STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055356	A. BUILDING _____ B. WING _____	**03/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PACIFIC GROVE HEALTHCARE CENTER	**200 LIGHTHOUSE AVENUE PACIFIC GROVE, CA 93950**

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F 0636 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to comprehensively analyze the use of merry walker (enclosed walking and sitting safety device) for one of one resident reviewed (Resident 2). This placed the resident at risk for unidentified changes in mood, behaviors and decreased physical function status related to the use of the device. Findings: During review of the admission minimum data set (MDS, resident assessment tool) dated 12/01/19, indicated Resident 2 was admitted on [DATE], with [DIAGNOSES REDACTED]. The MDS indicated the resident was severe cognitively impaired and required limited assistance with one-person physical assist for transfers and supervision with one-person physical assist for walk-in corridor, locomotion on and off unit. Wheelchair was the only one marked in section G0600 (Mobility devices). Resident 2 had not used a merry walker and had no history of falls. In multiple observations on 3/02/2020 at 10:24 a.m., 3/03/2020 at 10:00 a.m., and 3/04/2020 at 11:30 a.m., Resident 2 was seen in his merry walker in the hallways of the unit. The resident had lack of socialization with peers, staff, activities, engagement and supervision. He walked in his merry walker as needed. He would stand, take one to two steps and sit down. This repeated several times throughout the day. Resident 2 presented with a furrowed brow and with bruise on left hand. Staff did not offer him to sit in a standard chair. During review of Resident 2's MDS record, there was no comprehensive assessment done to reflect if Resident 2 had improved or worsened in functional status. In an interview with the MDS Coordinator (MDS-C) on 3/04/2020 at 9:05 a.m., the MDS-C confirmed the lack of comprehensive assessment done for Resident 2 other than physical therapy (PT) evaluation on 12/09/19. The MDS-C also stated it was unclear to her how the merry walker had improved Resident 2's functional status and she would not even know if she would code it as restraint or mobility device till the interdisciplinary team discuss this.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement a comprehensive, collaborative care plan (directs the nursing care of the resident) for one of two hospice residents (Resident 12), when there was a 18 day delay for an order of a low air loss mattress (LAL,mattress designed to prevent and treat pressure ulcer). This failure could potentially not provide the resident the necessary care and comfort necessary in hospice care (care of terminally ill residents with focus on comfort). Findings: Review of Resident 12's Physician Summary report dated 3/3/2020, Resident 12 was admitted to the hospice program on 12/4/19 with terminal [DIAGNOSES REDACTED]. Resident 12 was also a bilateral knee [MEDICAL CONDITION] related to complications of diabetes (high blood sugar). An order dated 2/14/2020, indicated LAL mattress for comfort. During an observation of Resident 12 on 3/2/2020 at 9:09 a.m., Resident 12 was lying on a regular foam mattress. During an follow-up observation on 3/3/2020 at 8 a.m., Resident 12 had a regular foam mattress. During an observation on 3/4/2020 at 9 a.m., Resident 12 was lying on a LAL mattress. He stated it was delivered late last night. He stated it felt comfortable especially on his spine. Review of Resident's comprehensive care plan did not indicate use of the LAL mattress for resident's comfort. During an interview with the director of nursing (DON) on 3/4/2020 at 9:19 a.m., she stated the LAL mattress was ordered through hospice services. She stated the facility called hospice services for a follow-up but confirmed there was no documentation of a follow-up. She acknowledged nursing should have followed up more since it was a collaborative plan of care between the facility and hospice. During a telephone interview with the director of care services for hospice (DCSH), on 3/5/2020 at 8:49 a.m., she stated hospice received the order request on 2/20/2020. It was originally not approved. The DCSH stated on 3/3/2020, the facility contacted hospice services and stated Resident 12 would benefit highly from the LAL mattress. The DCHS stated it was approved and delivered the same day. Review of the facility's revised policy, Hospice Program, indicated . In general, It is the responsibility of the hospice to manage the resident's care as it relates to terminal illness and related conditions including providing medical supplies, durable medical equipment (DME), and medications for the palliation of pain and symptoms . Responsibility of the facility includes . Communicating with the hospice provider to ensure the needs of the resident are addressed and met 24 hours per day . Coordinated care plans for residents receiving hospice services will include the most recent hospice plan of care as well as the care and services provided by the facility in order to maintain the resident's highest practicable physical, mental, and psychosocial well-being.
F 0661 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure discharge summaries were completed for two of three residents' closed records reviewed (Residents 1 and 48), which had the potential to result in missed health information related to unmet care needs. Findings: 1. Review of Resident 1's Admission Record indicated she was admitted to the facility on [DATE] and discharged to another facility on [DATE]. Review of Resident 1's clinical record indicated she did not have a discharge summary from the physician for her discharge to another facility. During an interview with the director of nursing (DON) on [DATE] at 10:05 a.m., she confirmed Resident 1 did not have a discharge summary from the physician. The facility's ,[DATE] policy, Discharge Summary and Plan, indicated When the facility anticipates a resident's discharge to a private residence, another nursing care facility, a discharge summary and a post-discharge plan will be developed which will assist the resident to adjust to his or her new living environment. 2. During review of Resident 48's closed record, Resident 48 was admitted on [DATE] with [DIAGNOSES REDACTED]. During review of Resident 48's progress notes dated [DATE], indicated Resident expired 1950. No signs of respiratory effort, no heart sounds. Hospice agency was notified. Family member called facility shortly after and was informed of resident passing. During review of Resident 48's clinical record, there was no discharge summary noted on the electronic medical record. During interview with medical record director (MRD) on [DATE] at 4:10 p.m., the MRD confirmed there was no discharge summary done because she missed the follow-up with the physician. During a review of the facility's ,[DATE] policy and procedure (P&P), Discharge Summary and Plan, indicated 6. A copy of the post-discharge plan and summary will be

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

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F 0661 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) provided to the resident and receiving facility, and a copy will be filed in the resident's medical records.
F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement care plan to prevent fall for one of two residents reviewed (Resident 49) who was assessed for fall high risk. Resident 49 had a fall on 12/19/19, hit her head and sustained a hematoma (blood leaks from blood vessel). Findings: During review of Resident 49's clinical record, indicated Resident 49 was admitted on [DATE], with [DIAGNOSES REDACTED]. During review of Resident 49's minimum data set (MDS, resident tool assessment) dated 12/20/19, the MDS indicated Resident 49 was severely cognitively impaired and required supervision with two-person physical assist during transfer. During review of Resident 49's fall risk assessment dated [DATE], score indicated 22, which means high risk for fall. During review of Resident 49's situation, background, assessment and, recommendation (SBAR, form of prompt communication) note dated 12/19/19, indicated at 12:32 a.m., three staff witnessed Resident 49 got out of bed and fell while walking in the hallway near other resident's room, with no apparent injury noted. Recommendations: landing mat in place and resident to monitor closely with one to one person. During review of Resident 49's SBAR note dated 12/19/19, indicated Unwitnessed fall at 7:45 p.m., the Nurse Practitioner (NP) heard a thump (as in was hit heavily), then found Resident 49 on floor on her knees next to her bed. The NP and another staff assisted transfer Resident 49 back to bed, sustained 3 X (by) 3 centimeters (cm, metric unit of length) hematoma on right forehead. During review of Resident 49's transfer to hospital summary note dated 12/20/19, Resident 49's daughter requested transfer Resident 49 to hospital for further evaluation due to Resident 49's history of head injury. The Physician (MD) was notified and Resident 49 was sent to hospital at noon time. During an interview with certified nursing assistant B (CNA B) on 03/04/2020 at 3:00 p.m., CNA B stated she did not provide one to one close monitoring with Resident 49 because she had other residents assigned with her to care for. During review of the facility's CNA assignment sheet dated 12/19/19, indicated there was no CNA assigned to provide one to one close monitoring for Resident 49. During an interview with the administrator (Admin) and licensed vocational nurse A (LVN A) on 03/05/2020 at 9:02 a.m., they stated they were not able to provide close monitoring for Resident 49. During review of Resident 49's fall care plan dated 12/18/19, indicated Monitor closely with one on one possibly male orderly if available. Provide assistance as identified in transfer and mobility. During a review of the facility's policy and procedure (P&P), Falls and fall Risk, managing, revised 2007, the P&P indicated 4. If falling recurs, despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant.
F 0726 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure competent staffing to care for residents' needs for two of five residents reviewed (Residents 38 and 40) when: 1. Licensed nurses (LN) did not know Resident 38 had a pacemaker (a small device that's placed in the chest or abdomen to help control abnormal heart rhythms) and did not know how to assess the resident with a pacemaker as ordered by the physician; 2. Registered nurse F (RN F) did not follow physician order [REDACTED]. These failures had placed the residents at risk of being improperly assessed and unmet care needs. Findings: 1. Review of Resident 38's Admission Record indicated she was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of Resident 38's physician orders [REDACTED]. During an interview with licensed vocational nurse C (LVN C) on 3/3/2020 at 1:50 p.m., she stated she monitored the malfunction of Resident 38's pacemaker by checking Resident 38's heart rate and monitored the pacemaker site for bleeding. During an interview with LVN D on 3/4/2020 at 9:16 a.m., she stated she monitored the pacemaker site to see if it was there, but she did not know where Resident 38's pacemaker was located. LVN D stated she monitored Resident 38's pacemaker malfunction by checking Resident 38's vital signs (pulse rate, respiratory rate, body temperature, and blood pressure). During an interview with LVN E on 3/5/2020 at 1:15 p.m., she stated she was not sure if Resident 38 had a pacemaker or not. LVN E stated she did not know what to monitor at the pacemaker site, and she monitored Resident 38's pacemaker malfunction by checking Resident 38's heart rate. 2. During an observation on 03/03/2020 at 1:30 p.m., RN F removed the old dressing to Resident 40's buttocks with her gloved hand, cleansed the wound with saline, applied wet gauze soaked with Puracyn (wound cleanser) for five minutes, then applied the antibiotic powder with her gloved hand towards the wound. RN F did not apply sure prep before covering with gentle foam. During an interview with RN F on 03/03/2020 at 3:00 p.m., RN F stated she forgot to apply sure prep on the wound edges before covering with gentle foam to protect the skin. Review of Resident 40's physician order [REDACTED]. 3. During review of Resident 40's clinical record, there was lack of weekly skin assessment for the following periods: 12/30/19 to 1/03/2020; 1/13/2020 to 1/17/2020; 1/20/2020 to 1/24/2020; 1/27/2020 to 1/31/2020; and 2/24/2020 to 2/28/2020. During an interview with the director of nursing (DON) on 03/03/2020 at 3:45 p.m., she confirmed the lack of weekly skin assessments on those period dates because the designated licensed nurses missed to do it.
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** Based on interview and record review, the facility failed to ensure 6 of 9 residents (5, 6, 27, 29, 43, and 49) were free from unnecessary [MEDICAL CONDITION] medications when 1. Resident 5 did not have the physician's rationale for maintaining the same dose for [MEDICATION NAME] (a drug used to treat [MEDICAL CONDITION] which is a medical illness that causes feelings of sadness and/or a loss of interest in activities once enjoyed); 2. Resident 6's manifested behaviors were not monitored; 3. Resident 29's recommendation from psychologist for gradual dose reduction (GDR) for [MEDICATION NAME] (used to treat anxiety) was not presented to the physician; 4. Resident 43 did not have the physician's rationale for maintaining the same dose for [MEDICATION NAME]; 5. Resident 27 did not have the physician's rationale for maintaining the same dose for [MEDICATION NAME]; and 6. There was no stop date for Resident 49's use of [MEDICATION NAME] (as needed) within 14 days duration. Findings: 1. Review of Resident 5's Admission Record indicated he was admitted with [DIAGNOSES REDACTED]. The physician responded to maintain the same dose but did not provide the rationale. During an interview with the director of nursing (DON) on 3/5/2020 at 10:07 a.m., she confirmed there was no rationale provided for maintaining Resident 5's [MEDICATION NAME] at the same dose. 2. Review of Resident 6's physician order, dated 6/5/19, indicated she had an order for [REDACTED]. During an interview with the DON on 3/4/2020 at 3:20 p.m., she reviewed Resident 6's clinical record and was unable to find the monitoring for refusal of care such as not changing clothes, not taking medications. 3. Review of Resident 29's Admission Record indicated he was admitted with [DIAGNOSES REDACTED]. Review of Resident 29's physician order, dated 5/4/19, indicated he had an order for [REDACTED]. But there was no document that the psychologist's recommendation was presented to the physician. During an interview with the DON on 3/5/2020 at 10:10 a.m., she stated GDR needed to have the order from the physician, but the psychologist's recommendation for GDR for Resident 29's [MEDICATION NAME] was not presented to the physician for review. 4. Review of Resident 43's Admission Record indicated she was admitted on [DATE] with [DIAGNOSES REDACTED]. The physician responded to maintain the same dose but did not provide the rationale. During an interview with the director of nursing (DON) on 3/5/2020 at 10:14 a.m., she confirmed there was no rationale provided for maintaining Resident 43's [MEDICATION NAME] at the same dose 5. Review of Resident 27's clinical record indicated she was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of

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F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) Resident 27's physician order, dated 7/20/18, indicated an order for [REDACTED]. The physician's response was a check marked condition stable but did not provide a specific rationale for maintaining the dose. During a concurrent interview and record review with the DON on 3/5/2020 at 3:25 p.m., she acknowledged there was no specific rationale from the physician for maintaining the current dose. 6. During review of Resident 49's physician order [REDACTED]. Inject 2.5 mg intramuscularly every six hours as needed related to dementia. [MEDICATION NAME] tablet 5 mg ([MEDICATION NAME]). Give 1 tablet by mouth three times a day related to dementia. There was no stop date within duration of 14 days. During interview with LVN A on 03/05/2020 at 9:15 a.m., LVN A stated confirmed there was no stop date for the order and acknowledged that it should be limited to 14 days.
F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure medication error rates are not 5 percent or greater.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility had a 13.3% medication error rate when four medication errors out of 30 opportunities were observed during medication pass observation, for three of three randomly selected residents (Residents 27, 38, and 41). These failures could potentially jeopardize the residents' health. Findings: 1. During a medication pass observation on 3/2/2020 at approximately 4:55 p.m., registered nurse G (RN G) had four oral medications for Resident 27. The medications were [MEDICATION NAME] 5 milligram (mg. a metric unit of mass) 1 tablet for Alzheimer's, a progressive disease that destroys memory; Quetiapine 50 mg. (an antispychotic, drug to treat [MEDICAL CONDITION], mental disorder where there is a disconnection from reality); Calcium 600 mg. Vitamin D3 400 U 1 tablet (a Vitamin supplement); and [MEDICATION NAME] ER ,[DATE] mg.(extended release) 1 tablet for [MEDICAL CONDITION] (central nervous system disorder that affects causes tremors). RN G crushed all the medications and mixed them all in one cup with applesauce and administered it to Resident 27. During a concurrent interview with RN G, she stated she had to crush and mix the drugs with applesauce, as Resident 27 had trouble swallowing the pills. When informed that [MEDICATION NAME] was an ER (drugs formulated so the drug is released over time providing a more consistent level of drug in the body), she acknowledged that it should have not been crushed. Review of Resident 27's physician order, dated 12/7/19, indicated an order of [MEDICATION NAME]-[MEDICATION NAME] 50-200 mg. Give one tablet by mouth three times a day related to [MEDICAL CONDITION]. Should be taken at least 30-60 minutes prior to any meals including protein. A physician's orders [REDACTED]. According to the website, http:// online.lexi.com/lco/action/home,(online reference for clinical drugs), indicated [MEDICATION NAME]-[MEDICATION NAME] tablet should be swallowed whole; do not crush, or chew. Review of the facility's revised policy, dated 4/2007, Crushing medications, indicated . one of the guidelines to crushing a medication was . The Medication Administration Record [REDACTED]. 2. During a medication pass observation on 3/2/2020 at approximately 5 p.m., (RN G) stated she forgot to give one more medication to Resident 27. The medication was [MEDICATION NAME] HCL (medication for anxiety, a nervous disorder characterized by a state of excessive uneasiness and apprehension) 15 milligram (mg., a metric unit of mass) orally. RN G crushed the medication, mixed it with applesauce and gave it to the resident. Review of Resident 27's physician order [REDACTED]. three times a day related to anxiety disorder. Review of Resident 27's medication administration (MAR) for March 2020, indicated it was scheduled for 0900 (9 a.m.), 1500 (3 p.m.), and 2000 (8 p.m.). During an interview with the day shift licensed vocational nurse H (LVN H), on 3/3/2020 at 2:30 p.m., she stated she gave the 3 p.m. dose on 3/2/2020 at 2 p.m. (one hour before) as 3 p.m. was not a good time since it was change of shift. The MAR indicated [REDACTED]. However, she confirmed she did not check the MAR indicated [REDACTED]. During a med pass observation on 3/3/2020 at 7:57 a.m., licensed vocational nurse C (LVN C) had 11 oral medications and 1 oral inhaler to administer to Resident 41. One of the oral medications to be administered was [MEDICATION NAME] (a nerve pain medication and medication also for [MEDICAL CONDITION]) 600 mg, one tablet, which was not available at that time. During a concurrent interview with LVN C, she stated the nurse would usually send a refill request to pharmacy with enough time (i.e. three days before it runs out) for pharmacy to send the refill. LVN C peeled the sticker form the bubble pack (medication individually packed in a plastic bubble). She stated the pharmacist would usually send it through same day delivery and usually in the afternoon. Review of Resident 41's physician's orders [REDACTED]. one tablet by mouth two times a day related to other chronic pain. The resident missed the 9 a.m. medication and not given as documented in the MAR. 4. During a medication pass observation on 3/3/2020 at approximately 8:35 a.m., LVN C stated she had a nasal spray medication for Resident 38. She stated Resident usually administered her own nasal spray under her supervision. LVN C showed this surveyor Azelastine 0.1% nasal spray (medication used to relieve nasal symptoms such as runny/itching/stuffy nose, sneezing, and post nasal drip caused by allergies [REDACTED]. Resident 38 stated she was a retired RN and administered 2 separate nasal sprays in each nostril. Review of Resident 38's physician's orders [REDACTED]. During an interview and concurrent record review with LVN C on 3/4/2020 at 9:30 a.m., she stated the label indicated "2 sprays. She stated she knew it was a new order as Resident 38 had requested for two sprays. LVN C confirmed the order and acknowledged she did not check the physician's orders [REDACTED]. She also confirmed there was no order clarification made from the physician. Review of the facility's revised policy, dated 12/2012, indicated .Medications must be administered in a safe and timely manner and as prescribed . Medications must be administered in accordance with the orders, including any required time frame.
F 0770 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide timely, quality laboratory services/tests to meet the needs of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow physician's orders for two of 12 residents (Residents 6 and 12) when 1. Resident 6's hepatic function panel (a blood test to check how well the liver is working) and serum creatinine (a waste product that forms when [MEDICATION NAME], which is found in the muscle, breaks down) and electrolytes panel (measures the blood levels of sodium, potassium, chloride, and carbon [MEDICATION NAME]; creatinine and electrolytes levels are factors in determining the kidney health) were not done in 9/2019; and 2. Resident 12's hemoglobin A1C (HgA1C, blood test that indicate average level of blood sugar (BS) over a period of two-three months) every three months was not done in 12/2019. These failures had the potential to jeopardize the health and safety of the residents by causing a delay in appropriate treatment. Findings: 1. Review of Resident 6's Admission Record indicated she was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of Resident 6's physician order indicated she had orders for [MEDICATION NAME] (a drug used to treat manic-depressive illness; it may cause serious allergic reactions affecting multiple body organs such as liver or kidney) 250 milligrams (mg, a metric unit of mass) in the morning for [MEDICAL CONDITION], started on 3/1/19, and 500 mg in the evening for delusional disorder, started on 4/3/19. Resident 6 also had physician orders for hepatic function panel every six months, started on 3/19/19, and serum creatinine and electrolytes panel every six months, started on 3/28/19. Review of Resident 6's clinical record indicated hepatic function panel was done on 3/20/19, but it was not done in 9/2019, and serum creatinine and electrolytes panel was done on 3/29/19, but it was not done in 9/2019. During an interview with the director of nursing (DON) on 3/4/2020 at 4:58 p.m., she reviewed Resident 6's clinical record and was unable to locate 9/2019 laboratory results for hepatic function panel and serum creatinine and electrolytes panel. 2. Review of Resident 12's clinical record, indicated he was originally admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident 12's physician order dated 12/4/19, indicated an order for [REDACTED]. A lack of insulin causes a form of diabetes). Review of Resident's laboratory results for HgA1C, indicated results for the following months: 3/6/19 = 6 (H high), 6/6/19 = 6.3 (H), and 9/7/19 = 6.5 (H). There was no result for December. During an interview with licensed vocational nurse A (LVN A) on 3/5/2020 at 9 a.m., she confirmed the finding. She stated she would review the medical records. During an interview with the medical record director (MDR) on 3/5/2020 at 12: 29 p.m., she confirmed there was no HgA1C done for the month of December. Review of the California Board of Registered Nursing website, California Business and Professions Code, Division 2, Chapter 6, Article 2, Section 2725(b)(2), indicated registered nurses should ensure the safety, protection of residents; administration of medications, and therapeutic agents, necessary to implement a treatment, disease prevention, ordered by and within the scope of the licensure of a physician.
F 0912 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.** Based on observation, interview, and document review, the facility failed to ensure multiple resident rooms had at least 80 square feet per resident. Having less than 80 square feet per resident could potentially compromise the care and services

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F 0912 **Level of harm -** Potential for minimal harm **Residents Affected -** Some	(continued... from page 3) the residents receive. Findings: The resident room measurements were as follows: Room Number Bed Capacity Square Feet Per Resident 1 2 72.00 2 3 66.12 3 2 79.25 4 3 68.45 5 2 74.29 6 3 75.03 7 3 75.03 10 3 74.20 11 2 72.00 12 2 72.00 14 2 72.00 17 4 69.70 18 2 72.00 19 2 72.00 20 2 78.00 22 3 76.00 During the survey, residents were observed in their rooms. Nursing care and services were not impacted by the shortage of space. The closets and storage were sufficient to accommodate the needs of the residents. Residents were interviewed and stated they did not have any concerns regarding room size, provision of care, or privacy. Staff members were interviewed and stated they were able to safely provide care to the residents, even in rooms with less than 80 square feet per resident. Recommend continuance of room waiver.