acute	3476 W. Wilson St. Banning, CA 92220

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49113 Based on interview and record review, the facility failed to ensure education and resources regarding Advance Directive (AD - written statement of a person's wishes regarding medical treatment) were provided to the residents and/or resident reresentatives, for three of eight residents reviewed for Advance Directives (Residents 40, 46, and 54). This failure had the potential for Residents 40, 46, and 54 and the resident representatives uninformed about AD which could result in the facility being unable to know and honor the residents' wishes regarding their medical treatment. Findings: On August 6, 2024, Residents 40, 46, and 54's medical records were reviewed and indicated the following: 1. A review of Resident 40's ADMISSION RECORD, indicated Resident 40 was admitted to the facility on [DATE], with diagnoses which included bipolar disease (a disorder associated with mood swings), anxiety (worry about future concerns) and schizoaffective (mental health condition). A review of Resident 40's Minimum Data Set (MDS - an assessment tool), dated February 8, 2024, indicated, Resident 40 had a Brief Interview for Mental Status (BIMS - to assess cognitive function in residents) Score of 14 (cognitively intact). A review of Resident 40's AD acknowledgement form indicated Resident 40 does not have an AD. There was no documented evidence Resident 40 was provided education and resources regarding formulation of AD. 2. A review of Resident 46's ADMISSION RECORD, indicated Resident 46 was admitted to the facility on [DATE], with diagnoses which included dementia (general term for loss of memory, language and problem solving), Alzheimer (a disease that destroys the memory) and anxiety (feeling of worry and nervousness). A review of Resident 46's MDS, dated [DATE], indicated Resident 46 had a BIMS Score of 6 (severe cognitive impairment). (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident 46's record, indicated there was no documented evidence Resident 46 and or her representative was provided education and resources regarding formulation of AD. 3. A review of Resident 54's ADMISSION RECORD, indicated Resident 54 was admitted to the facility on [DATE], with diagnoses which included hemiplegia (partial or total paralysis of one side of the body), schizoaffective disorder (mental health condition characterized by mixed moods) and depression (persistent feelings of sadness). A review of Resident 54's MDS, dated [DATE], indicated Resident 54 had a BIMS Score of 11 (moderately impaired cognition). Further review of Resident 54's record indicated, there was no documented evidence Resident 54 and or his representative was provided education and information regarding formulation of AD. On August 7, 2024, at 4:29 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated the AD is initiated by nursing at admission, and the Social Services Director (SSD) is the responsible person. On August 7, 2024, at 4:36 p.m., a concurrent interview and record review was conducted with Social Services Director (SSD) of Resident 40, 46, and 54's medical records. The SSD stated the process for AD is when residents are admitted to the facility she offers and provide education and information about AD to the resident/and or representative if the resident is not able to make decisions. On August 8, 2024, at 4:55 p.m. during a concurrent interview and record review with the SSD, she stated Residents 40, 46, and 54 do not have AD. The SSD further stated she did not provide AD education to Residents 40, 46, 54, or their RP's regarding formulation of AD. The SSD fruther stated she should have provided AD education and information to give Residents 40, 46, 53 and their RP's the opportunity to make their medical decisions known. The facility's Policy and Procedures titled, Advanced Directives, dated December 2016, indicated .Upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advanced directive if he or she chooses to do so .Prior to or upon admission of a resident, the Social Services Director or designee will inquire of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives . Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49113 Based on observation, interview and record review, the facility failed to ensure a comfortable environment was provided, for eight of eight residents (Residents 40, 36, 28, 15, 17, 32, 48, and 53), when the temperature in the resident's rooms were above 81 degrees Fahrenheit. On August 5, 2024, at 7:51 p.m., the Administrator (ADM), the Director of Nursing (DON), and the Director of Staff Development (DSD), were verbally notified of the Immediate Jeopardy (IJ-situation in which the provider's noncompliance with one or more requirements of participation has caused or likely to cause serious injury, harm, impairment, or death, to a resident), due to the facility's failure to provide a comfortable environment for eight residents (Residents 40, 36, 28, 15, 17, 32, 48, and 53) when the resident's room temperature were above 81 degrees Fahrenheit. These failures resulted in the discomfort for Residents 40, 36, 28, 15, 17, 32, 48, and 53, particularly for Resident 17 who could not breathe properly and for Resident 53 who experienced agitation. In addition, this failure had the potential for the residents to experience exacerbation of respiratory and chronic illnesses. On August 6, 2024, 10:36 a.m., the facility presented an acceptable plan of actions which included the following: -The facility purchased additional five large swamp coolers and 10 free standing air-conditioning (AC) units on August 5, 2024. The swamp coolers (a device that cools air through the process of evaporation [liquid turns to gas])were placed in the hallways and the free-standing AC were placed in the hot and uncomfortable residents' rooms. -The facility identified the affected residents (Residents 15, 40, 36, 28, 17, 32, 53, and 48) and were assessed and monitored for adverse effects. -The facility-initiated room temperature checks in the affected resident rooms on August 5, 2024, starting 8 p. m., then every two hours and documented in the temperature log. -The facility staff will provide hydration every two hours from 10 a.m. to 8 p.m. -The ADM signed a contract to replace the AC units on August 6, 2024, and scheduled to install the AC units on August 13 to 15, 2024. -The affected residents will be interviewed by the activities staff during morning shift and the Certified Nursing Assistants (CNAs) during afternoon and evening shifts. If the resident's room temperature will not be controlled, the facility will provide room changes and close the affected rooms until the new AC will be installed. If there will be no available beds to accommodate room changes, the facility will utilize emergency transfer to other facilities. -New window treatment heat reduction film/tint will be placed on the windows and sliding doors of affected rooms on August 6, 2024; and (continued on next page)

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F 0584 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-The ADM will report average room temperature levels in the affected rooms every quarterly Quality Assurance (QA) meeting. On August 6, 2024, at 1:52 p.m. the Immediate Jeopardy was removed in the presence of the ADM, upon onsite verification of the implementation of the plan of actions. On August 6, 2024, at 2:03 p.m., the ADM was notified an extended survey would be conducted due to the substandard quality of care issues. Findings: 1. On August 5, 2024, at 10:56 a.m., an observation and interview with Resident 40 was conducted. Resident 40 was observed sitting up at the side of the bed watching television. Resident 40 stated it was warm in her room. On August 6, 2024, Resident 40's ADMISSION RECORD was reviewed. Resident 40 was admitted to the facility on [DATE], with diagnoses which included bipolar disorder (mental health condition associated with emotional highs and lows), hypertension (high blood pressure), and anxiety (feelings of worry about something of an uncertain outcome). A review of Resident 40's Minimum Data Set (MDS - an assessment tool), dated February 8, 2024, indicated a BIMS (Brief Interview for Mental Status) score of 13 (cognitively intact). 2. On August 5, 2024, at 11:10 a.m., a concurrent observation and interview were conducted with Resident 36, who was observed lying in bed. Resident 36 stated she felt warm in the room. On August 5, 2024, at 5:16 p.m., a concurrent observation and interview were conducted with the Maintenance Supervisor (MS). The MS checked the temperature in Resident 36's room on the wall above Resident 36's bed using the handheld infrared thermometer gun (a device that measured an object's temperature without making physical contact with it). The temperature read 87.4 degrees Fahrenheit. The MS stated the room temperature in Resident 36's room was not within the required comfortable range of 71 to 81 degrees Fahrenheit. On August 6, 2024, Resident 36's ADMISSION RECORD was reviewed. Resident 36 was admitted on [DATE], with diagnoses which included chronic obstructive pulmonary disease (a common lung disease that causes breathing problems and restricted airflow) hypertension (high blood pressure), and dementia (loss of cognitive function, memory and thinking). A review of Resident 36's MDS, dated [DATE], indicated a BIMS score of 3 (severe cognitive impairment). (continued on next page)

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F 0584 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	3. On August 5, 2024, at 11:18 a.m., a concurrent observation and interview was conducted with Resident 28. Resident 28 was observed lying in bed, receiving oxygen via nasal canula (a device that delivers extra oxygen through a tube and into your nose) which was connected to an oxygen concentrator [a machine which delivers supplemental oxygen]. The oxygen concentrator had cluttered personal items on top of it. A floor fan was observed blowing directly on Resident 28's face. In a concurrent interview, Resident 28 stated it was hot in the room and she had informed the nursing staff, the MS, and the maintenance assistant about the heat, but nothing was done. Resident 28 stated the heat problem in the room had been over a month. Resident 28 stated the facility provided a cooler outside her door, but they were so noisy, especially with the television on. On August 5, 2024, at 11:35 a.m., a concurrent observation and interview were conducted with the MS. The MS was observed to use a portable infrared handheld thermometer gun to check the temperature in Resident 28's room. The MS checked the temperature in the following areas of Resident 28's room with the following readings: - On the wall above Resident 28's head: 83.7 degrees Fahrenheit; - Above Resident 28's bed (at the level of bed light): 82.9 degrees Fahrenheit; and - The wall by the bathroom: 82.4 degrees Fahrenheit. During further interview with the MS, the MS stated the temperature should be between 65 to 85 degrees Fahrenheit. On August 5,2024, at 2:31 p.m., a concurrent observation and interview were conducted with the MS. The clock thermometer in Resident 28's room showed a reading of 85 degrees Fahrenheit, while Resident 28's personal room thermometer showed a reading of 84.4 degrees Fahrenheit. The MS was observed checking the temperature by the head of Resident 28's bed using a thermometer gun, which showed a reading of 87.7 degrees Fahrenheit. On August 5, 2024, Resident 28's ADMISSION RECORD was reviewed. Resident 28 was admitted to the facility on [DATE], with diagnoses which included asthma (a condition in which a person's airways become inflamed, narrow and swell, and produce extra mucus, which makes it difficult to breathe) and chronic respiratory failure (long-term condition that occurs when the body's respiratory system cannot exchange oxygen and carbon dioxide properly). A review of Resident 28's MDS, dated [DATE], indicated a BIMS score of 12 (cognitively intact). 4. On August 5, 2024, at 11:20 a.m., Resident 15 was observed lying in bed. Resident 15 was not able to answer questions appropriately when asked about the heat inside her room. On August 5, 2024, Resident 15's ADMISSION RECORD was reviewed. Resident 15 was admitted on [DATE], with diagnoses which included Alzheimer's disease (progressive disease that destroys the memory), and hypertension. A review of Residents 15's MDS, dated [DATE], indicated a BIMS score of 3 (severe cognitive impairment). (continued on next page)

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F 0584 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On August 5, 2024, at 2:42 p.m., the Administrator (ADM) was interviewed. The ADM stated he was initially made aware the air conditioning (AC) was broken around the first week of July 2024. The ADM stated the facility received a recommendation order for AC units 4 and 5 and obtained price quotes on July 10, 2024 and August 2, 2024. The ADM stated the facility acquired portable cooler fans and placed them in the hallway near the back hall station. The ADM stated the facility was not achieving the appropriate temperature level for resident's comfort. The ADM stated the MS checked the facility temperature daily and the facility's policy indicated the room temperature should be between 68 and 85 degrees Fahrenheit. The ADM stated he felt the humidity in Resident 28's room and found it uncomfortable. On August 5, 2024, at 4:45 p.m., the MS was interviewed. The MS stated two AC units had broken sometime in July 2024. The MS stated these broken AC units affected the rooms of Residents 15, 40, 36, 17, 32, 53, and 48. The MS stated they called an AC professional who recommended replacing the two broken AC units. The MS stated he received several price quotes for the AC units in July 2024, and submitted to the ADM. The MS stated the two broken AC units had not yet been replaced as of this time. The MS stated they have placed portable AC units in the hallways outside the affected residents' rooms. The MS stated the portable AC units were not sufficient to provide cooler air in the residents' rooms. The MS stated the required room temperature should be 71 to 81 degrees Fahrenheit. On August 5, 2024, at 4:47 p.m., a concurrent interview and review of room temperature monitoring log from July 2024 to August 2024, were conducted with the MS. The MS stated room temperatures were checked twice a day by him, and two other maintenance staff members. The MS stated, the temperature monitoring log did not indicate any temperature readings below 71 degrees Fahrenheit or above 81 degrees Fahrenheit. The MS stated the facility did not have a policy and procedure on how to accurately check a resident's room temperature using the infrared thermometer gun. 50122 5. On August 5, 2024, at 5:15 P.M., during a concurrent observation in Resident 17's room and interview with Resident 17, Resident 17 was observed lying in bed, awake. Resident 17 stated she felt hot. Resident 17 stated she had spoken to her Family Member (FM) about her concerns related to the room temperature. On August 5, 2024, at 5:19 P.M., an observation with a concurrent interview was conducted with the MS. The MS used a thermometer gun to check the room temperature in Resident 17's room. The MS pointed the thermometer gun at the wall above Resident 17's headboard which showed a temperature of 91 degrees Fahrenheit. The MS stated the required comfortable room temperature was from 71 degrees Fahrenheit to 81 degrees Fahrenheit. The MS stated Resident 17's room temperature was not good. On August 6, 2024, at 8:45 A.M., an interview was conducted with Resident 17's FM. The FM stated the room temperature in Resident 17's room was uncomfortable since early June 2024. The FM stated the room temperature in Resident 17's room was hot and uncomfortable. The FM further stated the temperature in Resident 17's room was hot and uncomfortable and Resident 17 had complained about the heat, which made it difficult for her to breathe properly. The FM stated the air conditioner (AC) felt like it was blowing hot air which made Resident 17 uncomfortable in her room. The FM stated she was unaware if the facility staff had offered Resident 17 a room change. (continued on next page)

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F 0584 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On August 7, 2024, Resident 17's ADMISSION RECORD was reviewed. Resident 17 was admitted to the facility on [DATE], with diagnoses which included dementia (memory loss), anxiety (type of mental disorder), diabetes (high blood sugar), and hypertension (high blood pressure). A review of Resident 17's Minimum Data Set, dated dated [DATE], indicated Resident 17's BIMS score was 8 (moderate cognitive impairment). 6. On August 5, 2024, at 5:20 P.M., a concurrent observation and interview was conducted with Resident 32 in her room. Resident 32 was observed sitting on the edge of bed and was awake. Resident 32 stated it had been hot in the room for the past month and the fan was not helping. Resident 32 stated the room temperature was unusually hot and the facility had never offered a room change due to the increased room temperature. Resident 32 stated she was not aware of any issue with the AC units. On August 5, 2024, at 5:22 p.m., an observation with a concurrent interview were conducted with the MS. The MS used a thermometer gun to check the room temperature in Resident 32's room. The MS pointed the thermometer gun at the wall above Resident 32's headboard. The thermometer gun read the temperature at 90.5 degrees Fahrenheit. The MS stated the required comfortable room temperature was from 71 degrees Fahrenheit to 81 degrees Fahrenheit. The MS stated Resident 32's room temperature was not good. On August 7, 2024, Resident 32's 'ADMISSION RECORD was reviewed. Resident 32 was admitted to the facility on [DATE], with a diagnosis that included bilateral osteoarthritis of knee (bone disease of both knees), fibromyalgia (a chronic disorder that causes widespread pain and tenderness in the body), dementia, and depression (feeling of hopelessness). A review of Resident 32's MDS, dated [DATE], indicated Resident 32's BIMS score was 15 (cognitively intact). 7. On August 5, 2024, at 5:23 p.m., a concurrent observation and interview were conducted with Resident 48 in his room. Resident 48 was observed lying on bed and was awake. Resident 48 stated the temperature in the room was hotter than usual and this was the first time he had experienced such high temperatures. Resident 48 stated staff had never offered any help or a room change due to increased room temperature. On August 5, 2024, at 5:23 p.m., an observation with a concurrent interview were conducted with the MS. The MS used a thermometer gun to check the room temperature in Resident 48's room. The MS pointed the thermometer gun at the wall above Resident 48's headboard which showed a temperature of 88.7 degrees Fahrenheit. The MS stated the required comfortable room temperature range is from 71 degrees Fahrenheit to 81 degrees Fahrenheit. The MS stated Resident 48's room temperature does not meet required criteria for a safe room temperature. On August 7, 2024, Resident 48's ADMISSION RECORD was reviewed. Resident 48 was admitted to the facility on [DATE], with a diagnosis of cerebral infarction (disrupted blood flow in the brain) with left sided deficit (weakness), diabetes mellitus (abnormal blood sugar), morbid obesity, depression (feeling of sadness), and cardiomegaly (enlarged heart). A review of Resident 48's MDS, dated [DATE], indicated Resident 48's BIMS score was 13 (cognitively intact). (continued on next page)

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F 0584 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	8. On August 5, 2024, at 5:24 p.m., a concurrent observation and interview were conducted with Resident 53 in his room. Resident 53 was observed lying on bed and was awake. Resident 53 stated the temperature in the room had been hot for the past two months and the staff had not offered assistance, or a room change despite the increased temperature. Resident 53 stated he had told nursing staff multiple times over the past month about the discomfort, but no help was offered. Resident 53 stated he was not aware of any issues related to the AC. Resident 53 became agitated and yelled at the MS due to the extreme heat and the lack of information about why the temperature was elevated. On August 5, 2024, at 5:25 p.m., a concurrent observation and interview were conducted with the MS. The MS was observed using the thermometer gun to check the temperature above Resident 53's bed. The thermometer gun recorded a temperature of 87.3 degrees Fahrenheit. A review of the facility's policy and procedure titled, Quality of Life-Homelike Environment, dated 2002, indicated, .The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include .Comfortable and safe temperatures (71 F - 81 F) . A review of the undated facility's policy and procedure titled, Providing Comfortable and Safe Temperature Levels for Residents, indicated, .It is the policy to provide comfortable and safe temperature levels for the residents. The facility will maintain a temperature range of 71-81 F .The facility will follow regulations and maintain an acceptable temperature level for the residents. The facility will measure the air temperature above floor level in resident rooms, dining areas, and common areas. If the temperature is out of the 71-81-degree range, the staff will report this to the maintenance department who then will check the system. Actions will be taken by maintenance department and staff when residents complain of heat or cold, e.g., check and fix air conditioning system .provide extra fluids during heat waves .

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49113 Based on interview and record review, the facility failed to ensure for one of six residents reviewed (Resident 32), the resident was able to voice a grievance without feeling uncomfortable. This failure had the potential for Resident 32's concerns to go unaddressed, leading to ongoing dissatisfaction and affecting the resident's quality of life. Findings: A review of Resident 32's ADMISSION RECORD, indicated, Resident 32 was admitted to the facility on [DATE], with diagnoses which included bilateral osteoarthritis of the knee (bone disease of both knees), fibromyalgia (chronic disorder that causes widespread pain in the body), dementia (disease characterized by loss of memory and language) and depression (feelings of hopelessness). A review of Resident 32's Minimum Data Set (an assessment tool) dated July 3, 2024, indicated Resident 32's Brief Interview for Mental Status (tool to assess cognitive function in residents) score was 15 (cognitively intact). On August 7, 2024, at 9:57 a.m., during the Resident's Council meeting, Resident 32 stated she was not comfortable filing a grievance with the SSD. Resident 32 further stated the SSD had an attitude. On August 8, 2024, at 2:51 p.m., an interview was conducted with the Administrator (ADM) about grievances. The ADM stated grievances are filed and followed up by the SSD. The ADM further stated his expectation is for residents to feel comfortable approaching the SSD or any staff when filing a grievance. The ADM further stated that the SSD should not have an attitude with residents. The facility's Policy and Procedures titled, Resident Rights, dated February 2021 stated .Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include resident's right to: voice grievance to the facility, or other agency that hears grievances, without discrimination or reprisal and without fear of discrimination or reprisal .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36684 Based on observation, interview, and record review, the facility failed to ensure the medication Carvedilol (medication used to treat high blood pressure) was administered as directed by the licensed nurse, for one of nine residents observed for medication administration (Resident 47). This failure has the potential for the resident to experience adverse effects of the medication if not taken as directed. Findings: On August 7, 2024, at 8:37 a.m., a medication administration observation was conducted with Licensed Vocational Nurse (LVN) 3. LVN 3 prepared Resident 47's medication that included Carvedilol 3.125 milligrams (mg- unit of measurement). The instructions on the medication bubble pack indicated to give one tablet of Carvedilol 3.125 mg by mouth. The medication label included an instruction to give the medication with food. On August 7, 2024, at 8:50 a.m., LVN 3 administered Resident 47's medication including the one tablet of Carvedilol 3.125 mg. LVN 3 was observed to not have given food to Resident 47 before and/or after she administered the medication Carvedilol. On August 7, 2024, at 9:02 a.m., LVN 3 proceeded to prepare the medication of the residents across Resident 47's room. LVN 3 was still not observed to have provided food or snack to Resident 47. On August 7, 2024, at 9:20 a.m., an observation, interview, with a concurrent record review was conducted with LVN 3. LVN 3 stated, Resident 47 had a physician's order to give Carvedilol 3.125 mg one tablet by mouth two times a day. LVN was observed to have pulled out Resident 47's Carvedilol medication bubble pack and stated the medication label indicated to give with food. LVN 3 stated she Resident 47 had breakfast earlier at around 7 a.m. LVN 3 reviewed Res 47's record and stated the Certified Nursing Assistant (CNA) did not document Resident 47's food intake for breakfast. LVN stated she did not know if Resident 47 ate breakfast because it was not documented. LVN 3 stated she should have given the Carvedilol with food when she administered the medication to Resident 47 on August 8, 2024, at 8:50 a.m. LVN 3 stated Resident may experience dizziness, nausea and vomiting if she took the Carvedilol without food. On August 7, 2024, Resident 47's record was reviewed. Resident 47 was admitted to the facility on [DATE], with diagnoses hypertension (high blood pressure). The physician's order dated October 19, 2024, indicated to give one tablet Carvedilol of Carvedilol by mouth twice a day. (continued on next page)

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Sunrise Post Acute	3476 W. Wilson St. Banning, CA 92220

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The care plan dated October 17, 2023, indicated, .Focus .Hypertension .Interventions .Carvedilol as ordered by MD (Medical Doctor) . The Lexicomp drug reference (electronic drug reference) indicated the side effects of Carvedilol including, . feeling dizzy .upset stomach, or throwing up .Take this drug with food . The facility's policy and procedure titled, Administering Medications, dated April 2019, was reviewed. The policy indicated, .Medications are administered in a safe and timely manner, and as prescribed .Medication administration times are determined by resident need and benefit .Factors that are considered include . enhancing the optimal therapeutic effect of the medication .preventing potential medication and food interactions .

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 36684 Based on observation, interview, and record review, the facilty failed to ensure Licensed Vocational Nurse (LVN) 1 was provided adequate training in the documentation of a narcotic pain medication administration for two of three residents reviewed (Residents 6 and 14). This failure has the potential to result in inaccurate assessment of the resident's pain and documentation of pain medication administration. Findings: On August 8, 2024, at 10:29 a.m., an observation, interview, with a concurrent record review was conducted with Registered Nurse (RN) 1. A narcotic medication reconciliation was conducted and the following were observed: a. Resident 14 had a medication bubble pack for the medication Oxycodone-Acetaminophen (narcotic pain medication that is controlled due to it's high potential for addiction) 10-325 milligrams (mg - unit of measurement) with a stock dose of 13 tablets. The medication count sheet for the Oxycodone-Acetaminophen 10-325 mg indicated one tablet was signed out on July 23, 2024 at 12:53 p.m., by LVN 1 and LVN 3. In a concurrent interview, RN 1 stated, the electronic Medication Administration Record (eMAR) dated July 1 to 31, 2024, did not indicate if LVN 1 administered the Oxycodone-Acetaminophen to Resident 14 on July 23, 2024 at 12:53 p.m. RN 1 stated there was no documented evidence of a pain assessment conducted on Resident 14 when the Oxycodone-Acetaminophen was signed out from the medication count sheet by LVN 1 and LVN 3 on July 23, 2024 at 12:53 p.m. RN 1 stated there was a documented medication administration entry electronically signed by LVN 1 on July 23, 2024, at 1:30 p.m. indicating that the medication was administered by LVN 1 to Resident 14 because of Resident 14's complain of shoulder pain. RN 1 further stated this medication administration entry was striked-out (crossed-out and/or cancelled) by LVN 1 on August 2, 2024, at 6:26 a.m. RN 1 stated she did not know the reason why LVN 1 striked out the medication administration note on August 2, 2024, at 6:26 a.m. RN 1 stated she did not find any other documentation if the medication was administered to Resident 14 on July 23, 2024. b. Resident 6 had a medication bubble pack for the medication Oxycodone HCL (narcotic pain medication that is controlled due to it's high potential for addiction) 5 milligrams (mg-unit of measurement) with a stock dose of 11 tablets. The medication count sheet for the Oxycodone HCL indicated one tablet was signed out by LVN 1 on July 30, 2024, at 9:00 p.m. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a concurrent interview, RN 1 stated the electronic Medication Administration Record (eMAR) dated July 1 to 31, 2024, did not indicate if LVN 1 administered the Oxycodone HCL to Resident 6 on July 30, 2024, at 9:00 p.m. RN 1 stated there was no documented evidence of a pain assessment conducted on Resident 6 when the Oxycodone HCL was signed out from the medication count sheet by LVN 1 on July 30, 2024 at 9:00 p.m. RN 1 stated there was a documented medication administration entry electronically signed by LVN 1 on July 30, 2024, at 8:30 p.m. indicating that the medication was administered by LVN 1 to Resident 14 because of Resident's complain of pain with a pain level of 8/10 (pain level of 1 to 2 for mild pain, 3 to 5 for moderate pain, 6 to 8 for severe pain, 9 to 10 for very severe pain). RN 1 further stated this medication administration entry was striked-out (crossed-out and/or cancelled) by LVN 1 on August 2, 2024 at 6:27 a.m. RN 1 stated she did not know the reason why LVN 1 striked out the medication administration note on August 2, 2024, at 6:27 a.m. RN 1 further stated she did not find any other documentation if the medicatin was administered to Resident 6 on July 30, 2024, at 9:00 p.m. RN 1 stated the facility's process in administering as needed (PRN) narcotic pain medication. RN 1 stated Licensed Nurse (LN) will assess resident for pain level, location, will offer non-pharmacological intervention, if ineffective, will check physician order for medication that is due. RN 1 stated, if a narcotic pain medication was due to be given, the LN will sign out the narcotic pain medication from the Medication Count Sheet, , administer the medication, sign the eMAR as administered, and then evaluate after a couple of minutes resident for the effectiveness of the medication. RN 1 stated there was no documented evidence this process was followed by LVN 1 when he signed out the Oxycodone-Acetaminophen 10-325 mg on July 23, 2024, at 12:53 p.m. for Resident 6, and the Oxycodone HCL on July 30, 2024, at 9:00 p.m. for Resident 14. On August 8, 2024, at 4:15 p.m., an interview witha concurrent record review was conducted with the Director of Nursing. the following records were reviewed: a. For Resident 14, the eMAR, dated July 1 to 31, 2024, indicated previously unsigned as administered, the medication Oxycodone-Acetaminophen 10-325 mg was now signed as administered by LVN 1 July 23, 2024 at 12:53 p.m. In addition, the facility document titled, .Medication Administration Note, indicated, .Effective Date: 07/23/2024 .Created by: (name of LVN 1) .Created Date: 8/8/2024 12:25 p.m .oxyCODONE-Acetaminophen Oral Tablet 10-325 MG .Give 1 tablet by mouth every 4 hours as needed .c/o (complained of) shoulder pain 8/10 . b. For Resident 6, the eMAR, dated July 1 to 31, 2024, indicated previously unsigned as administered , the medication Oxycodone HCL 5 mg was now signed as administered by LVN 1 on July 30, 2024, at 9:00 a.m. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In addition, the facility document titled, .Medication Administration Note, indicated, .Effective Date: 07/23/2024 .Created by: (name of LVN 1) .Created Date: 8/8/2024 12:37 p.m .oxyCODONE HCL Oral Tablet 5 MG .Give 1 tablet by mouth every 4 hours as needed for moderate to severe BTP (breakthrough pain) . PRN (as needed) Administration was: Effective . In a concurrent interview, the DON stated she did not know LVN 1 created a late entry on August 8, 2024, (back dated) for the narcotic pain medications supposedly administered to Resident 14 on July 23 and Resident 6 on July 30. The DON stated LVN 1 should have signed these medications as administered tight after giving ther medication to Residents 14 and 6. On August 8, 2024, at 6:01 p.m., an interview was conducted with LVN 1. LVN 1 stated he was the licensed nurse who signed out the narcotic pain medication for Resident 14 (Oxycodone-Acetaminophen) on July 23, 2024, at 12:53 p.m. and Residnet 6 (Oxycodone HCL 5 mg) on July 30, 2024, at 9:00 p.m. LVN 1 stated he administered the narcotic pain medication to both Residents 14 and 6 under the supervision of another licensed nurse (LVNs 3 and 4) and he signed the eMAR after the administration of the medication. LVN 1 stated on August 2, 2024, he stressed out and he assumed he should have not signed the eMARs for both Residents 14 and 6 after he administered the PRN narcotic pain medication on July 23 and July 30, 2024, because he was still in training'. LVN 1 stated he did not notify anyone that he striked out the PRN narcotic pain medication eMAR entries for both Residents14 and 6 on August 2, 2024. LVN 1 stated he did not notify anyone when he accessed Residents 14 and 6 electronic records on August 8, 2024, to create a late entry for the PRN narcotic pain medication administered to Resident 14 on July 23, 2024, and Resident 6 on July 30, 2024. LVN 1 further stated he was unsure of his documentation on Residents 14 and 6's medical record. LVN 1 stated his actions were due to lack of knowledge and training on proper documentation on resident's records. On August 8, 2024, at 6:41 p.m., an interview with a concurrent record review was conducted with the Director if Staff Development (DSD). LVN 1's Medication Pass Observation Skills Check was condcuted by the DON on July 13, 2024. The Medication Pass Observation list indicated .Signed for administered medications . In a concurrent interview, the DSD stated LVN 1 needed more on competency and skills check in medication pass and documentation. The DSD further stated she did not know what to say because LVN 1 had his training skills check during his orientation. The facility's policy and procedure titled, Administering Pain Medications, dated march 2020 was reviewed. The policy indicated, .Documentation .Document the following in the resident's medical record .Result of pain assessment .Medication .Dose .Route of administration .Results of the medication .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36684 Based on interview, and record, review, the facility failed to ensure the licensed nurse documented the medication Hydrocodone-Acetaminophen (controlled drug pain medication) as administered for one of three residents reviewed (Resident 34). This failure resulted to the delay in the identification of drug discrepancies and possible medication diversion of controlled medications. Findings: On August 8, 2024, at 10:55 a.m., an observation, interview, and record review was conducted narcotic medication reconciliation was conducted with Registered Nurse (RN) 1. Resident 34 was admitted to the facility on [DATE], with diagnoses that included osteoarthritis (type of degenerative joint disease that can affect joint tissues, usually manifested by pain). The Physician's Order dated March 12, 2024, indicated to give Norco Oral (brand name of narcotic pain medication) 5-325 milligrams (mg) one tablet by mouth every six hours as needed for moderate to severe pain. The Medication Count Sheet indicated Licensed Vocational Nurse (LVN 2) signed out one tablet of Norco 5-325 mg on July 16, 2024, at 5:20 a.m. The electronic Medication Administration Record (eMAR) dated July 1 to 31, 2024, did not indicate if the Norco 5-325 mg, signed out by LVN 2, was administered to Resident 34 on July 16, 2024, at 5:20 a.m. There was no documented evidence the medication Norco 5-325 mg was documented as administered to Resident 34 by LVN 2 on July 16, 2024, at 5:20 a.m. RN 1 stated the facility's process in administering PRN narcotic pain medication. RN 1 stated Licensed Nurse (LN) will assess resident for pain level, location, will offer non-pharmacological intervention, if ineffective, will check physician order for medication that is due. RN 1 stated, if a narcotic pain medication was due to be given, the LN will sign out the narcotic pain medication from the Medication Count Sheet, , administer the medication, sign the eMAR as administered, and then evaluate after a couple of minutes resident for the effectiveness of the medication. RN 1 stated she did not find documentation if this process was followed by LVN 2 on Resident 34. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's undated policy and procedure titled, Policy and Procedures for Pharmaceutical Services (Name of Pharmacy), was reviewed. The policy indicated, .Drugs with high abuse potential will be subject to special handling, storage, disposal, and record keeping .The nurse has to enter the following information on the narcotic drug record immediately after a dose of a controlled drug is administered .Date and time of administration .Dose administered .signature of then nurse that administered the medication .

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47202 Based on interview and record review, the facility failed, for three of five residents reviewed for unnecessary medication (Residents 5, 53, and 56), to ensure: a. An assessment was conducted for the continued use of antipsychotic medications (medication to treat mental disorders) for Residents 5, 53 and 56; and b. Monitoring for the use of hypnotic medication (medication use to help people fall asleep) for Resident 56. These failures had the potential for Residents 5, 53 and 56 to not be properly monitored and to receive unnecessary medications that could cause harm and or death. Findings: 1. On August 7, 2024, Resident 5's ADMISSION RECORD, was reviewed. Resident 5 was admitted to the facility on [DATE], with diagnoses which included bipolar disorder (mental disorder that causes extreme mood swings). A review of Resident 5's History and Physical dated July 11, 2024, indicated Resident 5 can make decisions. A review of Resident 5's Order Summary Report, dated July 1- 31, 2024, indicated, .Aripiprazole (an antipsychotic) Oral Tablet 30 mg (milligrams - unit of measurement) give 1 (one) tablet by mouth in the morning for Bipolar Disorder . A review of Resident 5's Interim Medication Regimen Review, dated July 11, 2024, indicated, .Potentially Inappropriate Medications .Aripiprazole .Oral antipsychotic meds (sic) (medications) . Further review of Resident 5's record indicated, there was no documented evidence the physician assessed Resident 5 for the continued use of Aripiprazole. On August 8, 2024, at 11:21 a.m., a concurrent interview and review of Resident 5's record was conducted with the Director of Nursing (DON). The DON stated the process for continued use of antipsychotic medication involves the physician assessing the resident upon admission and reviewing (reconciling) the medication for appropriateness. The DON stated Resident 5 was not assessed by the physician for the continued use of Aripiprazole. The DON further stated the physician should have assessed Resident 5 and documented the reason for the continued use of Aripiprazole to ensure safety and that the medication remains appropriate. 36684 (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On August 7, 2024, at 11:21 a.m., an interview with a concurrent record review was conducted with the Director of Nursing (DON). Resident 53 was admitted to the facility on [DATE], with diagnoses that included insomnia (sleeplessness), anxiety, and psychosis (type of behavioral disorder). The physician's order dated May 17, 2024, indicated to give Ambien (brand name of a medication used to treat sleeplessness) 5 mg by mouth for bedtime for insomnia manifested by inability to sleep. The physician's order dated June 1, 2024, indicated to monitor and document Resident 53's hours of sleep daily from the evening shift (3 p.m. to 11 p.m.) and night shift (11 p.m. to 7 a.m.) related to Ambien use. The physician's order dated December 28, 2023, indicated Resident 53 was capable of giving informed consent and/or able to participate in treatment plan. The Consultant Pharmacist (CP) document dated June 13, 2024, indicated, .Note to Attending Physician/Prescriber .Currently on Ambien QHS (at night) routinely for insomnia. Can it be tried as giving 1 or 2 nights off per week if clinically indicated/appropriate .Physician/Prescriber Response .Disagree .Pt. (patient) cannot tolerate .(signature of physician) .Date 6/17/2024 . The physician's progress notes, dated June 17, 2024, indicated, .unable to taper down Ambien, cannot sleep . The Psychotropic Summary Record indicated the facility's monitoring of Resident 53's inability to sleep in the evening and night shift on the following dates: - May 1 to 31, 2024 - 10 episodes; - June 1 to 30, 2024 - 0 episodes; and - July 1 to 31, 2024 - 13 episodes. The following electronic Medication Administration Records indicated Resident 53's recorded number of sleeping hours during the evening and night shift: - May 1 to 31, 2024, indicated hours of sleep were ranging from 5 (x1 episode) to 10 hours ; - June 1 to 31, 2024, indicated sleep hours were ranging from 6 to 10 hours - July 1 to 31, 2024, indicated sleep hours were ranging 4 hrs (x1 episode) to 10 hours. The Interdisciplinary (IDT) Psychotherapeutic Review, dated July 10, 2024, created by Licensed Vocational Nurse (LVN) 5, did not indicate if the medication Ambien and the effectiveness of the medication were discussed with the psychiatrist during the July 10, 2024, visit to the resident. There was no documented evidence the physician or psychiatrist evaluated Resident 53's continued use of Ambien 5 mg by mouth every night routinely and had attempted a frequency reduction (do not give one to two days at night per week) of the dose as recommended by the CP on June 13, 2024. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a concurrent interview with the DON, she stated Resident 53's physician should have documented a rationale as to why he did not agree to an attempt frequency reduction on the Ambien on June 17, 2024. The DON stated there was no documented evidence the licensed nurses had attempted a frequency reduction on Resident 53's Ambien use since recommended by the CP on June 13, 2024. In addition, the DON stated there was no documented evidence the IDT behavioral management team, discussed with the psychiatrist on July 10, 2024, the CP recommendation to attempt medication frequency reduction on June 13, 2024. On August 7, 2024, at 4:05 p.m., an observation with a concurrent interview, was conducted with Resident 53. Resident 53 was in his room, alert and interviewable. Resident 53 stated he was aware he was taking Ambien and he was able to sleep well at night. Resident 53 further stated no one from the facility, referring to the licensed nurses or physician, had ever asked him if he could do a trial attempt on taking the routine Ambien to five times a week at night. On August 8, 2024, at 8: 17 a.m., an interview with a concurrent review was conducted with the DON. The DON stated Resident 53's insomnia manifested by inability to sleep was being monitored by the licensed nurses through documentation of the resident's hours of sleep in the evening and night shift. The DON stated at least a minimum of five hours of sleep was considered an adequate hours of sleep for Resident 53. Discussed with the DON the recorded numbers of episodes of inability to sleep in the Psychotropic Summary Record (May to June 2024) versus the recorded hours of sleep in the eMAR (May to June 2024). The DON stated the monitoring of Resident 53's hours of sleep in the eMAR (May to June 2024) was not consistent with the documented episodes in the Psychotropic Summary Record (May to June 2024). The DON stated Resident 53's physician progress notes on June 17, 2024 .unable to taper down Ambien, cannot sleep . was not consistent with Res 53's recorded information on the hours of sleep in May and June 2024. The DON stated there was no documented evidence the effectiveness of the medication Ambien on Resident 53 was monitored accurately and was discussed with the physician and psychiatrist. The facility's policy and procedure titled, Psychotropic Medication Use, dated July 2022 was reviewed. The policy indicated, .Residents will not receive medications that are not clinically indicated to treat a specific condition .Nursing staff will observe, document, and report to the attending physician information regarding the effectiveness of any interventions, including psychotropic medications .The physician shall respond appropriately by changing or stopping problematic doses or medications, or clearly documenting based on assessing the situation) why the benefits of the medication outweigh the risks . (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. On August 8, 2024, an interview with a concurrent record review was conducted with the Director of Nursing (DON). Resident 56 was admitted to the facility on [DATE], with diagnoses including bipolar disorder (type of behavioral disorder), major depressive disorder, suicidal ideation (type of behavioral disorder). The physician's order dated July 18, 2024, indicated Divalproex Sodium Oral Tablet (medication used to treat bipolar disorder) Delayed Release 250 MG (milligrams) give three tablet by mouth two times a day for bipolar disorder m/b (manifested by) mood swings medication. The physician's order dated July 31, 2024, indicated Haloperidol (medication used to treat psychosis) Oral Tablet 5 mg to give one tablet by mouth two times a day for psychotic disorder m/b mood swings and suicidal ideation. The physician's order dated July 18, 2024, indicated Trazodone HCl Oral Tablet (medication used to treat insomnia) to give one tablet by mouth at bedtime for depression m/b inability to sleep. The physician's order dated July 18, 2024, indicated to give (medication used to treat depression) Delayed Release Sprinkle 30 mg to give one capsule by mouth three times a day for depression m/b worriness r/t medical condition. The History and Physical (H&P) physician notes, dated July 19, 2024, indicated Resident 56 did not have the capacity to understand and make decisions. The H&P did not indicate an evaluation or an assessment conducted to justify the continued use of the psychotropic medication, Depakote,Trazodone, Duloxetine Hcl, from admission in July 18, 2024. There was no documented evidence of an assessment or evaluation conducted on Resident 56 to justify the need to continue Trazodone, Divalproex Sodium Oral Tablet, and Duloxetine Sodium Oral Capsule from admission on July 18, 2024. In a concurrent interview, the DON stated upon admission the nurses verify with the resident's primary physician if it was okay to continue with the admission orders from the hospital including the use of psychotropic medications, but they do not conduct an assessment or evaluation on the need to continue the use. On August 8, 2024, at 9:24 am, an interview with a concurrent record review was conducted with Social Service Director (SSD). The SSD stated sometimes she does and sometimes she does not conduct an assessment on the continued use of psychotropic medications from admission, The SSD stated the Social History Assessment she had conducted on Resident 56 in July 28, 2024, did not include an assessment or evaluation that would justify the need to continue the current medication dose of Trazodone, Divalproex Sodium Oral Tablet, and Duloxetine Sodium Oral Capsule. (continued on next page)

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	555319	A. Building B. Wing	08/08/2024

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Sunrise Post Acute	3476 W. Wilson St. Banning, CA 92220

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's policy and procedure titled, Psychotropic Medication Use, dated July 2022 was reviewed. The policy indicated, .Residents will not receive medications that are not clinically indicated to treat a specific condition .Residents who are admitted from the community or transferred from a hospital and who are already receiving psychotropic medications will be evaluated for the appropriateness and idications for use. The interdisciplinary team will .re-evaluate the use of the psychotropics at the time of admission and/or within two weeks .to consider whether or not the medication can be reduced, tapered, or discontinued .

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50122 Based on observation, interview, and record review, the facility failed to provide timely dental services for one of nine residents, (Resident 21). This failure had the potential to lead to mouth pain, infection, and/or complications related to dental and nutritional needs for Resident 21 if left untreated. Findings: On August 5, 2024, Resident 21's ADMISSION RECORD, was reviewed. Resident 21 was admitted to the facility on [DATE], with diagnoses which included multiple sclerosis (a central nervous system autoimmune disease, and anxiety disorder (a chronic condition characterized by an excessive and persistent sense of apprehension). A review of Resident 21's Care Plan, dated January 12, 2024, indicated, .Has oral/dental health problems r/t (related to) obvious or likely cavity or broken natural teeth . Coordinate arrangements for dental care, transportation as needed/as ordered, report to MD (physician) s/sx (signs and symptoms) of oral/dental problems needing attention . A review of Resident 21's Minimum Data Set (MDS-an assessment tool), Section L (Oral/Dental Status,) dated January 19, 2024, indicated, .Obvious or likely cavity or broken natural teeth . On August 6, 2024, at 10:41 a.m., a concurrent observation and interview were conducted in Resident 21's room. Resident 21 had no dentition on the left upper side of her mouth. Resident 21 stated she had missing teeth, and no dentures. Resident 21 further stated the facility had not arranged a dental appointment. On August 8, 2024, at 9:48 a.m., an interview was conducted with the Social Service Director (SSD), she stated Resident 21 had missing dentition when admitted to the facility. The SSD stated she had not referred Resident 21 to the dentist for the missing teeth. The SSD further stated she should have made a referral to prevent pain, redness or swelling to the residents's mouth. On August 8, 2024, at 10:04 a.m., a concurrent interview and record review of Resident 21 MDS was conducted with Licensed Vocational Nurse (LVN) 5. LVN 5 stated Resident 21 had missing teeth and dental issues and had not been referred to the dentist. LVN 5 further stated, Resident 21 should have been referred to the dentist for dental care. LVN 5 stated it is important for residents to receive dental services to prevent pain or swelling in the mouth. A review of the policy and procedure titled, Social Services, dated October 2010 indicated, . facility provides medically-related social services to assure that each resident can attain or maintain his/her highest practicable physical, mental, or psychosocial well-being .Medically-related social services is provided to maintain or improve each resident's ability to control everyday physical needs .e.g. appropriate adaptive equipment for eating .and mental and psychosocial needs .

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 47202 Based on interviews and record reviews, the facility failed to ensure dietary staff were able to carry out the functions of food and nutrition services safely and effectively when [NAME] (CK) 1 and Dietary Aide (DA) 1 were unable to accurately verbalize the cool down process for hot food and ambient food temperatures. This failure had the potential to place residents at risk for food borne diseases (illness resulting from ingestion of contaminated food) that can cause sickness and or death. Findings: On August 6, 2024, at 12:50 p.m., during an interview with DA 1 regarding the cool-down process for hot food and ambient food temperatures inside the kitchen, DA 1 stated she does not know the cool-down process for hot food. DA 1 further stated I will put ice on it. DA 1 stated for cooling down ambient food temperatures, such as tuna salad, she would place the tuna on ice after the food is made. DA 1 further stated she does not know the process for cooling down ambient food like tuna. On August 6, 2024, at 1 p.m., during an interview with CK 1 regarding the cool-down process for ambient food temperature, CK 1 stated after food is made, the food is placed in the refrigerator and checked after four hours, aiming for temperature of 41 degrees or below. CK 1 further stated if the food does not reach the target temperature after four hours, she would place the tuna back into the refrigerator for one to two hours. CK 1 stated the total cooldown time for ambient food temperatures is five to six hours. On August 8, 2024, at 8:16 a.m., during an interview with the Registered Dietitian (RD), the RD stated the cool-down process for ambient food temperatures, like tuna, requires the food to reach 41 degrees within four hours; if that temperature is not achieved, the food will be discarded. The RD stated the cooling process for hot food involves lowering the temperature from 140 degrees to 70 degrees within two hours, and then to 40 degrees within four hours, with a total cool-down time of six hours. The RD stated that her expectation is for the dietary staff to follow the policy and procedure for the rapid cooling of hazardous foods to prevent bacterial growth that could lead to food borne illness and to provide safe food to the facility's residents. A review of the facility's policy and procedure titled, Cooling and Reheating of Potentially Hazardous or Time/Temperature Control for Safety Food, dated 2023, indicated, .Cooked Potentially Hazardous Food (PHF) or Time/Temperature Control for Safety (TCS) food shall be cooled .in a method to ensure food safety . Cool cooked food from 140 F to 70 F within two hours .Then cool from 70 F to 41 F or less in an additional 4 hours .total cooling time of six hours . A review of the facility's policy and procedure titled, Cooling and Reheating of Potentially Hazardous or Time/Temperature Control for Safety Food, dated 2023, indicated, .Ambient Temperature Food .PHF or TCS food shall be cooled within 4 hours to 41 degrees of less .such as canned tuna .Corrective Action is to be taken when cool down is not done correctly .Discard above 41 degrees . (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility document titled, Cook, dated 2003, indicated, .Ensures that all food procedures are followed in accordance with established policies . A review of the facility's document titled, Dietary Aide, dated 2003, indicated, .Ensures that all food procedures are followed in accordance with established policies .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47202 Based on observation, interview, and record review, the facility failed to ensure a sanitary environment, prepare, and served food in accordance with professional standards for food service safety, when multiple sheet pans were found with brown-black discoloration. This failure had the potential to place residents at risk for food borne diseases (illness that result from ingestion of contaminated food) that can cause sickness and or death. Findings: On August 5, 2024, at 8:15 a.m., during a concurrent walk-through observation and interview inside the kitchen with the Director of Food and Nutrition Services (DFS), one piece half-sheet pan and six full-sheet pans were found to have brown-black grime build up. The DFS stated the the pans are very old and needs to be replaced, and the brown- black discoloration was food residue. The DFS further stated the pans should not be in that condition, as the grime can cross-contaminate food and cause food borne illness to the residents. On August 8, 2024, at 8:16 a.m., during an interview with the RD, she stated that her expectation is the kitchen and all kitchen equipment to be clean with no grime build up. The RD further stated the sheet pans should have been clean with no grime build up, which could cross contaminate the residents' food and lead to foodborne illness. A review of the facility policy and procedure titled, Sanitation, dated 2023, indicated, .All utensils, Counters, shelves, and equipment shall be kept clean . A review of the Federal and Drug Administration (FDA) Food Code 2022, 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. indicated, .EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch .The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations .

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. 47202 Based on interview and record review, the facility failed to ensure the Quality Assessment and Performance Improvement (QAPI) committee monitored and re-evaluated identified concern regarding hot temperature levels in resident rooms (rooms 22, 23, 24 and 25). This failure resulted in unsafe and uncomfortable temperature levels (above 81 degrees Fahrenheit) in resident rooms, affecting the quality of care, quality of life, and resident safety (cross-reference F584). Findings: On August 8, 2024, at 12:58 p.m., a concurrent interview and record review of the facility QAPI meeting was conducted with the Administrator (ADM). The ADM stated during the QAPI meeting on July 24, 2024, it was identified that resident rooms 22, 23, 24 and 25 had hot temperatures due to the facility central air conditioning (AC) units 4 and 5 breaking down on July 9, 2024. The ADM stated fans were placed inside the affected rooms and large coolers were placed in the hallway to help cool down the residents room temperatures. The ADM further stated the facility did not monitor or re-evaluate the effectiveness of the fans and coolers in providing comfortable temperature levels. The ADM stated the facility should have re-evaluated and monitored the effectiveness of the fans and coolers to ensure safe and comfortable temperature levels were maintained and provided to the facility residents. A review of the facility policy and procedure titled, Quality Assurance Performance Improvement (QAPI), dated February 2020, indicated, .The QAPI plan describes the process for identifying and correcting quality deficiencies .Identify and Prioritize quality deficiencies .Developing and implementing corrective action or performance improvement .Monitoring or evaluating the effectiveness of corrective action/performance improvement .and revising as needed .

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49113 Based on observation and interview the facility failed to ensure for one of one resident (Resident 54) a pest free environment when one fly was observed on resident 54's lunch meal. This failure had the potential to place Resident 54 at risk for food borne illness (illness caused by food contaminated with bacteria) that can cause sickness and or death. Finding: On August 6, 2024, Resident 54's ADMISSION RECORD, was reviewed. Resident 54 was admitted on [DATE], with diagnoses which included hemiplegia (partial or total paralysis on one side of the body), hemiparesis (partial paralysis or weakness), and cognitive communication deficit (difficulty communicating due to disruption in cognition). A review of Resident 54's History and Physical indicated, Resident 54 does not have the capacity to understand and make decisions. A review of Resident 54's Minimum Data Set (an assessment tool), dated May 23, 2024, indicated, Resident 54 had a Brief Interview for Mental Status (a tool to assess cognitive function in resident) Score of 11 (moderate cognitive impairment.) On August 5, 2024, at 12:05 p.m. during a concurrent observation and interview of Resident 54's lunch meal in the dining room with the Director of Nursing (DON), a fly was observed landing on the gravy. The DON stated Resident 54 had a fly on his lunch plate which flew and landed on the gravy. The DON further stated flies should not be present and flies carry diseases that could cause food borne illness to the residents. On August 7, 2024, at 11:18 a.m., an interview was conducted with Certified Nursing Assistant (CNA) 1, who stated that flies landing on resident's food is unsanitary and could cause sickness among the residents. The facility Policy and Procedures titled Pest Control, revised May 2008 stated .This facility maintains an on-going pest control program to ensure that the building is kept free from insects and rodents .