STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055052	A. Building B. Wing	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
California Post-Acute Care	3615 E. Imperial Hiwy Lynwood, CA 90262

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47679 Based on observation, interview, and record review, the facility failed to provide dignity and respect the rights of one of 32 sampled residents (Resident 66 and Resident 99) by failing to remove Resident 99's breakfast tray from his room. These deficient practices resulted in Resident 99 feeling frustrated and unattended to. Findings: During a review of Resident 99's Admission Record (Face Sheet), the Face Sheet indicated Resident 99 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included acute myocardial infarction (heart attack), low back pain, and type two diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 99's Minimum Data Set ([MDS], a resident assessment tool), dated 12/5/2024, the MDS indicated Resident 99's cognition (process of thinking) was moderately impaired. The MDS indicated Resident 99 required maximal assistance (helper does more than half the effort) with oral hygiene, upper body dressing, and personal hygiene. During a review of Resident 99's History and Physical (H&P), dated 10/19/2024, the H&P indicated Resident 99 had the capacity to understand and make decisions. During a review of Resident 99's Order Recap Report, dated 9/12/2024, the Order Recap Report indicated to provide a regular diet (a meal plan that allows the individual to eat a variety of foods without restrictions) with double protein portions. During a concurrent observation and interview on 2/24/2025 at 10:26 a.m. with Resident 99, in Resident 99's room, Resident 99's breakfast meal tray was observed on top the resident's bedside table containing an empty plate. Resident 99 stated he finished eating his breakfast hours ago and no one came into his room to remove his tray. Resident 99 stated sometimes his breakfast tray would stay in his room until the lunch trays were passed out. Resident 99 stated having his breakfast tray on his bedside table, hours after finishing eating, made him feel frustrated and forgotten. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055052	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/28/2025
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 2/24/2025 at 10:30 a.m. in Resident 99's room, Licensed Vocational Nurse (LVN) 4 was observed entering Resident 99's room asking about the resident's pain. LVN 4 did not ask Resident 99 if he (LVN 4) could remove the breakfast tray from the room prior to exiting the room. Resident 99's breakfast tray remained on his bedside table. During an observation on 2/24/2025 at 10:40 a.m. in Resident 99's room, LVN 5 was observed entering Resident 99's room to administer medication. LVN 5 did not ask Resident 99 if she (LVN 5) could remove the breakfast tray from the room prior to exiting the room. Resident 99's breakfast tray remained on his bedside table. During an observation on 2/24/2025 at 11:05 a.m. in Resident 99's room, Certified Nursing Assistant (CNA) 4 was present at Resident 99's bedside as a translator between Resident 99 and the facility's Wound Care Specialist. CNA 4 did not ask Resident 99 if she could remove the breakfast tray from the room prior to exiting the room. Resident 99's breakfast tray remained on his bedside table. During an interview on 2/26/2025 at 8:07 a.m., with CNA 4, CNA 4 stated the CNAs were responsible for distributing the breakfast trays to the residents and prior to assisting residents with feeding, the CNAs were supposed to if any residents finished their meal and remove the breakfast tray from the room. CNA 4 stated some residents take longer to finish their meal and the breakfast tray may stay longer in the room. CNA 4 stated any staff member, if they see a meal tray in the room, they should ask the resident if the tray could be removed from the room. CNA 4 stated she recalled translating for Resident 99 and did not ask to remove his breakfast tray from the room. CNA 4 stated leaving the breakfast tray in the room for a prolonged period and not acknowledging the tray could make the resident feel unimportant and leave them frustrated. During an interview on 2/28/2025 at 8:32 a.m., with the Director of Nursing (DON), the DON stated after the breakfast trays were distributed and all the residents were assisted with feeding, the CNAs were responsible for removing breakfast trays if the resident was done eating. The DON stated breakfast trays should not be left in the residents' rooms until the next mealtime. The DON stated Resident 99 should have been asked if his breakfast tray could be removed from his room. The DON stated leaving the breakfast tray could cause Resident 99 to feel unattended and frustrated the tray was taking up space on the bedside table which could be used for something else in his routine. During a review of the facility's policy and procedure (P&P) titled, Assisting the Impaired Patients with In-Room Meals, dated 4/2018, the P&P indicated, Remove the tray when the patient has finished his or her meal.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47679 Based on interview and record review, the failed to obtain informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) prior to the administration of Trazodone (an antidepressant [a medication used to treat depression, which is a mood disorder that causes a persistent feeling of sadness and loss of interest]) on 6/19/2024 and Seroquel (antipsychotic medication [medications that affect the mind, emotions, and behavior]) on 6/20/2024 for one of five sampled residents (Resident 81). This deficient practice resulted in the removal of Resident 81's right to make decisions about his care and treatments received in the facility. Findings: During a review of Resident 81's Admission Record (Face Sheet), the Face Sheet indicated Resident 81 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety disorder (a mental health condition that involves excessive fear, worry, and dread), and encephalopathy (general condition where brain function is impaired). During a review of Resident 81's Minimum Data Set ([MDS], a resident assessment tool), dated 1/31/2025, the MDS indicated Resident 81's cognition (process of thinking) was intact. The MDS indicated Resident 81 was dependent on staff's assistance with toileting, bathing, and lower body dressing. The MDS indicated Resident 81 received antipsychotic and antidepressant medication. During a review of Resident 81's History and Physical (H&P), dated 1/28/2024, the H&P indicated Resident 81 had the capacity to understand and make decisions. During a review of Resident 81's Order Recap Report, dated 6/1/2024 through 2/28/2025, the Order Recap Report indicated to: a. Give Trazodone 50 milligrams (mg, unit of measurement), by mouth, at bedtime for depression as manifested by verbalization of sadness. The order date was 6/19/2024. b. Give Seroquel 100mg, by mouth, one time a day, for psychosis (a mental health condition characterized by a loss of contact with reality) as manifested by auditory hallucinations (hearing sounds or voices that are not real) of commanding voices. During a review of Resident 81's Medication Administration Record ([MAR], a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 6/1/2024 through 6/30/2024, the MAR indicated: a. Resident 81 initially received Trazodone 50mg on 6/19/2024. b. Resident 81 initially received Seroquel 100mg on 6/20/2024. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 2/26/2025 at 10:19 a.m. with Registered Nurse (RN) 2, Resident 81's Psyche Consents, dated 12/8/2022 through 11/27/2024, were reviewed. RN 2 stated Resident 81 did not have a Psyche Consent completed for Trazodone on 6/19/2024 nor Seroquel on 6/20/2024. RN 2 stated informed consent was obtained by the resident's physician then verified by the licensed nurse. RN 2 stated Trazodone and Seroquel were medications that required verification of informed consent. RN 2 stated verifying informed consent from Resident 81 would ensure Resident 81 was fully informed of the medication's indication of use, side effects, and associated risks. During an interview on 2/28/2025 at 8:38 a.m., with the Director of Nursing (DON), the DON stated once the order for Trazodone and Seroquel for Resident 81 were received, the licensed nurse was responsible for verifying that Resident 81 consented to receive those medications. The DON stated verifying informed consent with Resident 81 would indicate Resident 81 understood the indication for the medications, the side effects, and the risks. The DON stated Resident 81 should have been given the opportunity to exercise his right to make an informed decision regarding his care. During a review of the facility's policy and procedure (P&P) titled, Psychoactive Medication Informed Consent, dated 3/2024, the P&P indicated, Informed consent will be obtained from the resident, who has decisional capacity, whenever psychoactive medications are prescribed, ordered, or when orders are increased by the physician. Informed consent will either be noted in the physician order for the psychoactive medication, on the appropriate consent form, or documented elsewhere in the medical records.

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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** 48131 Based on observation, interview, and record review, the facility failed to: 1. Ensure the medical record was updated to show documentation that an advance directive (a legal document indicating resident preference on end-of-life treatment decisions) was discussed with the resident and/or responsible parties for one of eight sampled residents (Resident 109). 2. Review and complete Resident's 277's Physician Orders for Life-Sustaining Treatment ([POLST], a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end-of life). These deficient practices violated Resident 109's and Resident 109's representative's right to be fully informed of the option to formulate their advance directives which had the potential to cause conflict with the resident's wishes regarding health care and had the potential to result in Resident 277's wishes for life-sustaining treatment to be unacknowledged, which could result in Resident 277 receiving unwanted treatment. Findings: a. During a review of Resident 109's Admission Record, dated 2/27/2025, the admission record indicated Resident 109 was admitted to the facility on [DATE] and readmitted on [DATE]. The admission record indicated Resident 109 had the following diagnoses which included schizophrenia (a mental illness that is characterized by disturbances in thought), psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), dementia (a progressive state of decline in mental abilities) and alcohol dependence with alcohol-induced persisting amnestic disorder (a mental disorder that impairs memory and learning and is caused by chronic alcohol abuse). During a review of Resident 109's Minimum Data Set (MDS - a resident assessment tool), dated 1/20/2025, the MDS indicated Resident 109's cognitive skills (ability to think, remember and reason) were severely impaired. The MDS indicated Resident 109 had behaviors of hallucinations (to see, hear, feel, or smell something that does not exist) and delusions (having false or unrealistic beliefs). The MDS further indicated Resident 109 had the ability to eat independently and required moderate assistance (helper does half the effort) with toileting and bathing. During a review of Resident 109's' History and Physical (H&P), dated 11/2/2024, the H&P indicated Resident 109 had fluctuating capacity to understand and make decisions. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 2/26/2025 at 9:21 a.m., with the Case Manager (CM), Resident 109's medical records were reviewed. The CM stated she was responsible for acquiring an advance directive for Resident 109. The CM stated Resident 109's advance directive was not included in the medical records because she had not been able to contact Resident 109's responsible party. The CM stated she attempted to get the Resident 109's responsible party to come to the facility on several occasions since the resident's admission but the responsible party informed her that the facility was too far. The CM stated it was important for Resident 109 to have an advance directive because the resident was unable to make her own decisions and needed assistance from her responsible party to ensure her wishes were carried out. During an interview on 2/27/2025 at 2:51 p.m., with the Director of Nursing (DON), the DON stated the advance directive should have been done immediately after the resident was admitted . The DON stated the consent for the care was included in the advance directive and established the Resident 109's plan of care with the responsible party. The DON stated if the advance directive was not done, the facility would have to contact the responsible party to find out what the responsible party wanted to do in case of an emergency. The DON stated it was best to have that advance directive completed so the facility would know what the responsible party's and Resident 109's wishes were. The DON stated if Resident 109's responsible party was unable to come in to sign an advanced directive in person, then the CM could have gotten an acknowledgement over the telephone and documented this on the advance directive. 47679 b. During a review of Resident 277's Admission Record, the admission record indicated Resident 277 was admitted to the facility on [DATE] with diagnoses that included bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), type two diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing), and sepsis (a life-threatening blood infection). During a review of Resident 277's MDS, dated [DATE], the MDS indicated Resident 277's cognition was moderately impaired. The MDS indicated Resident 277 required moderate assistance (helper does less than half the effort) with toileting, bathing, upper body dressing, and personal hygiene. During a review of Resident 277's H&P, dated 2/15/2025, the H&P indicated Resident 277 had the capacity to understand and make decisions. During a concurrent interview and record review on 2/26/2025 at 9:35 a.m. with the Social Services Assistant (SSA), Resident 277's POLST, undated, was reviewed. The SSA stated Resident 277's POLST was not filled out with the information to direct the staff on the life-sustaining care to provide Resident 277. The SSA stated upon admission, she was responsible for reviewing the POLST with the resident or their responsible party to answer any questions and to provide additional information. The SSA stated the POLST should be completed within five days of the resident's admission. The SSA stated Resident 277 was admitted to the facility on [DATE] and it had been 12 days without a POLST created. The SSA stated the purpose of the POLST was to document Resident 277's treatment wishes. The SSA stated without a completed POLST, if Resident 277 became unresponsive, Resident 277 would be provided full treatment (primary goal of prolonging life by all medically effective means). The SSA stated Resident 277 was not asked her wishes, therefore, the staff may provide treatment Resident 277 does not desire. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Physician's Order on Life Sustaining Treatment (POLST) Policy, dated 12/2016, the P&P indicated to provide a POLST form for the physician and the resident to discuss, fill out, and sign. During a review of the facility's P&P titled, Advanced Directives, dated 2/2017, the P&P indicated, The resident has a right to accept or refuse medical or surgical treatment and to formulate an advance directive in accordance with state and federal law. The facility uses its best efforts to comply with the wishes of resident as expressed in an advance directive and will not condition the provision of care or otherwise discriminate against an individual based on whether the individual has executed an advance directive. The P&P indicated upon admission the facility will provide a resident or the resident's representative with written information regarding the facility's policies on advance directives and a copy of this policy. The P&P indicated the facility will inquire at the time of admission whether the resident has previously executed an advance directive.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45009 Based on interview and record review, the facility failed to notify the physician or responsible party of a change in condition for three of three sampled residents (Resident 4, 18 and 97) when: 1. Resident 4 did not receive oxybutynin chloride (used to treat symptoms of an overactive bladder, such as incontinence (loss of bladder control) or a frequent need to urinate) 5 milligrams ([mg] one thousand of a gram) on 2/21/2025 and 2/22/2025, as ordered. 2. Responsible Party (RP) 2 was not notified of Resident 18's verbal altercation with another resident. 3. RP 1 was not notified of Resident 97's elopement (the act of leaving a facility unsupervised and without prior authorization) attempt on 2/23/2025. 4. Inform the physician and RP 1 the Resident 97 had obtained possession of a used, disposable razor without facility staff supervision or knowledge on 2/24/2025. These deficient practices caused a delay in care and services related to Residents 4, 18, and 97's health and safety, and could potentially lead to negative health outcomes. Findings: 1. During a review of Resident 4's Admission Record, the admission record indicated Resident 4 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses of neuromuscular dysfunction of the bladder ([neurogenic bladder] a condition where the nerves controlling bladder function are damaged, leading to impaired bladder muscle activity and resulting in problems like urinary incontinence and lack of awareness of bladder fullness) and benign prostatic hyperplasia [(BPH] is a noncancerous enlargement of the prostate gland that causes frequent urination, weak urine stream, and difficulty in starting to urinate). During a review of Resident 4's History and Physical (H&P) dated 1/21/2024, the H&P indicated Resident 4 had the capacity to understand and make decisions. During a review of Resident 4's Minimum Data Set (MDS, a resident assessment tool), dated 1/1/2025, the MDS indicated Resident 4's cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making was intact. The MDS indicated Resident 4 required maximal assistance (helper does more than half the effort) for upper body dressing, showering/bathing and personal hygiene. The MDS indicated Resident 4 required set up assistance for eating. During a review of Resident 4's Medication Administration Record (MAR) dated 2/1/2025 - 2/28/2025, the MAR indicated on 2/21/20225 and 2/22/2025 Resident 4 did not receive oxybutynin chloride 5 mg. During a review of Resident 4's electronic medical record, unable to locate the physician's notification of Resident 4's missed oxybutynin chloride 5 mg medication dose on 2/21/2025 and 2/22/2025. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/24/2025 at 11:31 a.m. with Resident 4, Resident 4 stated he did not receive oxybutynin chloride 5 mg medication a couple of times. Resident 4 stated he became upset because he did not receive his medication because the medication helped him with bladder spasm prevention. Resident 4 stated he felt unimportant to have nurses know he was low on medication but did not bother to reorder timely. During an interview on 2/27/2025 at 2:20 p.m. with Licensed Vocational Nurse (LVN) 8, LVN 8 stated Resident 4 did not receive oxybutynin chloride 5 mg on 2/21/2025 and 2/22/2025 because the facility did not have the medication. LVN 8 stated he was supposed to notify Resident 4's physician about not administering the medication to Resident 4 or about any changes but he did not. 47679 2. During a review of Resident 18's Admission Record, the admission record indicated Resident 18 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included schizophrenia (a mental illness that is characterized by disturbances in thought), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 18's MDS, dated [DATE], the MDS indicated Resident 18's cognition was severely impaired. The MDS indicated Resident 18 required moderate assistance (helper does less than half the effort) with toileting, bathing, dressing, and personal hygiene. During a review of Resident 18's H&P, dated 1/8/2025, the H&P indicated Resident 18 had the capacity to understand and make decisions. During a review of Resident 18's Progress Note, dated 2/26/2025 and timed at 6:20 p.m., the Progress Note indicated on 2/26/2025, Resident 18 made bad comments to her roommate. The Progress Note indicated Resident 18 was told, [I] will F her up if she will not stop talking. During an interview on 2/27/2025 at 12:47 a.m., with Registered Nurse (RN) 1, RN 1 stated on 2/26/2025, she was informed of the verbal altercation between Resident 18 and her roommate, where Resident 18 was verbally threatened. RN 1 stated her and LVN 6 worked together to ensure Resident 18 stayed safe by assigning two Certified Nursing Assistants (CNAs) to stay in the room until Resident 18's roommate could be relocated. RN 1 stated she did not inform Resident 18's responsible party (RP 2) of the verbal altercation because RN 1's role after the verbal altercation was to ensure Resident 18's safety. During an interview on 2/27/2025 at 1:46 p.m., with the DON, the DON stated after a verbal altercation, especially if a resident was verbally threatened, the resident's responsible party should be notified. The DON stated she was aware of the verbal altercation but did not try to contact RP 2. The DON stated informing RP 2 was important to ensure RP 2 was aware of the incident and to be reassured the facility put interventions into action to keep Resident 18 safe. 47858 (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. During a review of Resident 97's Admission Record, the Admission Record indicated Resident 97 was admitted to the facility on [DATE]. Resident 97's diagnoses included schizophrenia, Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities), dementia (a progressive state of decline in mental abilities), and an immunosuppressed disease (a state in which the immune system's ability to fight infectious diseases and cancer is compromised or entirely absent). During a review of Resident 97's MDS, dated [DATE], the MDS indicated Resident 97's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 97 required set up or clean up assistance for toileting, oral hygiene, and dressing, and required clean-up assistance when performing personal hygiene. During a review of Resident 97's Nursing Progress Note, dated 2/23/2025, the progress note indicated on 2/23/2025, Resident 97's was agitated (feeling of unease) and attempted to leave the facility. There was no documentation to indicate Resident 97's responsible party (RP 1) was made aware. During an interview on 2/28/2025 at 1:46 p.m. with RP 1, RP 1 stated the MDS Nurse (MDSN) left a voicemail on her phone around 1:00 p.m. on 2/28/2025 informing her an incident occurred on Sunday (2/23/2025). RP 1 stated she was never made aware any incidents that occurred on 2/23/2025. During an interview on 2/28/2025 at 2:00 p.m. with the MDSN, the MDSN stated she attempted to call RP 1 to inform her of Resident 97's elopement attempt and left a voicemail on 2/28/2025. The MDSN stated RP 1 should have been notified on 2/23/2025 of Resident 97's elopement attempt because it was RP 1's right to be informed of any incidents regarding RP 1's father. 4. During an observation on 2/24/2025 at 4:15 p.m., Resident 97 was observed walking with a fast pace in the hallway with a razor in his right hand, unsupervised. During an interview on 2/27/2025 at 3:37 p.m. with LVN 1, LVN 1 stated he was the assigned LVN for Resident 97 on the 3 p.m. to 11 p.m. shift on 2/24/2025 and witnessed Resident 97 with a razor in his right hand in the hallway on 2/24/2025. LVN 1 stated the physician and RP 1 were to be made aware of any changes in the physical or mental condition for a resident. LVN 1 stated he should have made RP 1 and Resident 97's physician aware Resident 97 obtained a used razor without facility knowledge, but did not have time during the shift to do so. LVN 1 stated it was RP 1's right to be informed of any changes that occurred for Resident 97. LVN 1 stated he should have made Resident 97's physician aware so he could have obtained an order for one-to-one supervision for Resident 97 or received orders to further address Resident 97's behaviors. LVN 1 stated this resulted in Resident 97 obtaining a razor again on 2/25/2025. During an interview on 2/28/2025 at 1:46 p.m. with RP 1, RP 1 stated she was not aware Resident 97 obtained possession of a used, disposable razor without facility staff supervision or knowledge on 2/24/2025. During a review of the facility's Policy and Procedure (P&P) titled Change of Condition dated 8/2017, the P&P indicated the facility would promptly notify the resident, his or her attending physician, and representative of changes in residents medical/mental condition and/or status. The P&P indicated the license nurse would document in the nurses' notes information relative to changes in the resident's medical/mental condition or status. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER California Post-Acute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 3615 E. Imperial Hiwy Lynwood, CA 90262	

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Abuse and Neglect Prohibition Policy, dated 6/2022, the P&P indicated, All reports of suspected abuse will also be reported to the resident's family and attending physician.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47679 Based on interview and record review, the facility failed to report abuse allegations to the State Agency (Department of Public Health), the ombudsman (an advocate for residents of nursing homes, board and care centers, and assisted living facilities), and the police department for two of 32 sampled residents (Residents 18 and 103) when: 1. Resident 18 and Resident 103 had a verbal altercation, on 2/26.2025, with both residents saying hurtful things to one another. 2. Resident 103 informed the Director of Nursing (DON), on 2/26/2025, that Certified Nursing Assistant (CNA) 1, made her feel unsafe in the facility. These deficient practices resulted in the delay of notification to the State Agency, ombudsman, and police department and had the potential to result in a delay of an onsite inspection. Cross Reference F610. Findings: 1a. During a review of Resident 18's Admission Record (Face Sheet), the Face Sheet indicated Resident 18 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included schizophrenia (a mental illness that is characterized by disturbances in thought), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 18's Minimum Data Set ([MDS], a resident assessment tool), dated 1/9/2025, the MDS indicated Resident 18's cognition (process of thinking) was severely impaired. The MDS indicated Resident 18 required moderate assistance (helper does less than half the effort) with toileting, bathing, dressing, and personal hygiene. During a review of Resident 18's History and Physical (H&P), dated 1/8/2025, the H&P indicated Resident 18 had the capacity to understand and make decisions. During a review of Resident 18's Progress Note, dated 2/26/2025 and timed at 6:20 p.m., the Progress Note indicated Resident 18 was making bad comments to her roommate. 1b. During a review of Resident 103's Admission Record (Face Sheet), the Face Sheet indicated Resident 103 was admitted to the facility on [DATE] with diagnoses that included epilepsy (a chronic brain disorder that causes seizures), muscle weakness (when muscles do not have the strength they normally do), and hypertension (high blood pressure). (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 103's MDS, dated [DATE], the MDS indicated Resident 103's cognition was intact. The MDS indicated Resident 103 required set up or clean-up assistance with eating, oral hygiene, and upper body dressing. During a review of Resident 103's H&P, dated 1/26/2025, the H&P indicated Resident 103 had the capacity to understand and make decisions. During a review of Resident 103's Progress Note, dated 2/6/2025 and timed at 5:20 p.m., the Progress Note indicated on 2/6/20205, Resident 18 spoke bad words to Resident 103 and Resident 103 responded to Resident 18 that she will F [Resident 18] up if [Resident 18] will not stop talking. During an interview on 2/27/2025 at 12:36 a.m., with Registered Nurse (RN) 1, RN 1 stated on 2/26/2025, she was informed of the verbal altercation between Resident 18 and Resident 103. RN 1 stated she informed the DON and the Administrator (ADM). During an interview on 2/27/2025 at 2:07 p.m., with the ADM, the ADM stated when there was knowledge of an abuse allegation or altercation had to be reported to the State Agency, the ombudsman, and law enforcement within two hours. The ADM stated he was aware of the verbal altercation between Resident 18 and Resident 103 but did not know Resident 103 stated, I will F you up to Resident 18. The ADM stated the altercation was not reported because he thought the altercation was a simple argument and was not aware any threats were made. The ADM stated due to Resident 103's verbal threat towards Resident 18, the altercation should have been reported. 2. During a review of Resident 103's Progress Note, dated 2/26/2025 and timed at 8:06 p.m., the Progress Note indicated on 2/26/2025, Resident 103 called the police because she feels unsafe here. The Progress Note indicated a CNA was in her face while lying in bed. During an interview on 11:59 a.m., with Resident 103, Resident 103 stated CNA 1 was very prejudice (feeling unfavorable toward a person) against her and CNA 1 made her feel unsafe in the facility. Resident 103 stated she informed the RN on duty of her feelings. During an interview on 2/27/2025 at 12:47 p.m., with RN 1, RN 1 stated Resident 103 told her, that lady threatening, as she referred to CNA 1. RN 1 stated Resident 103 did not elaborate how CNA 1 threatened her, only that Resident 103 stated, I do not feel safe. RN 1 stated the DON and ADM were made aware of Resident 103's allegation. During an interview on 2/27/2025 at 1:40 p.m., with the DON, the DON stated she was made aware of Resident 103's statement to RN 1 of feeling unsafe in the facility. The DON stated she interviewed Resident 103 who stated, The CNA was in my face and was being smart with me and that Resident 103 called the police because she felt unsafe in the facility. The DON stated she interviewed Resident 103's roommate, who was a witness to the interaction between Resident 103 and CNA 1. The DON stated based on Resident 103's roommate's statement, she determined it was a misunderstanding and did not need to be reported. The DON stated the facility was required to report all abuse allegations, whether the reporter believes the allegation was true or false. The DON stated Resident 103's allegation should have been reported. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/27/2025 at 2:12 p.m., with the ADM, the ADM stated he was aware there was an exchange of words between Resident 103 and CNA 1 but determined there were no threats made after Resident 103's roommate was interviewed. The ADM stated he was unaware Resident 103 stated she felt unsafe in the facility. The ADM stated Resident 103's allegation and statement of feeling unsafe in the facility should have been reported to the State Agency, the ombudsman, and law enforcement to ensure notification and to ensure an onsite inspection was conducted. During a review of the facility's policy and procedure (P&P) titled, Abuse and Neglect Prohibition Policy, dated 6/2022, the P&P indicated all alleged violations regarding suspected or alleged abuse were to be reported, no later than two hours to the State Agency, the ombudsman, and law enforcement.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47679 Based on interview and record review, the facility failed to implement interventions to prevent further potential abuse for one of three sampled residents (Resident 103) when Resident 103 informed the Director of Nursing (DON), on 2/26/2025, that Certified Nursing Assistant (CNA) 1, made her feel unsafe in the facility. This deficient practice resulted in CNA 1 not being suspended for the rest of her shift, which put Resident 103 and the other residents in the facility at risk of further potential abuse. Cross Reference F609. Findings: During a review of Resident 103's Admission Record (Face Sheet), the Face Sheet indicated Resident 103 was admitted to the facility on [DATE] with diagnoses that included epilepsy (a chronic brain disorder that causes seizures), muscle weakness (when muscles do not have the strength they normally do), and hypertension (high blood pressure). During a review of Resident 103's Minimum Data Set ([MDS], a resident assessment tool), dated 1/31/2025, the MDS indicated Resident 103's cognition (process of thinking) was intact. The MDS indicated Resident 103 required set up or clean-up assistance with eating, oral hygiene, and upper body dressing. During a review of Resident 103's History and Physical (H&P), dated 1/26/2025, the H&P indicated Resident 103 had the capacity to understand and make decisions. During a review of Resident 103's Progress Note, dated 2/26/2025 and timed at 8:06 p.m., the Progress Note indicated on 2/26/2025, Resident 103 called the police because she feels unsafe here. The Progress Note indicated a certified nursing assistant (CAN) was in her face while lying in bed. During an interview on 11:59 a.m., with Resident 103, Resident 103 stated CNA 1 was very prejudice (feeling unfavorable toward a person) against her and CNA 1 made her feel unsafe in the facility. Resident 103 stated she informed the registered nurse (RN) on duty of her feelings. During an interview on 2/27/2025 at 12:47 p.m., with RN 1, RN 1 stated Resident 103 told her, That lady threatening, referring to CNA 1. RN 1 stated Resident 103 did not elaborate how CNA 1 threatened her, only that Resident 103 stated, I do not feel safe. RN 1 stated the Director of Nursing (DON) and Administrator (ADM) were made aware of Resident 103's allegation. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/27/2025 at 1:40 p.m., with the DON, the DON stated she was made aware of Resident 103's statement to RN 1 of feeling unsafe in the facility. The DON stated she interviewed Resident 103 who stated, The CNA was in my face and was being smart with me and that Resident 103 called the police because she felt unsafe. The DON stated she interviewed Resident 103's roommate, who was a witness to the interaction between Resident 103 and CNA 1. The DON stated based on Resident 103's roommate's statement, she determined it was a misunderstanding. The DON stated although she did an initial investigation to ensure Resident 103 was safe, a thorough investigation by the Administrator had to be conducted to ensure Resident 103's and other resident's safety. The DON stated when an abuse allegation was made against a staff member in the facility, that staff member had to leave the facility immediately and suspended for the duration of the investigation. The DON stated CNA 1 worked the rest of her shift on 2/26/2025 and was not suspended. During an interview on 2/27/2025 at 2:12 p.m., with the ADM, the ADM stated he was aware there was an exchange of words between Resident 103 and CNA 1 but determined there were no threats made after Resident 103's roommate was interviewed. The ADM stated he was unaware that Resident 103 stated she felt unsafe. The ADM stated CNA 1 should not have been allowed to finish her shift on 2/26/2025 and should have been sent home after the facility gained knowledge of Resident 103's allegation. The ADM stated suspending CNA 1, while the facility conducted a thorough investigation, would ensure no other potential abuse could occur by CNA 1, if CNA 1 was found to be at fault. The ADM stated although Resident 103 was moved to a different room and did not have further contact with CNA 1, allowing CNA 1 to continue working put other residents in her care at risk for abuse. During a review of the facility's policy and procedure (P&P) titled, Abuse and Neglect Prohibition Policy, dated 6/2022, the P&P indicated, The facility will protect the resident from further harm during the investigation period . The employee alleged to have committed the act of abuse will be immediately removed from duty, pending investigation.

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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** 46832 Based on interview and record review, the facility failed to ensure a smoking safety assessment was complete for one of five sampled residents (Resident 115). This deficient practice had the potential to result in injuries during smoke breaks for Resident 48. Findings: During a review of Resident 115's Admission Record, the admission record indicated Resident 115 was admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing), muscle weakness (a decreased ability of muscles to contract and generate force), Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), and abnormalities of gait and mobility (changes in walking or movement that can occur due to a number of possible causes). During a review of Resident 115's Minimum Data Set (MDS- a resident assessment tool), dated 11/19/2024, indicated Resident 115's cognitive skills was intact (ability to think and reason). The MDS also indicated Resident 115 required setup assistance with activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) such as toileting needs, showering and upper/lower body dressing. During a review of the facility's residents smoking list, the smoking list indicated Resident 115 smoked cigarettes. During a review of Resident 115's medical chart, the medical chart indicated there was no smoking assessment. During an observation, on 2/26/2025, at 10:01 a.m., Resident 115 was observed smoking with four other residents on the smoking patio. Resident 115 was observed not wearing a smoking apron. During an interview, on 2/27/2025 at 2:30 p.m., with the Director of Nursing (DON), the DON stated all residents who smoked required a smoking assessment. The DON stated the smoking assessment was used to determine if a resident can smoke independently or required supervision and safety materials. The DON stated Resident 115 was a smoker. The DON stated Resident 115 did not have a smoking assessment. The DON stated the risk of not completing a smoking assessment could result in inadequate supervision, safety issues, and injuries. During a review of the facility's policy and procedures (P&P), titled Safety and Supervision of Residents, dated 1/2018, the P&P indicated Our individualized, resident-centered approach to safety addresses safety and accident hazards for individual residents. and The interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for individual residents.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46832 Based upon interview and record review, the facility failed to ensure a quarterly Minimum Data Set (MDS- a mandated resident assessment tool) assessment was completed for two out of two residents (Resident 1 and Resident 51). This deficient practice had the potential to negatively affect the provision of necessary care and services. Findings: a. During a review of Resident 1's Admission Record, the admission record indicated Resident 1 was originally admitted on [DATE] and readmitted on [DATE] with diagnoses which included hypotension (low blood pressure), schizophrenia (a mental illness that is characterized by disturbances in thought), rheumatoid arthritis (a chronic progressive disease-causing inflammation in the joints and resulting in painful deformity and immobility) and epilepsy (seizures, a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness). During a review of Resident 1's MDS, dated [DATE], the MDS indicated Resident 1's cognitive skills (the mental processes your brain uses for thinking, learning, remembering, and problem-solving) were severely impaired. The MDS indicated Resident 1 required maximal assistance with activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) such as toileting needs, showering and upper/lower body dressing. During a review of Resident's 1's MDS's, the MDS's indicated Resident 1's last quarterly (every 3 months) MDS was completed on 10/15/2024. Resident 1's quarterly MDS dated [DATE] was in progress and not submitted. During a concurrent interview and record review, on 02/27/2025, at 11:52 a.m., with the MDS Nurse (MDSN), the MDSN stated assessments were completed upon admission, quarterly and at discharge. The MDSN stated Resident 1's last quarterly MDS was completed on 10/15/2024. The MDSN stated Resident 1's next quarterly MDS assessment should had completed in January 2025. The MDSN stated Resident 1's January 2025 MDS assessment was not completed and in progress. The MDSN stated the risk of not completing a resident quarterly MDS assessment in a timely manner could result in not keeping track of a resident's progress. During a concurrent interview and record review, on 2/27/2025, at 2:30 p.m., with the Director of Nursing (DON), the DON stated Resident 1's last quarterly MDS was 10/15/2024. The DON stated Resident 1 should have had another MDS assessment completed in January 2025. The DON stated it was not completed. The DON stated the risk of not completing a MDS assessment could result in missing a resident's change of condition from prior assessments. The DON stated, I'm not sure exactly what happened, it was an oversight and was not caught. 47679 (continued on next page)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. During a review of Resident 51's Admission Record, the admission record indicated Resident 51 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included type two diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing), chronic kidney disease (condition where the kidneys are damaged and cannot filter blood properly), and chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing). During a review of Resident 51's History and Physical (H&P), dated 4/17/2024, the H&P indicated Resident 51 had the capacity to understand and make decisions. During a concurrent interview and record review on 2/26/2025 at 8:24 a.m., with the MDSN, Resident 51's MDS, dated [DATE], was reviewed. The MDSN stated Resident 51's MDS was not completed by 1/17/2025 and submitted no later than 14 days after. The MDSN stated the residents' MDS's were completed at least upon admission, quarterly, and annually. The MDSN stated Resident 51's MDS was not on her calendar, and she overlooked completing Resident 51's MDS on time. The MDS stated it was important to conduct the residents' MDS on time to ensure accurate assessments were available. During an interview on 2/28/2025 at 8:45 a.m., with the DON), the DON stated a resident's MDS was a full assessment and provided a full picture of who the resident is. The DON stated the MDS was utilized to create the plan of care for each resident. The DON stated when a MDS was not completed on time, the facility would not have the current and most accurate picture of the resident, and the facility could potentially not give the most appropriate care the resident required. During a review of the facility's policy and procedure (P&P) titled, Minimum Data Set (MDS) Assessment Schedule, dated 10/2023, the P&P indicated, The facility conducts a comprehensive assessment to identify patient's needs per the guidelines set by the Resident Assessment Instrument (RAI). The following assessments will be completed based on the guidelines set by the RAI Manual: Admission Assessment, Significant Change of Condition, Quarterly Assessments, Medicare Pay Per Performance (PPS) Assessments, Correction Assessments, Tracking Assessments, [and] Discharge Assessments. A review of the facility's policy and procedures, titled Minimum Data Set Assessment (MDS) Schedule, dated 10/2023, indicated Non-comprehensive MOS assessments include a select number of items on the MDS used to track the resident's status between comprehensive assessments and to ensure monitoring of critical indicators of the gradual onset of significant changes in resident status. Non-comprehensive assessments include Quarterly and SCQA assessments.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47858 Based on interview and record review, the facility failed to ensure the Preadmission Screening and Resident Review (PASRR- a federal assessment requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are placed in facilities that can provide the appropriate care) Level II Evaluations for four out of four sampled residents (Resident 5, Resident 19, Resident 97, and Resident 60) were completed. This deficient practice had the potential to result in inappropriate placement and unidentified specialized services for Residents 5,19, 97, and 60. Findings: a. During a review of Resident 97's Admission Record, the Admission Record indicated Resident 97 was admitted to the facility on [DATE]. Resident 97's diagnoses included schizophrenia (a mental illness that is characterized by disturbances in thought), Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities), and dementia (a progressive state of decline in mental abilities). During a review of Resident 97's Minimum Data Set ([MDS], a resident assessment tool), dated 12/25/2024, the MDS indicated Resident 97's cognitive skills (ability to think and reason) for daily decision making was severely impaired. The MDS indicated Resident 97 required set up or clean up assistance for toileting, oral hygiene, and dressing, and required clean-up assistance when performing personal hygiene. During a review of Resident 97's Level I Screen PASRR, dated 12/5/2024, the Level I PSARR Screen indicated Resident 97 required a Level II PASRR evaluation. During an interview on 2/26/2025 at 11:06 a.m. with the Admissions Coordinator (AC), the AC stated Level II PASRR screens were important because the Department of Mental Health Care Services would need to make an evaluation to determine the appropriateness of the facility for the resident. The AC stated if the Level II PASRR screen was not complete, there would be potential for a resident to remain at the facility that would not be able to provide the appropriate care for him or her. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 2/28/2025 at 10:30 a.m. with the Director of Nursing (DON), Resident 97 's Department of Health Care Services (DHS) letter, titled Notice of Attempted Evaluation Letter (Level II PASRR), dated 12/5/2024, was reviewed. The letter indicated facility staff were unresponsive to two or more separate attempts of communication within 48 hours of the Level I PASRR screen to complete the Level II PASRR screen. The DON stated all PASRRs had to be performed and completed as soon as possible, and if the Department of Health Care Services could not successfully complete the screen due to a lack of response from the facility, then a new Level I PASRR screen would need to be performed again. The DON stated Level II PASRR screens were important because it helped confirm whether a resident had a serious mental illness and if the facility had the proper resources to provide appropriate care for the resident. The DON stated the screen could also determine if the resident was appropriately placed in the facility or if the resident would need to be transferred elsewhere. The DON stated the facility did not follow up on the completeness of the Level II PASRR screen (since 12/5/2024). The DON stated that it was important to complete Resident 97's Level II PASRR screen due to his known psychiatric and behavioral issues. The DON stated there was a possibility that Resident 97 has not received the proper psychiatric services or care since the first day of Resident 97's admission (9/17/2024). 45009 b. During a review of Resident 5's Admission Record, the admission record indicated Resident 5 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses of bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs) and schizophrenia. During a review of Resident 5's History and Physical (H&P) dated 12/26/2024, the H&P indicated Resident 5 did not have the capacity to understand and make decisions. During a review of Resident 5's MDS, dated [DATE], the MDS indicated Resident 5's cognitive skills for daily decision making was moderately impaired. The MDS indicated Resident 5 was dependent on staff for all activities of daily living. During a review of Resident 5's PASRR Level I Screening, dated 1/2/2025, the PASRR Level I screening indicated result was positive for a serious mental illness (SMI). The PASRR Level I screening indicated a SMI level II mental health evaluation was required. During a review of Resident 5's electronic medical record, unable to locate a SMI level II health evaluation. c. During a review of Resident 19's Admission Record, the admission record indicated Resident 19 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses of bipolar disorder and dementia. During a review of Resident 19's H&P dated 12/14/2024, the H&P indicated Resident 19 had the capacity to understand and make decisions. During a review of Resident 19's MDS, dated [DATE], the MDS indicated Resident 19's cognitive skills for daily decision making was intact. The MDS indicated Resident 19 needed supervision for eating, shower/bathing, dressing and oral hygiene. (continued on next page)

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California Post-Acute Care	3615 E. Imperial Hiwy Lynwood, CA 90262

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F 0645

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

During a review of Resident 19's PASRR Level I Screening, dated 12/13/2024, the PASRR Level I screening indicated result was positive for SMI. The PASRR Level I screening indicated a SMI level II mental health evaluation was required.

During a review of Resident 19's electronic medical record, unable to locate a SMI level II health evaluation.

46832

d. During a review of Resident 60's Admission Record, the admission record indicated Resident 60 was admitted on [DATE] with diagnoses which included schizophrenia, hydrocephalus (a build-up of fluid in the cavities deep within the brain), chronic inflammation disease of the uterus (a long-term irritation or inflammation of the uterine lining) and type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing).

During a review of Resident 60's MDS, dated [DATE], the MDS indicated Resident 60's cognitive skills were moderately impaired. The MDS indicated Resident 60 was dependent on staff members with activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) such as toileting needs, showering and upper/lower body dressing.

During a review of Resident 60's Level 1 PASARR, dated 12/09/2024, Resident 60's Level 1 PASRR indicated Resident 60 had a serious mental health illness and required at Level 2 PASRR.

During a review of Resident 60's Department of Health Care Services (DHS) letter, titled Notice of Attempted Evaluation, dated 12/9/2024, the letter indicated a Level 2 PASRR screening was unable to be completed due to facility staff not responding to two or more separate attempts of communication within 48 hours of Level 1 screening.

During a concurrent interview and record review, on 2/26/2025, at 9:46 a.m. with the AC, the AC stated he was responsible for submitting and resubmitting PASRRs for all residents. The AC stated DHS attempted to contact the facility for Resident 60's Level 2 PASRR screening. The AC state the facility did not respond to DHS attempts. The AC stated Resident 60's PASRR should had been resubmitted. The AC stated the risk of not resubmitting a PASRR for a resident could result in a delay of necessary mental health services and recommendations.

During an interview, on 2/27/2025, at 2:30 p.m., with the Director of Nursing (DON), the DON stated all residents were to have a Level 1 PASRR screening upon admission. The DON stated if a resident required a Level 2 PASRR screening, DHS would call the facility to conduct a Level 2 screening. The DON stated Resident 60 required a Level 2 screening. The DON stated Resident 60's Level 2 screening was not conducted due to failed attempts of communication from the facility. The DON stated Resident 60's PASRR should had been resubmitted. The DON stated the risk of not resubmitting a PASRR screening could result in not providing the further mental health services as needed.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's Policy and Procedure (P&P), titled, Preadmission Screening and Resident Review, revised 12/2022, the P&P indicated the facility was to ensure a PASRR Level II evaluation was conducted before admission if a Level I screening indicated the presence of a serious mental disorder (SMI), intellectual disability (ID), or developmental disability (DD). The P&P indicated the facility would comply with all state and federal regulations to ensure appropriate placement and services for PASRR-identified individuals. The P&P indicated the following for PASRR-Positive Individuals: a. The facility may admit PASRR-positive individuals if: b. The Level II evaluation confirms that facility placement is appropriate. c. Specialized services recommended in the evaluation can be provided within the facility or through external partnerships. d. The individual's care plan includes all recommended support and services

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47858 Based on observation, interview, and record review, the facility failed to develop a person-centered care plan (document that helps nurses and other team care members organize aspects of resident care) and/or implement interventions (actions a nurse takes to implement a care plan, intend to improve the resident's comfort and health) for of 32 sampled residents (Residents 36, 8, 115, 81, 99, and 97) by failing to: 1. Implement Resident 97's Attempted Elopement Care Plan, initiated 10/5/2024, and Resident 97's At Risk for Elopement Care Plan Intervention, dated 1/24/2025, to ensure Resident 97's location was monitored every 60 minutes, one-on-one sitter was provided and a wander guard (a device placed on the resident that triggers an alarm when a resident attempts to exit the facility) was placed on Resident 97 after he attempted to elope on 2/23/2025. 2. Implement Resident 97's Self-harm Care Plan, initiated 12/2/2024, to provide Resident 97 one-to-one monitoring at all times after Resident 97 was observed with a razor on 2/24/2025. 3. Implement Resident 97's Suicidal Ideation Care Plan, initiated 12/21/2024, when two cords and nail clippers were observed in Resident 97's room. These deficient practices had the potential to result in self-harm, injury, and elopement for Resident 97. 4. Develop a care plan to address Resident 8's weight loss. This deficient practice had the potential to delay and negatively affect the delivery of care for Resident 8's weight loss. 5. Develop a care plan for Resident 36's oxygen use. This deficient practice had the potential to delay necessary monitoring and safety interventions related to Resident 36's oxygen administration 6. Develop a smoking care plan for Resident 115. This deficient practice had the potential to result in inadequate supervision which could lead to serious injury while smoking. 7. Develop a care plan for Resident 81's use of apixaban (an anticoagulant medication, used to prevent blood clots from forming in the blood vessels and the heart). This deficient practice had the potential to result in Resident 81 suffering from undetected bleeding. 8. Develop a care plan for Resident 99's primary language of Spanish. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficient practice had the potential to result in the facility unable to provide the necessary care to Resident 99 and Resident 99 being unable to convey his needs in his primary language. Cross Reference F689. Findings: 1. During a review of Resident 97's Admission Record, the Admission Record indicated Resident 97 was admitted to the facility on [DATE]. Resident 97's diagnoses included schizophrenia (a mental illness that is characterized by disturbances in thought), Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities), dementia (a progressive state of decline in mental abilities), and an immunocompromised disease (an impaired immune system). During a review of Resident 97's Minimum Data Set ([MDS], a resident assessment tool), dated 12/25/2024, the MDS indicated Resident 97's cognitive skills (ability to think and reason) for daily decision making was severely impaired. The MDS indicated Resident 97 required set up or clean up assistance for toileting, oral hygiene, and dressing, and required clean-up assistance when performing personal hygiene. During a review of Resident 97's Attempted Elopement Care Plan, initiated 10/5/2024, the care plan indicated to monitor Resident 97's location every 60 minutes and provide one-on-one sitter to closely monitor the resident and prevent from leaving the facility. During a review of Resident 97's Elopement Risk Assessment, dated 10/5/2024, the risk assessment indicated Resident 97 was at high risk for elopement. During a review of Resident 97's Risk for Self-harm Care Plan, initiated 12/2/2024, the care plan indicated the facility was to render close supervision by sustaining observation or awareness at all times by being on one- to-one monitoring. The care plan also indicated the nurse would remove all potentially harmful objects such as sharp objects, cords, and medications from the resident's environment. During a review of Resident 97's At Risk for Elopement Care Plan Intervention, dated 1/24/2025, the care plan intervention indicated to monitor wander guard on Resident 97's right wrist for placement every shift. During a review of Resident 97's Order Recap Summary Report, dated 2/25/2025, the report indicated Resident 97 was ordered one-to-one continuous monitoring on 10/7/2024. During a review of Resident 97's Nursing Progress Note, dated 2/23/2025, the progress note indicated Resident 97 was agitated and attempted to leave the facility. There was no documentation to indicate one-to-one supervision was rendered. During observations made on 2/24/2025 at 2:30 p.m., 2/24/2025 at 4:15 p.m., and 2/25/2025 at 9:30 a.m., Resident [NAME] was not on one-to-one supervision by facility staff. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 2/25/2025 at 9:15 a.m. with Certified Nursing Assistant (CNA) 2, Resident 97's wrists, arms, legs, and ankles were observed. CNA 2 stated Resident 97 did not have a wander guard and should have had one placed on his wrist or ankle. During an interview on 2/26/2025 at 1:24 p.m. with Registered Nurse (RN) 3, RN 3 stated she was the assigned registered nurse on the 7 a.m. to 3 p.m. shift on 2/23/2025. RN 3 stated she witnessed Resident 97 run into the lobby and attempt to leave the facility on 2/23/2025. RN 3 stated Resident 97 was not placed on continuous one-to-one supervision because the facility did not have sitters. During a concurrent interview and record review on 2/28/2025 at 10:30 a.m. with the Director of Nursing (DON), Resident 97's Attempted Elopement Care Plan, initiated 10/5/2024, At Risk for Elopement Care Plan Intervention, dated 1/24/2025, and Order Recap Summary Report, dated 2/25/2025, were reviewed. The DON stated the nursing staff should have carried out the order for one-to-one supervision (since 10/7/2024) because it was still considered an active order. The DON stated Resident 97 should have had a wander guard in place, especially after Resident 97 attempted to elope on 2/23/2025. The DON stated there was potential for Resident 97 to elope the facility because the care plan interventions were not implemented. 2. During an observation on 2/24/2025 at 4:15 p.m., Resident 97 was observed walking with a fast pace in the hallway (unsupervised) with a razor in his right hand. During an interview on 2/25/2025 at 9:36 a.m. with the Director of Staff Development (DSD), the DSD stated she observed Resident 97 shaving unsupervised with a disposable razor in his hand inside of his restroom on 2/25/2025 at 8:30 a.m. The DSD stated Resident 97 told her Resident 97 stuck his hand inside of the sharps container, located inside of shower room A to grab a disposable razor. During a concurrent interview and record review on 2/26/2025 at 12:44 p.m. with the DON, Resident 97's Self-harm Care Plan, dated 12/2/2024, was reviewed. The DON stated the care plan indicated staff were to provide Resident 97 with one-to-one monitoring at all times. The DON stated the nursing staff did not follow the care plan interventions, and the nursing staff should have implemented one-to-one supervision to ensure Resident 97 would not be able to obtain a used, disposable razor on 2/24/2025 and 2/25/2025. During a concurrent interview and record review on 2/27/2025 on 9:31 a.m. with Licensed Vocational Nurse (LVN 2), Resident 97's SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents), dated 12/2/2024, was reviewed. The SBAR indicated Resident 97 tied the strings of his hooded sweatshirt tightly around his neck, became agitated, demanded a fork and stated, I can do whatever I want, and nobody can stop me. The SBAR indicated Resident 97 proceeded to motion his hands as if he pretended to shoot a gun. The SBAR indicated Resident 97's behavior escalated and 911 was called, and Resident 97 was sent to the general acute care hospital (GACH). LVN 2 stated she authored the SBAR and recalled that Resident 97 came back from the hospital around 4 p.m. LVN 2 stated there was a lack of documentation to indicate Resident 97 was rendered one-to-one supervision upon his arrival. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 2/27/2025 on 9:31 a.m. with LVN 2, Resident 97's Order Recap Summary Report, dated 2/25/2025, and Resident 97's Self-harm Care Plan, dated 12/2/2024, was reviewed. LVN 2 stated the report indicated Resident 97 was ordered one-to-one continuous monitoring since 10/7/2024. LVN 2 stated the facility nursing staff should have rendered one-to-one supervision since the date it was ordered (10/7/2024), and especially because it was listed as a care plan intervention since 12/2/2024. LVN 2 stated the facility should have done a better job at supervising (from 12/2/2024 to 2/2025) Resident 97 due to his medical psychiatric diagnoses, history of suicidal ideation, and behavioral issues. 3. During observations made on 2/25/2025 at 3:49 p.m., 2/26/2025 at 7:31 a.m., and 2/27/2025 at 7:32 a.m., Resident 97's room was observed. Resident 97 had two long cords plugged into the electrical outlet in the wall. On 2/25/2025, Resident 97 had nail clippers on his bed side table. During a concurrent observation and interview on 2/25/2025 at 9:01 a.m. with Certified Nursing Assistant (CNA) 2, Resident 97's room was observed. CNA 2 stated Resident had nail clippers on his bedside table and two cords plugged into his outlet near his bed. During an interview on 2/28/2025 at 10:30 a.m. with the DON, the DON stated the facility did not follow Resident 97's Suicidal Ideation Care Plan if there had been two cords and nail clippers left in his room. The DON stated there was potential for Resident 97 to use those items to harm himself or others. During a review of the facility's Policy and Procedure (P&P), titled, Care Plans, Comprehensive Person-Centered, dated 1/2018, the P&P indicated the facility was to ensure a comprehensive, person-centered care plan included measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs was developed and implemented for each resident. 45009 4. During a review of Resident 8's Admission Record, the admission record indicated Resident 8 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses of diabetes mellitus ([DM] a disorder characterized by difficulty in blood sugar control and poor wound healing) and hemiplegia (condition caused by a brain injury, that results in a varying degree of weakness, stiffness and lack of control in one side of the body). During a review of Resident 8 's H&P dated 10/17/2024, the H&P indicated Resident 8 did had the capacity to understand and make decisions. During a review of Resident 8's MDS dated [DATE], the MDS indicated Resident 8's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 8 required maximal assistance (helper does more than half the effort) for personal hygiene, dressing and shower/bathing. The MDS indicated Resident 8 required set up assistance for eating. During a review of Resident 8's Interdisciplinary ([IDT] collaborative approach to patient care) Weight Meeting notes, dated 2/6/2025, the IDT notes indicated interdisciplinary interventions were developed for Resident 8's nutritional review. The IDT notes indicated Resident 8 was reviewed for weight loss in the last 6 months. The IDT notes indicated Resident 8's weight was semi stable between 169 - 174 pounds the last three months. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 8's Annual Nutritional Assessment, dated 9/19/2024, the nutritional assessment indicated Resident 8's nutritional problem was significant weight loss. During a review of Resident 8's monthly weight report, dated 8/2024, the weight report indicated Resident 8 weighed 180.4 pounds. During a review of Resident 8's monthly weight report, dated 2/2025, the Weight report indicated Resident 8 weighed 171.8 pounds. During a review of Resident 8's electronic medical record, unable to locate a care plan for Resident 8's weight loss. During a concurrent record review and interview on 2/29/2025 at 1:38 p.m. with the DON, Resident 8's care plan, dated 2/2025 was reviewed. The DON stated Resident 8 did not have a care plan for weight loss. The DON stated a care plan must be developed when a resident has weight loss. The DON stated a care plan for weight loss must be in place to develop a plan of care to prevent further weight loss. The DON stated a care plan served as guidance to nurses because it set goals and interventions to prevent further weight loss. The DON stated if a resident did not have a care plan, the nursing staff would not have a plan of care to follow and would not know a resident had a weight loss problem. 48131 5. During a review of Resident 36's Admission Record, dated 2/27/2024, the admission record indicated Resident 36 was initially admitted to the facility on [DATE] and readmitted on [DATE]. The admission record indicated the following diagnoses which included acute respiratory failure with hypoxia (when the lungs suddenly fail to adequately provide oxygen to the body, resulting in a dangerously low level of oxygen in the blood), congestive heart failure (CHF- a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), end stage renal disease (ESRD - irreversible kidney failure), and dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed). During a review of Resident 36's H&P, dated 11/21/2024, the H&P indicated Resident 36 had the capacity to understand and make decisions. During a review of Resident 36's MDS, dated [DATE], the MDS indicated Resident 36's cognition was moderately impaired. The MDS indicated Resident 36 eats independently and was dependent (helper does all the effort) for toileting, bathing and personal hygiene. During a review of Resident 36's Order Summary Report dated 2/27/2025, the order summary report indicated Resident 36 had an active order on 2/22/2025 for oxygen at two liters (unit of volume) per minute (LPM) via nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) as needed for shortness of breath to keep oxygen saturation (O2 sat - a measurement of how much oxygen the blood is carrying as a percentage) equal or more than 92 percent (%) (normal O2 sat - 95% to 100%). May titrate (to adjust the flow of oxygen to meet the resident's needs) oxygen flow to two to four LPM. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 2/27/2025 at 8:02 a.m. with the Minimum Data Set Nurse (MDSN) 2, MDSN 2 reviewed Resident 36's care plans. MDSN 2 stated she was responsible for reviewing all residents' hospital documentation, and diagnosis and completing care plans and MDS upon admission. MDSN 2 stated she could not find an oxygen care plan in Resident 36's chart. MDSN 2 stated if Resident 36 was on oxygen, the resident should have a care plan. MDSN 2 stated the licensed nurse that placed Resident 36 on oxygen should have created the oxygen care plan. MDSN 2 stated any licensed nurse could have initiated a care plan. MDSN 2 stated the care plan was important because this document was the road map of how to plan the resident's care. MDSN 2 stated if there was no care plan a lot of things could go wrong because there was nothing to follow regarding the resident's care. MDSN 2 stated Resident 36's oxygen was initiated over the weekend; however, she (MDSN 2) should have followed up on the oxygen care plan the following Monday but stated the care plan was somehow overlooked. During an interview on 2/27/2025 at 3:11 p.m. with the DON, the DON stated the licensed nurse who took Resident 36's oxygen order and initiated the oxygen should have also initiated a care plan for the oxygen. The DON stated the oxygen care plan was important so the staff would know the precautions needed for oxygen use and how to take care of a resident receiving oxygen. 46832 6. During a review of Resident 115's Admission Record, the admission record indicated Resident 115 was admitted to the facility on [DATE] with diagnoses which included COPD, muscle weakness (a decreased ability of muscles to contract and generate force), Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), and abnormalities of gait and mobility (changes in walking or movement that can occur due to a number of possible causes) During a review of Resident 115's MDS, dated [DATE], the MDS indicated Resident 115's cognitive skills was intact. The MDS indicated Resident 115 required setup assistance with activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) such as toileting needs, showering and upper/lower body dressing. During a review of the facility's residents smoking list, the smoking list indicated Resident 115 smoked cigarettes. During a review of Resident 115's care plan, Resident 115 did not have a care plan for smoking. During a concurrent interview and record review, on 2/27/2025 at 2:30 p.m., with the DON, the DON stated care plans were required for smoking residents. The DON stated Resident 115 did not have a smoking care plan. The DON stated care plans was a form of communication between the licensed staff. The DON stated the risk of not having a smoking care plan for Resident 115 could result in inadequate supervision and injuries. During a review of the facility's policy and procedures (P&P), titled Smoking Policy- Residents, dated 6/2022, the P&P indicated Any smoking-related privileges, restrictions, and concerns (for example, need for close monitoring) shall be noted on the care plan, and all personnel caring for the resident shall be alerted to these issues. 47679 (continued on next page)

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NAME OF PROVIDER OR SUPPLIER California Post-Acute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 3615 E. Imperial Hiwy Lynwood, CA 90262	

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7. During a review of Resident 81's Admission Record (Face Sheet), the Face Sheet indicated Resident 81 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety disorder (a mental health condition that involves excessive fear, worry, and dread), and encephalopathy (general condition where brain function is impaired). During a review of Resident 81's MDS, dated [DATE], the MDS indicated Resident 81's cognition was intact. The MDS indicated Resident 81 was dependent on staff's assistance with toileting, bathing, and lower body dressing. The MDS indicated Resident 81 received anticoagulant medication. During a review of Resident 81's H&P, dated 1/28/2024, the H&P indicated Resident 81 had the capacity to understand and make decisions. During a review of Resident 81's Order Recap Report, dated 6/1/2024 through 2/28/2025, the Order Recap Report indicated to give apixaban 5 milligrams (mg, unit of measurement), by mouth, every 12 hours, for blood clot. The order date was 1/27/2025. During a concurrent interview and record review on 2/26/2025 at 8:22 a.m. with the MDSN, Resident 81's Care Plans, dated 12/1/2022 through 2/25/2025, were reviewed. The MDSN stated Resident 81 did not have a care plan that addressed his use of apixaban. The MDSN stated a care plan should have been developed when Resident 81 initially started taking apixaban. The MDSN stated the interventions specific to Resident 81's use of apixaban would focus on monitoring for any drug interactions, side effects, adverse reactions, and for any signs of bleeding. The MDSN stated because Resident 81 did not have a care plan for his use of apixaban, the staff providing care may not be aware to monitor Resident 81 for bleeding. During an interview on 2/28/2025 at 8:47 a.m., with the DON, the DON stated care plans were a form a communication and they provide direction to the care team on how to care for each individual resident. The DON stated Resident 81 took apixaban daily and apixaban should have been care planned. The DON stated apixaban had a black box warning (a serious safety alert issued by the United States Food and Drug Administration [FDA] to inform healthcare professionals and patients about potential life-threatening or serious adverse effects associated with a medication) and the care plan would reflect the additional monitoring necessary to administer apixaban safely. The DON stated the care plan should include interventions to monitor for any signs of bleeding due to the blood thinning effect of apixaban. The DON stated without a care plan for the use of apixaban, Resident 81 was at risk of undetected bleeding, which could lead to hospitalization and further medical treatment. During a review of the facility's P&P titled, Anticoagulation Therapy Management, dated 7/2017, the P&P indicated to develop a care plan addressing for actual or potential risk of anticoagulant therapy issues and should address any drug to drug interaction, food to drug interaction, medical diagnosis, laboratory monitoring, and monitoring for adverse reaction of anticoagulation therapy. 8. During a review of Resident 99's Admission Record (Face Sheet), the Face Sheet indicated Resident 99 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included acute myocardial infarction (heart attack), low back pain, and type two diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing). The Face Sheet indicated Resident 99's primary language was Spanish. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 99's MDS, dated [DATE], the MDS indicated Resident 99's cognition was moderately impaired. The MDS indicated Resident 99 required maximal assistance with oral hygiene, upper body dressing, and personal hygiene. During a review of Resident 99's H&P, dated 10/19/2024, the H&P indicated Resident 99 had the capacity to understand and make decisions. During a concurrent interview and record review on 2/26/2025 at 8:14 a.m., with the MDSN, Resident 99's Care Plans, dated 6/27/2024 through 2/26/2025, were reviewed. The MDSN stated Resident 99 did not have a care plan that addressed his primary language of Spanish. The MDSN stated a care plan should have been developed to ensure the facility's staff were aware of Resident 99's preferred spoken language and to provide translator services when indicated. During an interview on 2/28/2025 at 8:49 a.m., with the DON, the DON stated Resident 99's preferred language should have been care planned to ensure the staff were able to attend to his needs, allowing Resident 99 to express himself, and to ensure Resident 99 understood others. The DON stated without interventions to guide the staff to speak with Resident 99 in Spanish, there may be miscommunications and Resident 99 could be left frustrated. During a review of facility's P&P titled Care Plans, Comprehensive Person-Centered dated 1/2018, the P&P indicated a care plan was a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The P&P indicated the care plan would include measurable objectives and timeframes, describes the services that are to be furnished to attain or maintain the resident's highest practical physical, mental, and psychosocial well-being. The P&P indicated care plans must be revised as information about the residents and the residents condition change. The P&P indicated a care plan must be updated when there has been a significant change in the resident's condition.

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F 0657

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 47858

Based on observation, interview, and record review, the facility failed to ensure the care plan was revised for one out of six sampled residents (Resident 97) after Resident 97's elopement (the act of leaving a facility unsupervised and without prior authorization) attempt on 2/23/2025, and after Resident 97 was observed with a disposable razor on 2/24/2025.

This failure resulted in Resident 97 obtaining a used, disposable razor on 2/24/2025 and 2/25/2025, which had the potential to result in self-harm and injury. This failure also had the potential for Resident 97 to elope the facility, which could have to bodily injury or death.

Cross reference F689 and F656.

Findings:

During a review of Resident 97's Admission Record, the Admission Record indicated Resident 97 was admitted to the facility on [DATE]. Resident 97's diagnoses included schizophrenia (a mental illness that is characterized by disturbances in thought), Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities), dementia (a progressive state of decline in mental abilities), and an immunocompromised (having an impaired immune system) infection.

During a review of Resident 97's Minimum Data Set ([MDS], a resident assessment tool), dated 12/25/2024, the MDS indicated Resident 97's cognitive skills (ability to think and reason) for daily decision making was severely impaired. The MDS indicated Resident 97 required set up or clean up assistance for toileting, oral hygiene, and dressing, and required clean-up assistance when performing personal hygiene.

During a review of Resident 97's Order Recap Summary Report, dated 2/25/2025, the report indicated Resident 97 was ordered one-to-one continuous monitoring on 10/7/2024.

1. During a review of Resident 97's Attempted Elopement Care Plan, initiated 10/5/2024, the care plan indicated to monitor Resident 97's location every 60 minutes and to provide one-on-one sitter to closely monitor the resident and prevent (Resident 97) from leaving the facility.

During a review of Resident 97's Nursing Progress Note, dated 2/23/2025, the progress note indicated Resident 97 became agitated and attempted to leave the facility. There was no documentation to indicate one-to-one supervision was rendered after the incident.

During an observation on 2/24/2025 at 4:15 p.m., Resident 97 was observed walking with a fast pace unsupervised in the hallway with a razor in his right hand.

During observations made on 2/24/2025 at 2:30 p.m., 2/24/2025 at 4:15 p.m., and 2/25/2025 at 9:30 a.m., Resident 97 was not observed with one-to-one supervision.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During a review of Resident 97's Risk for Self-harm Care Plan, initiated 12/2/2024, the care plan indicated the facility was to render close supervision to Resident 97 by sustaining observation or awareness at all times by being on one- to-one monitoring. During an interview on 2/26/2025 at 7:44 a.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated he witnessed Resident 97 with a razor in his right hand in the hallway on 2/24/2025. LVN 1 stated he did not revise Resident 97's Self-harm Care Plan because he knew there was a care plan already in place for self -harm and the facility staff were already handling the situation. LVN 1 stated that he should have revised the care plan to include additional safety measures and to ensure one-to-one supervision was rendered. LVN 1 stated there was potential for Resident 97 to inflict harm unto other residents and staff members and expose others and himself to blood borne pathogens. During a concurrent interview and record review on 2/28/2025 at 10:30 a.m. with the Director of Nursing (DON), Resident 97's Attempted Elopement Care Plan, initiated 10/5/2024 and Self-harm Care Plan, initiated 12/2/2024, were reviewed. The DON stated the two care plans should have been revised to include different interventions in addition to the implementation of one-to-one supervision and placement of a wander guard (a device placed on the resident that triggers an alarm when a resident attempts to exit the facility) on 2/23/2025. The DON stated if the care plans were revised, then Resident 97 would not have unsafely obtained a razor on 2/24/2025 and 2/25/2025 without staff knowledge. The DON stated the lack of care plan revisions on 2/23/2025 and 2/24/2025 resulted in missed opportunities to implement different safety interventions for Resident 97. During a review of the facility's Policy and Procedure (P&P), titled, Care Plans, Comprehensive Person-Centered, dated 1/2018, the P&P indicated the facility was to ensure assessments of residents were ongoing and care plans were revised as information about the residents and the residents' conditions changed.

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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** 47858 Based on observation, interview and record review, the facility failed to timely document and reassess the following for one out of six sampled residents (Resident 327): 1. Resident 327's temperature after his temperature was 101.4 degrees Fahrenheit (F [measure of temperature] normal range 97 to 99 degrees Fahrenheit) on 2/24/2025. 2. Resident 327's blood sugar level (measure of glucose [sugar] in the blood [normal range 70- 100 milligrams [mg, unit of measurement] per (/) deciliter [dl, unit of measurement] mg/dl) after his blood sugar level reading was 450 mg/dL before Resident 327 left for his dialysis session and after Resident 327 returned from dialysis on 2/24/2025. This failure had the potential to result in a delay of physician notification and necessary treatment for sepsis (a life-threatening blood infection) and a prolonged hyperglycemic episode (elevated, uncontrolled blood sugar) for Resident 327. Findings: During a review of Resident 327's Admission Record, the Admission Record indicated Resident 327 was admitted to the facility on [DATE]. Resident 327's diagnoses included sepsis, dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), history of traumatic brain injury (TBI-a disruption in the normal function of the brain that can be caused by a bump, blow, or jolt to the head), and muscle wasting (weakening, shrinking, and loss of muscle). During a review of Resident 327's Minimum Data Set ([MDS], a resident assessment tool), dated 2/10/2025, the MDS indicated Resident 327's cognitive skills (ability to think and reason) for daily decision making was severely impaired. The MDS indicated Resident 327 was dependent (helper does all the effort) on staff for assistance with toileting, eating, performing oral hygiene, dressing, and performing personal hygiene. 1. During a concurrent observation and interview on 2/24/2025 at 4:46p.m. with Licensed Vocational Nurse (LVN) 1, in Resident 327's room, Resident 327 was observed. LVN 1 stated Resident 327 was warm to touch, sweating, and breathing fast. LVN 1 stated Resident 327's temperature was 101.4 F and his respiratory rate was 36 breaths per minute (normal range 12-20 breaths per minute). (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 2/26/2025 at 7:44 a.m. with LVN 1, Resident 327's Vital Signs Summary, dated 2/2025, Nursing Progress Notes, dated 2/24/2025, and Medication Administration Record (MAR), dated 2/2025, were reviewed. LVN 1 sated he administered acetaminophen oral liquid 6.5 milliliters (ml- a unit of measurement) to Resident 327 at 5p.m. LVN 1 stated the Nursing Progress Notes indicated Resident 327's respirations improved, but his temperature remained 101.4 F at 7:35 p.m. LVN 1 stated there was no documentation to indicate Resident 327's temperature was reassessed within one hour after cooling measures (placement of a cool wet washcloth on Resident 327's forehead and removal of Resident 327's blankets) were rendered and after acetaminophen was administered. LVN 1 stated it was important to reassess (within one hour) a resident with a fever after interventions were rendered to ensure the resident's temperature normalized. LVN 1 stated there was a possibility Resident 327 exhibited a prolonged fever and a delay in physician notification if his temperature was not reassessed. 2. During a review of Resident 327's Order Summary, dated 2/26/2025, the Order Summary indicated Resident 327 was ordered insulin lispro injection solution (a medication to lower blood glucose) and blood glucose checks every six hours. During a concurrent interview and record review on 2/26/2025 at 7:44 a.m. with LVN 1, Resident 327's Blood Sugar Summary, dated 2/2025, MAR, dated 2/2025, Nursing Progress Notes, dated 2/24/2025, were reviewed. LVN 1 stated Resident 327's blood sugar level was 450 mg/dL on 2/24/2025 at 6:08 a.m. The MAR indicated 12 units of insulin lispro injection solution (a drug to lower blood sugar levels) was administered at 6:00 a.m. The Nursing Progress Notes indicated Resident 327 left the facility for his dialysis session on 2/24/2025 at 7:30 a.m. and arrived back at the facility around 2 p.m. LVN 1 stated there was no documentation to indicate the blood sugar level was rechecked before Resident 327 left for his dialysis session at 7:30 a.m. LVN 1 stated the Blood Sugar Summary indicated Resident 327's blood sugar was checked at 3:43 p.m. (on 2/24/2025). LVN 1 stated Resident 327's blood sugar level should have also been checked once Resident 327 arrived at the facility from dialysis (2 p.m.). LVN 1 stated Resident 327's blood sugar level should have been rechecked 15 minutes after the administration of insulin to ensure Resident 327's blood sugar level normalized before he was transported to dialysis. LVN 1 stated there was potential that Resident 327's blood sugars could have been too low or too high before or after is dialysis session, which would have led to delayed physician notification. During an interview on 2/28/2025 at 10:30a.m. with the Director of Nursing (DON), the DON stated she expected the licensed nurses to recheck the temperature and blood sugar level if either or were abnormal. The DON stated the reassessment was important to ensure interventions were effective and if the physician needed to be called for orders. The DON stated there was potential Resident 327 could have exhibited a prolonged fever, altered mental status, or an emergent situation during and after dialysis. During a review of the facility's Policy and Procedure (P&P), titled, Physician Notification, dated 12/2016, the P&P indicated the licensed nurse to report immediately to the physician if the resident exhibited the following: 1. Blood glucose greater than 300 mg/dl. 2. Respiratory rate above 28 breaths/ minute. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Temperature greater than 100.5 degrees F. During a review of the facility's P&P, titled, Hemodialysis, Care of Residents, dated 6/2023, the P&P indicated the facility provides residents with safe, accurate, and appropriate care, assessments and interventions to improve resident outcomes for residents on hemodialysis. During a review of the facility's LVN Job Description, revised 10/19/2015, the Job Description indicated the LVN delivered efficient and effective nursing care while achieving positive clinical outcomes.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45009 Based on observation, interview, and record review, the facility failed to ensure the low air loss mattress ([LALM] a mattress designed to distribute the individual's body weight over a broad surface area and help prevent skin breakdown) was set according to the resident's weight for four out of four sampled residents (Resident 4, 36, 60, and 110). This deficient practice had the potential to cause the development, worsening or reinjury of pressure ulcers (injuries to the skin and underlying tissue) to Resident 4, 36, 60, and 110. Findings: During an observation on 2/24/2025 at 11:35 a.m. in Resident 4's room, Resident 4's LALM was set to 250 pounds. During an observation on 2/27/2025 at 3:12 p.m. in Resident 4's room, Resident 4's LALM was set to 250 pounds. During an observation on 2/28/2025 at 12:33 p.m. in Resident 4's room LALM set to 250 pounds 1. During a review of Resident 4's Admission Record, the admission record indicated Resident 4 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses of neuromuscular dysfunction of the bladder ([neurogenic bladder] a condition where the nerves controlling bladder function are damaged, leading to impaired bladder muscle activity and resulting in problems like urinary incontinence and lack of awareness of bladder fullness) and benign prostatic hyperplasia [(BPH] is a noncancerous enlargement of the prostate gland that causes frequent urination, weak urine stream, and difficulty in starting to urinate). During a review of Resident 4's History and Physical (H&P) dated 1/21/2024, the H&P indicated Resident 4 had the capacity to understand and make decisions. During a review of Resident 4's Minimum Data Set (MDS), (a resident assessment tool), dated 1/1/2025, the MDS indicated Resident 4's cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making was intact. The MDS indicated Resident 4 required maximal assistance (helper does more than half the effort) for upper body dressing, shower/bathing and personal hygiene. The MDS indicated Resident 4 required set up assistance for eating. During an interview on 2/27/2025 at 3:12 p.m. with Resident 4, Resident 4 stated he weighed between 160 - 170 pounds. Resident 4 stated staff had not informed him what the LALM should be set to. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/28/2025 at 12:42 p.m. with Treatment Nurse (TN) 1, TN 1 stated a LALM was used to prevent pressure injuries ([PI] injury to skin and underlying tissue resulting from prolonged pressure on the skin) and for current pressure injuries to get better. TN 1 stated residents that are bedridden get a LALM due to prolonged pressure on skin. TN 1 stated LALM should be set to Residents weight. TN1 stated if LALM was overinflated the bed would be on uncomfortable and create pressure on skin. TN !1stated if LALM was underinflated the bed would be too soft and resident could sink in the bed. TN 1 sated Resident 4's LALM has to be set to his weight for it to be beneficial. TN 1 stated Resident 4 had no weight documented because he refused to get weighed and the LALM setting was an estimate of his weight. During an interview on 2/28/2025 at 1:45 p.m. with the Director of Nursing (DON), the DON stated a LALM was used for skin management and skin injury prevention. The DON stated the LALM should be set closest to Resident 4's weight. The DON stated it was important to set the LALM accurately for it to be beneficial to residents. The DON stated Resident 4's LALM was not set to his weight because they did not know his weight. The DON stated the LALM was set according to Resident 4's comfort. 47679 2. During a review of Resident 110's Admission Record, the admission record indicated Resident 110 was admitted to the facility on [DATE] with diagnoses that included sepsis (a life-threatening infection), epilepsy (a brain disease where nerve cells do not signal properly, which causes seizures), and adult failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity). During a review of Resident 110's MDS, dated [DATE], the MDS indicated Resident 110's cognition was severely impaired. The MDS indicated Resident 110 was dependent on a helper's assistance with oral hygiene, toileting, bathing, dressing, and personal hygiene. The MDS indicated Resident 110 had a Stage Four (4) pressure ulcer (full thickness tissue loss with exposed bone, endon, or muscle) that was present upon admission. The MDS indicated Resident 110 utilized a pressure reducing device for the bed. During a review of Resident 110's H&P, dated 1/9/2025, the H&P indicated Resident 110 did not have the capacity to understand and make decisions. During a review of Resident 110's Order Recap Report, dated 1/1/2025 through 2/28/2025, the Order Recap Report indicated to use a LALM for wound management. The order date was 1/17/2025. During a review of Resident 110's Weight, dated 2/2025, the Weight indicated Resident 110 weighed 102.4 pounds (lbs, unit of measurement). During an observation on 2/24/2025 at 9:38 a.m., 2/24/2025 at 11:28 a.m., and 2/25/2025 at 8:21 a.m., in Resident 110's room, Resident 110 was observed lying on the bed. Resident 110's LALM pump was set to 180lbs. During an interview on 2/26/2025 at 9 a.m., with TN 1, TN 1 stated LALM were utilized by residents who have pressure ulcers and those who are at risk of developing pressure ulcers. TN 1 stated the LALM operated by offloading (minimizing) pressure on the resident's body. TN 1 stated the LALM setting was based on the resident's weight and should be set to the closest number. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 2/26/2025 at 9:02 a.m. with TN 1, in Resident 110's room, Resident 110 was observed lying on the bed. Resident 110's LALM pump was set to 130 lbs. TN 1 stated due to Resident 110 weighing 102 lbs, Resident 110's LALM pump could either be set at 90 lbs or 130 lbs. TN 1 stated if Resident 110's LALM was set to 180 lbs, the mattress would become too firm and would cause an increase in pressure on Resident 110's body. TN 1 stated Resident 110 had a Stage 4 pressure ulcer and having a too firm mattress could cause her pressure ulcer to worsen. During an interview on 2/28/2025 at 9:08 a.m., with the Director of Nursing (DON), the DON stated the LALM should be let according to the resident's weight as directed in the manufacturer's guideline. The DON stated setting the LALM too high could delay wound healing of existing pressure injuries and could cause the development of new skin breakdown. 48131 3. During a review of Resident 36's Admission Record, the admission record indicated Resident 36 was initially admitted to the facility on [DATE] and readmitted on [DATE]. The admission record indicated the following diagnoses which included acute respiratory failure with hypoxia (when the lungs suddenly fail to adequately provide oxygen to the body, resulting in a dangerously low level of oxygen in the blood), congestive heart failure (CHF- a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), end stage renal disease (ESRD - irreversible kidney failure), and dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed). During a review of Resident 36's H&P, dated 11/21/2024, the H&P indicated Resident 36 had the capacity to understand and make decisions. During a review of Resident 36's MDS, dated [DATE], the MDS indicated Resident 36's cognition was moderately impaired. The MDS indicated Resident 36 eats independently and was dependent (helper does all the effort) for toileting, bathing and personal hygiene. During a review of Resident 36's Order Summary Report dated 2/27/2025, the order summary report indicated Resident 36 May have low air mattress for skin integrity, dated 1/29/2025. During a review of Resident 36's Order Summary Report dated 2/27/2025, the order summary report indicated to Monitor LAL mattress for proper functioning and appropriate setting, every shift, dated an order dated 1/29/2025. During a review of Resident 36's care plan titled, Potential for Impairment to Skin Integrity related to Fragile Skin, initiated on 1/29/2025, the care plan indicated Resident 36 would maintain or develop clean and intact skin. The care plan interventions indicated Resident 36 may have a low air loss mattress for skin maintenance. During an observation on 2/24/2025 at 10:51 a.m., while in Resident 36's room, observed Resident 36 lying on a LALM. Resident 36's LALM was set to an undetermined weight below 170 lbs. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation, interview, and record review on 2/24/2025 at 3:50 p.m., with Licensed Vocational Nurse (LVN) 3, Resident 36 was observed lying on the LALM. Resident 36's weight was reviewed in the resident's medical record. LVN 3 stated Resident 36's weight was 196.9 lbs. LVN 3 stated as the charge nurse he was responsible for monitoring the LALM however, the treatment nurse (TN) was responsible for setting the LALM to the correct weight. LVN 3 stated he was unable to determine the set weight of the LALM and could not have been certain if the LALM was set according to Resident 36's weight. During a concurrent observation and interview on 2/26/2025 at 4:06 p.m., with the Quality Assurance Nurse (QA Nurse), Resident 36's LALM settings were reviewed. The QA Nurse stated some of the LALM were set incorrectly because the nurses were forgetting to place the settings in a locked position. The QA Nurse stated the LALM should have been set according to the resident's weight. The QA nurse stated an arrow should have been placed on the LALM control next to the correct weight to ensure all staff were aware of the correct weight setting Resident 36. The QA Nurse stated she was unsure of the weight setting for Resident 36's LALM. The QA nurse stated she (QA Nurse) would have to refer to the user's manual to find how to set the LALM to the correct setting. The QA nurse stated it was important for Resident 36's LALM to have been set to the correct setting and according to his weight. The QA Nurse stated the bed should not have been too hard or too soft for Resident 36 because this could potentially have caused the skin to break down. During an interview on 2/27/2025 at 3:14 p.m., with the DON, the DON stated Resident 36's mattress was set to 150 lbs. which was lower than Resident 36's current weight. The DON stated she had to determine the weight settings on Resident 36's LALM manually because the manufacturer instructions did not spell out what each weight increment meant. The DON stated if Resident 36 was heavier than the mattress weight setting, the resident could begin to sink and end up resting on a hard surface causing his skin to break down. 46832 4. During a review of Resident 60's Admission Record, the admission record indicated Resident 60 was admitted on [DATE] with diagnoses which included schizophrenia (a mental illness that is characterized by disturbances in thought), hydrocephalus (a build-up of fluid in the cavities deep within the brain), chronic inflammation disease of the uterus (a long-term irritation or inflammation of the uterine lining) and type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 60's MDS, dated [DATE], the MDS indicated Resident 60's cognitive skills were moderately impaired. The MDS indicated Resident 60 was dependent on staff members with activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) such as toileting needs, showering and upper/lower body dressing. During an observation, on 2/24/2025, at 9:30 a.m., in Resident 60's room, Resident 60 was observed lying on a LALM. Resident 60's air loss mattress settings indicated Resident 60 weighed 330 lbs. During a review of Resident 60's H&P, dated 10/19/2024, the H&P indicated Resident 60 weighed 126 lbs. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation, interview and record review, on 02/26/25 at 9:46 a.m., with LVN 8, LVN 8 stated low air loss mattresses were used to protect residents from skin breakdown and pressure ulcers. LVN 8 observed Resident 60's low air loss mattress and stated the mattress set to 330 lbs. LVN 8 stated Resident 60 did not weigh 330 lbs. LVN 8 stated Resident 60 weighed 169lbs. LVN 8 stated the settings on the low air loss mattress were incorrect. LVN 8 stated the risk of setting a low air loss mattress to a incorrect weight could result in further skin breakdown. During a concurrent interview and record review, on 2/27/2025, at 2:30 p.m., with the DON, the DON stated Resident 60 weighed 169 lbs. The DON stated Resident 60's low air loss mattress should not had been set at 330lbs. The [NAME] stated the risk of setting a low air loss mattress to an incorrect weight could result in skin breakdown. The DON stated, Setting a low air loss mattress at the wrong weight for a resident defeats the purpose of therapeutic care. During a review of the facility's policy and procedure (P&P) titled, Pressure Reducing Mattress, dated 4/2022, the P&P indicated to set the pressure reducing mattress according to the resident's height and weight. During a review of the facility's document titled, Domus 4 User's Manual, undated, the document indicated, According to the weight and height of the patient, adjust the pressure setting to the most comfortable level without bottoming out. During a review of the facility's document titled, [NAME] Elite User's Manual, undated, the user manual indicated, According to the weight and height of the patient, adjust the pressure setting to the most comfortable level without bottoming out.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47858 47679 46832 Based on observation, interview and record review, the facility failed to ensure three of eight sampled residents (Resident 97, 277 and 115) were free of accidents and hazards by failing to: 1. Follow its policy and procedure (P&P) titled, Safety and Supervision of Residents, which indicated the facility would ensure resident safety and supervision and assistance to prevent accidents were facility-wide priorities by failing to ensure the following for Resident 97: a. Resident 97, who was assessed at risk for wandering and elopement (the act of leaving a facility unsupervised and without prior authorization), with a history of Immunocompromised disease (having an impaired immune system), schizophrenia (a mental illness that is characterized by disturbances in thought), dementia (a progressive state of decline in mental abilities) and suicidal ideation, did not obtain a disposable razor on two occasions, on 2/24/2025 at 4:15 p.m. and 2/25/2025 at 8:30 a.m., without 1:1 monitoring or any staff present. b. Resident 97 was provided 1:1 supervision after Resident 97 attempted to elope on 2/23/2025 and after Resident 97 had obtained possession of a disposable razor on 2/24/2025. c. Resident 97's Attempted Elopement Care Plan was revised after Resident 97 attempted to elope on 2/23/2025 and Resident 97's Self-harm Care Plan was revised when he was observed with a disposable razor on 2/24/2025 to prevent Resident 97 from retrieving another disposable razor in the sharps container located in the shower rooms on 2/25/2025. d.Resident 97's physician and Resident 97's responsible party (RP), RP 1, were made aware Resident 97 had obtained possession of a used, disposable razor without facility staff supervision or knowledge on 2/24/2025. e.nUsed sharps were properly disposed of into the sharps container and the sharps container lids were secured so the contaminated sharps were not accessible to staff or other residents in shower rooms A and B. f. The facility's shower rooms' sharps containers were properly secured after the facility had knowledge (since January 2025) of Resident 97's behavior of walking into the shower room and grabbing a used disposable razor inside of the sharps container. g. Resident 97's Self-harm Care Plan Interventions, dated 12/2/2024, were implemented to provide Resident 97 one-to-one monitoring at all times. h. Resident 97's Suicidal Ideation Care Plan, initiated 12/21/2024, was implemented when two cords and nail clippers were observed in Resident 97's room. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	i. Resident 97's Attempted Elopement Care Plan, initiated 10/5/2024, and Resident 97's At Risk for Elopement Care Plan Intervention, dated 1/24/2025, were implemented to ensure one-on-one sitter was provided and a wander guard (a device placed on the resident that triggers an alarm when a resident attempts to exit the facility) was placed on Resident 97. j. An Interdisciplinary Team (IDT) meeting was held after each of the following documented incidents: -Resident 97's obtained a disposable razor without staff knowledge and cut himself while improperly shaving without staff supervision on 11/21/2024, 11/24/2024, 11/25/2024, 12/15/2024. -Resident 97 obtained a razor without staff knowledge on 12/12/2024 -Resident 97 was sent to the General Acute Care Hospital (GACH) after tightening the strings of a hooded sweater around his neck and for possible suicidal ideation on 12/2/2024. -Resident 97 asked facility staff for a sharp object on 11/24/2024 and 12/21/2024. 2. Complete Resident 277's 72-Hour Neurological Check (series of tests over a 72-hour period to assess for changes in neurological function). 3. Ensure smoking safety equipment and supervision was required during smoke breaks for Resident 115. 1. These failures resulted in Resident 97 unsafely, reaching into the facility's sharps container, located in the unlocked shower rooms, and obtaining previously used, disposable razors on 2/24/2025 and 2/25/2025 without staff knowledge. These failures had the potential to result in harm for Resident 97 by cutting himself with a used, disposable razor. These failures had the potential to result in harm for Resident 97, other residents, or staff members by contracting or transmitting blood borne diseases with a used, disposable razor. These failures also had the potential to result in Resident 97 eloping the facility, which could lead to bodily injury or death. 2. This failure had the potential for Resident 277 to suffer undetected neurological deficits. 3. This failure had the potential to put Resident 115 at risk for injury due to lack of supervision and maintain proper safety precautions while smoking. Findings: a. During an observation on 2/24/2025 at 4:15 p.m., Resident 97 was observed walking with a fast pace towards the state agency surveyor in the hallway with a razor in his right hand, which was lowered to his side (unsupervised). During a review of Resident 97's Admission Record, the Admission Record indicated Resident 97 was admitted to the facility on [DATE]. Resident 97's diagnoses included schizophrenia Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities), dementia, and immunocompromised disease. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 97's Minimum Data Set ([MDS], a resident assessment tool), dated 12/25/2024, the MDS indicated Resident 97's cognitive skills (ability to think and reason) for daily decision making was severely impaired. The MDS indicated Resident 97 required set up or clean up assistance for toileting, oral hygiene, and dressing, and required clean-up assistance when performing personal hygiene. During an interview on 2/25/2025 at 9:36 a.m. with the Director of Staff Development (DSD), the DSD stated she observed Resident 97 shaving unsupervised with a disposable razor in his restroom on 2/25/2025 at 8:30 a.m. The DSD stated Resident 97 told her Resident 97 stuck his hand inside of the sharps container, located inside of shower room A to grab a disposable razor. The DSD stated he should have been on one-to-one supervision if Resident 97 was observed with a razor the day before (on 2/24/2025) and if Resident 97 exhibited an episode of elopement on 2/23/2025 (two days prior). During a concurrent observation and interview on 2/25/2025 at 9:01 a.m. with Certified Nursing Assistant (CNA) 2, Resident 97's room was observed. CNA 2 stated Resident 97 was not on one-to-one supervision. CNA 2 stated Resident 97 required one-to-one supervision to protect himself, staff and other residents. CNA 2 stated there was a potential that Resident 97 could continue to cut himself or others. During an interview on 2/26/2025 at 7:44 a.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated he witnessed Resident 97 approach the state agency surveyor in the hallway with a razor in his right hand on 2/24/2025 at 4:15 p.m. LVN 1 stated Resident 97 admitted Resident 97 retrieved the disposable razor in shower room A's sharps container by reaching into the container and grabbing a used, disposable razor. During an interview on 2/26/2025 at 8:40 a.m. with Resident 97, Resident 97 stated he would take a disposable razor from the shower room sharps container every time staff confiscated a disposable razor from him. Resident 97 stated he would walk into the shower room and take a disposable razor while no staff were present or watching him. b. During a review of Resident 97's Order Recap Summary Report, dated 2/25/2025, the report indicated Resident 97 was ordered one-to-one continuous monitoring due to high risk for elopement on 10/7/2024. During a review of Resident 97's Nursing Progress Note, dated 2/23/2025, the progress note indicated Resident 97's was agitated and attempted to leave the facility. There was no documentation to indicate one-to-one supervision was rendered. During observations made on 2/24/2025 at 2:30 p.m., 2/24/2025 at 4:15 p.m., and 2/25/2025 at 9:30 a.m., Resident 97 was not on one-to-one supervision by facility staff. During an interview on 2/26/2025 at 1:24 p.m. with Registered Nurse (RN) 3, RN 3 stated she was the assigned registered nurse on the 7 a.m. to 3 p.m. shift on 2/23/2025. RN 3 stated she witnessed Resident 97 run into the lobby and attempt to leave the facility on 2/23/2025. RN 3 stated Resident 97 was not placed on continuous one-to-one supervision because she was a new grad and stated the facility did not have sitters. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 2/28/2025 at 10:30 a.m. with the Director of Nursing (DON), Resident 97's Self-harm Care Plan, initiated 12/2/2024, Attempted Elopement Care Plan, initiated 10/5/2024, and Order Recap Summary Report, dated 2/25/2025, were reviewed. The DON stated the nursing staff should have carried out the order for one-to-one supervision (since 10/7/2024) because it was still considered an active order. The DON stated the nursing staff should have implemented the care plan interventions for one-to-one supervision especially after Resident 97 attempted to elope on 2/23/2025. The DON stated the lack of one-to-one supervision allowed Resident 97 to obtain a used, disposable razor on 2/24/2025 and 2/25/2025 without staff knowledge. The DON stated there was potential for Resident 97 to continue to injure himself (by cutting himself by shaving), other residents, staff and spread blood borne viruses. c. During a review of Resident 97's Attempted Elopement Care Plan, initiated 10/5/2024, the care plan indicated to monitor Resident 97's location every 60 minutes and to provide one-on-one sitter to closely monitor the resident and prevent (Resident 97) from leaving the facility. During a review of Resident 97's Risk for Self-harm Care Plan, initiated 12/2/2024, the care plan indicated the facility was to render close supervision by sustaining observation or awareness at all times by being on one- to-one monitoring. The care plan also indicated the nurse would remove all potentially harmful objects such as sharp objects, cords, and medications from the resident's environment. During an interview on 2/26/2025 at 7:44 a.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated he witnessed Resident 97 with a razor in his right hand in the hallway on 2/24/2025. LVN 1 stated he did not revise Resident 97's Self-harm Care Plan because he knew there was a care plan already in place for self -harm and the facility staff were already handling the situation. LVN 1 stated that he should have revised the care plan to include additional safety measures and to ensure one-to-one supervision was rendered. LVN 1 stated there was potential for Resident 97 to inflict harm unto other residents and staff members and expose others and himself to blood borne pathogens. During a concurrent interview and record review on 2/28/2025 at 10:30 a.m. with the DON, Resident 97's Attempted Elopement Care Plan, initiated 10/5/2024 and Self-harm Care Plan, initiated 12/2/2024, were reviewed. The DON stated the two care plans should have been revised to include different interventions in addition to the implementation of one-to-one supervision and placement of a wander guard (a device placed on the resident that triggers an alarm when a resident attempts to exit the facility) on 2/23/2025. The DON stated if the care plans were revised, then Resident 97 would not have unsafely obtained a razor on 2/24/2025 and 2/25/2025 without staff knowledge. The DON stated the lack of care plan revisions on 2/23/2025 and 2/24/2025 resulted in missed opportunities to implement different safety interventions for Resident 97. d. During an interview on 2/27/2025 at 3:37 p.m. with Licensed Vocational Nurse (LVN)1, LVN 1 stated he was the assigned LVN for Resident 97 on the 3 p.m. to 11 p.m. shift on 2/24/2025 and witnessed Resident 97 with a razor in his right hand in the hallway on 2/24/2025. LVN 1 stated the physician, and the responsible party were to be made aware of any changes in the physical or mental condition for a resident. LVN 1 stated he should have made RP 1 and Resident 97's physician aware Resident 97 had obtained a used razor without facility knowledge, but did not have time during the shift to do so. LVN 1 stated it was RP 1's right to be informed of any changes that occurred for Resident 97. LVN 1 stated he should have made Resident 97's physician aware so he could have obtained an order for one-to-one supervision for Resident 97. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/28/2025 at 1:46 p.m. with Resident 97's Responsible Party (RP) 1, the RP 1 stated she was not made aware that Resident 97 had obtained possession of a used, disposable razor without facility staff supervision or knowledge on 2/24/2025. e. During a concurrent observation and interview on 2/25/2025 at 9:01 a.m. with CNA 2, shower room A was observed. CNA 2 stated Shower Room A door was unlocked, with no keypad entry. CNA 2 stated one sharps container was affixed on the shower room wall with one razor with the blades facing upward, sitting on the flip up lid of the sharp's container. During a concurrent observation and interview on 2/26/2025 at 8:45 a.m. with LVN 1, Shower Room B was observed. LVN 1 Shower Room B door was unlocked, with no keypad entry. LVN 1 stated the shower room had one sharps container affixed onto the shower wall with two nail clippers and one disposable razor sitting on the flip up lid of the sharps container. LVN 1 stated there was a possibility that any resident or staff member could easily enter the shower room, retrieve any, used disposable razor and harm or infect others or other residents. f. During an interview on 2/26/2025 at 2:14 pm with the DON, the DON stated she had knowledge had knowledge of Resident 97's tendencies to walk into the shower room and grab a used disposable razor in the sharps container since January 2025. The DON stated constant redirection was rendered for Resident 97 and believed that it was an effective intervention at the time. The DON stated there should have been a protective barrier or mechanism to ensure no other residents could grab any used sharps in the container since January 2025. g. During a review of Resident 97's Nursing Progress Note, dated 11/21/2024, the progress note indicated Resident 97 cut himself and used his blood to mark the toilet tank and [sink]. During a review of Resident 97's Nursing Progress Note, dated 11/24/2024, the progress note indicated Resident 97 was observed standing in the hallway opposite the room of a female resident for 30 minutes. The progress note indicated Resident 97 stated, I'm waiting here to get a razor and some sugar. The progress note indicated Resident 97 seemed confused and continuous monitoring was recommended. The note indicated Resident 97 continued to wander the facility and Resident 97's eyes were fixed the facility's exit doors. During a review of Resident 97's SBAR, dated 11/25/2024, the SBAR indicated Resident 97 was found with a razor and admitted to cutting himself. The SBAR indicated Resident 97 was observed with superficial linear cuts on the third middle finger approximately two centimeters (cm- a unit of measurement) in length with active bleeding. During a review of Resident 97's Risk for Self-harm Care Plan, initiated 12/2/2024, the care plan indicated the facility was to render close supervision by sustaining observation or awareness at all times by being on one- to-one monitoring. The care plan also indicated the nurse would remove all potentially harmful objects such as sharp objects, cords, and medications from the resident's environment. During a review of Resident 97's Nursing Progress Note, dated 12/12/2024, Resident [NAME] was found with a razor. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER California Post-Acute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 3615 E. Imperial Hiwy Lynwood, CA 90262	

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 97's Nursing Progress Note, dated 12/15/2024, the progress note indicated Resident 97 was found with razor and admitted to cutting himself. The progress note indicated Resident 97 had a superficial cut along [his] jaw line, nostril and cheek and was actively bleeding. During a review of Resident 97's SBAR, dated 12/21/2024, the SBAR indicated Resident 97 approached staff and requested a knife to cut something and did not specify what he wanted to cut. During a concurrent interview and record review on 2/26/2025 at 12:44 p.m. with the DON, Resident 97's Self-harm Care Plan, dated 12/2/2024, was reviewed. The DON stated the nursing staff did not follow the care plan interventions, and the nursing staff should have implemented one-to-one supervision (since 12/2/2024) to ensure Resident 97 would not be able to obtain a used, disposable razor on 2/24/2025 and 2/25/2025. During a concurrent interview and record review on 2/27/2025 on 9:31 a.m. with LVN 2, Resident 97's SBAR dated 12/2/2024, was reviewed. The SBAR indicated Resident 97 tied the strings of his hooded sweatshirt tightly around his neck, became agitated, demanded a fork and stated, I can do whatever I want, and nobody can stop me. The SBAR indicated Resident 97 proceeded to motion his hands as if he pretended to shoot a gun. The SBAR indicated Resident 97's behavior escalated and 911 was called, and Resident 97 was sent to the GACH. LVN 2 stated she authored the SBAR and recalled that Resident 97 came back from the hospital around 4 p.m. LVN 2 stated there was a lack of documentation to indicate Resident 97 was rendered one-to-one supervision upon his arrival. During a concurrent interview and record review on 2/27/2025 on 9:31 a.m. with LVN 2, Resident 97's Order Recap Summary Report, dated 2/25/2025, and Resident 97's Self-harm Care Plan, dated 12/2/2024, was reviewed. LVN 2 stated the report indicated Resident 97 was ordered one-to-one continuous monitoring since 10/7/2024. LVN 2 stated the facility nursing staff should have rendered one-to-one supervision since the date it was ordered (10/7/2024), and especially because it was listed as a care plan intervention since 12/2/2024. LVN 2 stated the facility should have done a better job at supervising (from 12/2/2024 to 2/2025) Resident 97 due to his medical psychiatric diagnoses, history of suicidal ideation, and behavioral issues. h. During observations made on 2/25/2025 at 3:49 p.m., 2/26/2025 at 7:31 a.m., and 2/27/2025 at 7:32 a.m., Resident 97's room was observed. Resident 97 had two long cords plugged into the electrical outlet in the wall. On 2/25/2025, Resident 97 had nail clippers on his bed side table. During a concurrent observation and interview on 2/25/2025 at 9:01 a.m. with Certified Nursing Assistant (CNA) 2, Resident 97's room was observed. CNA 2 stated Resident had nail clippers on his bedside table and two cords plugged into his outlet near his bed. During an interview on 2/28/2025 at 10:30 a.m. with the DON, the DON stated the facility did not follow Resident 97's Suicidal Ideation Care Plan if there had been two cords and nail clippers left in his room. The DON stated there was potential for Resident 97 to use those items to harm himself or others. i. During a review of Resident 97's SBAR, dated 9/26/2024, the SBAR indicated Resident 97 attempted to elope. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 97's SBAR, dated 10/5/2024, the SBAR indicated Resident 97 eloped, was found at a park and was returned to the facility two hours later by facility staff. During a review of Resident 97's Attempted Elopement Care Plan, initiated 10/5/2024, the care plan indicated to monitor Resident 97's location every 60 minutes and to provide one-on-one sitter to closely monitor the resident and prevent (Resident 97) from leaving the facility. During a review of Resident 97's Elopement Risk Assessment, dated 10/5/2024, the risk assessment indicated Resident 97 was high risk for elopement. During a review of Resident 97's One-to-One Monitoring Sheets, dated 10/6/2024 through 10/11/2024, the monitoring sheets indicated Resident 97 was rendered one-to-one supervision 10/6/2024 through 10/11/2024. No other one-to-one monitoring sheets were provided. During a concurrent interview and record review on 2/28/2025 at 10:30 a.m. with the Director of Nursing (DON), Resident 97's Attempted Elopement Care Plan, initiated 10/5/2024, At Risk for Elopement Care Plan Intervention, dated 1/24/2025, and Order Recap Summary Report, dated 2/25/2025, were reviewed. The DON stated the nursing staff should have carried out the order for one-to-one supervision (since 10/7/2024) because it was still considered an active order. The DON stated the nursing staff should have implemented one-to-one supervision and applied a wander guard especially after Resident 97 attempted to elope on 2/23/2025. The DON stated there was potential for Resident 97 to elope the facility on 2/23/2025 because the care plan interventions were not implemented. j. During a concurrent interview and record review on 2/26/2025 at 10:45 a.m. with the Minimum Data Set Nurse (MDSN), Resident 97's SBARs, dated 11/21/2024, 12/2/2024, and 12/21/2024, Nursing Progress Notes, dated 12/15/2024, and IDTs, dated 11/2024 through 12/2024, were reviewed. The SBAR, dated 11/21/2024, indicated Resident 97 was at risk for self-injury while shaving due to use of manual razor and reports of occasional nicks and cuts. The SBAR indicated Resident 97's technique and use of a manual razor increased the risk for future injuries. MDSN stated IDT meetings were held to discuss and formulate a proper plan of care specific to the resident. MDSN stated IDT meetings should have been held after each event that Resident 97 exhibited self-harming behaviors (11/21/2024) because it was considered changes of condition. MDSN stated the facility could have implemented measures to prevent further injury for Resident 97 if IDTs were held. MDSN stated the IDT meetings were not held because the incidents may have been missed during the holidays. MDSN stated she also relied on the former Social Services Director (SSD) to host IDT meetings, but the SSD had resigned in 12/2024. During a concurrent interview and record review on 2/28/2025 at 10:30 a.m. with the DON, Resident 97's SBARs and Nursing Progress Notes, dated 11/2024 through 2/2025, were reviewed. The DON stated an IDT allowed the facility staff, department heads, and RP to collaboratively work together to develop and implement interventions to address the problem or the issue at hand specific to a resident. The DON stated an IDT was performed as needed and when there was a change of condition, or after an incident. The DON stated that an IDT should have been held for Resident 97 every time Resident 97 had obtained possession of a disposable razor without staff knowledge, expressed desire for sharp objects, cut himself (by shaving) with a razor unsupervised, and after he had been hospitalized for possible suicidal ideation. The DON stated the lack of IDTs may have led to inappropriate care for Resident 97. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's Policy and Procedure (P&P), titled, One to One Patient Supervision, dated 1/2018, the P&P indicated the facility was to ensure the safety and well-being of all residents by providing one-to-one supervision when deemed necessary. The P&P indicated one-to-one supervision was implemented for residents who exhibited behaviors or conditions that pose a risk to themselves or others. During a review of the facility's P&P, titled, Care Plans, Comprehensive Person-Centered, dated 1/2018, the P&P indicated the facility was to ensure assessments of residents were ongoing and care plans were revised as information about the residents and the residents' conditions changed. The P&P indicated the Interdisciplinary Team was to review and update the care plan: a. When there was a significant change in the resident's condition; b. When the desired outcome was not met; c. When the resident was readmitted to the facility from a hospital stay; and d. At least quarterly, in conjunction with the required quarterly MDS assessment. During a review of the facility's P&P, titled, Change of Condition, revised 8/2017, the P&P indicated the facility was to promptly notify the resident's Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.). During a review of the facility's P&P, titled, Physician Notification, dated 12/2016, the P&P indicated the facility was to ensure the physician was notified when there is a change of condition. During a review of the facility's P&P, titled, Suicidal Precautions, dated 12/2026, the P&P indicated the facility was to reduce risks, provide intervention and guidance for residents that requires suicide/self-harm precautions. The P&P indicated close visual supervision was warranted if the resident was a significant and/or immediate risk to self/others; and likely to engage in the following: 1) Suicide attempt 2) Physical/sexual aggression 3) Property destruction 4) Elopement 5) Other dangerous behaviors 6) Wandering/exit seeking 7) Intrusiveness 8) Verbal aggression (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The P&P also indicated the staff responsibility was to provide one-to-one supervision after any significant events were report or if the resident was transferred to the hospital for psychiatric evaluation. During a review of the facility's P&P, titled, Care Planning-IDT, dated 1/2018, the P&P indicated the facility was to ensure the care planning/interdisciplinary team was responsible for the development of an individualized comprehensive care plan for each resident. 2. During a review of Resident 277's Admission Record, the Admission Record indicated Resident 277 was admitted to the facility on [DATE] with diagnoses that included bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), type two diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing), and sepsis (a life-threatening blood infection). During a review of Resident 277's MDS, dated [DATE], the MDS indicated Resident 277's cognition was moderately impaired. The MDS indicated Resident 277 required moderate assistance (helper does less than half the effort) with toileting, bathing, upper body dressing, and personal hygiene. During a review of Resident 277's History and Physical (H&P), dated 2/15/2025, the H&P indicated Resident 277 had the capacity to understand and make decisions. During a review of Resident 277's Morse Fall Risk Score, dated 2/14/2025, the Morse Fall Risk Score indicated Resident 277 was at risk for falls. During a review of Resident 277's SBAR dated 2/22/2025, the SBAR indicated Resident 277 was found on the floor, laying on her back. The SBAR indicated Resident 277 stated she stretched to reach something on her nightstand and slid to the floor. During a review of Resident 277's Care Plan, dated 2/22/2025, the Care Plan indicated Resident 277 had an actual fall on 2/22/2025 and was at risk for further falls. The Care Plan indicated to initiate Neurological Checks. During a concurrent interview and record review on 2/26/2025 at 9:55 a.m., with RN 2, Resident 277's Neurological Checks Forms, dated 2/22/2022 and timed at 8 a.m., 8:15 a.m., 8:30 a.m., 8:45 a.m., 9:15 a.m., 9:45 a.m., 10: 45 a.m., 11:45 a.m., and 1:45 p.m. were reviewed. RN 2 stated the licensed nurses were responsible for conducting Resident 277's neurological checks for 72 hours, however, Resident 277's neurological checks were only completed until 2/22/2025 at 1:45 p.m. RN 2 stated conducting the neurological checks for the full 72 hours was essential to monitor Resident 277 for any neurological problems presented over the 72-hour period. RN 2 stated an injury to the brain may not present signs and symptoms initially and without conducting the neurological checks at the indicated times, those signs and symptoms may not be detected in time to intervene. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/28/2025 at 10:14 a.m., with the DON, the DON stated after initiating the neurological checks, especially after an unwitnessed fall, the neurological checks were to be completed at specific intervals for a 72-hour period. The DON stated if a resident experienced any signs and symptoms of a head injury, the licensed nurses could escalate interventions and inform their physician of the change of condition. The DON stated Resident 277 did not have a complete neurological check, over the 72-hour period, where Resident 277 could have suffered an undetected neurological change. During a review of the facility's P&P titled, Neurological Assessment, dated 1/2018, the P&P indicated, Neurological assessments are indicated following an unwitnessed fall. The P&P indicated, Any change in vital signs or neurological status in a previously stable resident should be reported to the physician immediately. 3. During an observation, on 02/26/2025, at 10:01 a.m., Resident 115 was observed smoking with four other residents on the smoking patio. Resident 115 was observed not wearing a smoking apron. During a review of Resident 115's Admission Record, the Admission Record indicated Resident 115 was admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing), muscle weakness (a decreased ability of muscles to contract and generate force), Alzheimer's disease, and abnormalities of gait and mobility (changes in walking or movement that can occur due to a number of possible causes). During a review of Resident 115's MDS, dated [DATE], the MDS indicated Resident 115's cognitive skills was intact. The MDS also indicated Resident 115 required setup assistance with activities of daily living, such as toileting needs, showering and upper/lower body dressing. During a review of the facility's residents smoking list, the smoking list indicated Resident 115 smoked cigarettes. During a concurrent observation and interview, on 02/26/2025 at 8:43 a.m., with the Activities Assistant (AA), the AA stated the Activities staff were responsible for supervising residents during smoke breaks. The AA stated she was the only staff member who watched the residents during their smoking breaks on the patio. The AA stated residents could choose their own smoking time. The AA stated the smoking patio was only closed during lunch and dinner. The AA stated she was not sure on which residents required a smoking apron. During an interview, on 02/27/2025 at 2:30 p.m., with the DON, the DON stated Resident 115 was a smoker. The DON stated Resident 115 did not have a smoking assessment indicating if Resident 115 was an independent smoker or needed interventions such as supervision and/or smoking aprons. The DON stated the risk of Resident 115 not being properly supervised and wearing a smoking apron could result in staff being unaware of Resident 115 smoking status and a safety issue. During a review of the facility's P&P titled, Smoking Policy-Residents, dated 6/2022, the P&P indicated the facility shall establish and maintain safe resident smoking practices.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47679 48131 45009 Based on observation, interview, and record review, the facility failed to ensure three of four sampled residents (Residents 110, 66, and 4) received appropriate care and services by failing to: 1. Monitor Resident 110's urinary drainage from the indwelling urinary catheter (a hollow tube inserted into the bladder to drain or collect urine [pee]) for presence of sediment (a buildup of particles within the catheter tubing, often caused by factors like dehydration, urinary tract infection [UTI- an infection in the bladder/urinary tract], improper catheter care, or the presence of certain bacteria that promote crystal formation), urine color, and foul odor. 2a. Ensure Resident 66's condom catheter (a medical device that fits like a condom [rubber covering worn over the penis] to collect urine) had a physician's order. b. Ensure Resident 66's condom catheter urine collection bag was covered with a privacy bag. c. Ensure Resident 66's urine output was documented in the medical records and monitored for signs of infection. d. Ensure Resident 66's urine collection bag was not lying on the floor. 3. Cover Resident 4's urinary catheter collection bag. These deficient practices had the potential for undetected issues regarding the urine quality, cause a UTI, delay the identification and treatment of a UTI, jeopardized the respect and dignity of Resident 4 and Resident 66. Findings: 1. During a review of Resident 110's Admission Record, the Admission Record indicated Resident 110 was admitted to the facility on [DATE] with diagnoses that included sepsis (a life-threatening infection), epilepsy (a brain disease where nerve cells do not signal properly, which causes seizures), and adult failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity). During a review of Resident 110's Minimum Data Set ([MDS], a resident assessment tool), dated 1/14/2025, the MDS indicated Resident 110's cognition (process of thinking) was severely impaired. The MDS indicated Resident 110 was dependent on a helper's assistance with oral hygiene, toileting, bathing, dressing, and personal hygiene. The MDS indicated Resident 110 had an indwelling urinary catheter. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 110's History and Physical (H&P), dated 1/9/2025, the H&P indicated Resident 110 did not have the capacity to understand and make decisions. During a review of Resident 110's Order Recap Report dated 1/1/2025 through 2/28/2025, the Order Recap report indicated to have an indwelling urinary catheter to bedside drainage for wound management of a stage four pressure ulcer (full thickness tissue loss with exposed bone, tendon, or muscle). The order date was 1/27/2025. During a review of Resident 110's Care Plan, dated 1/8/2025, the Care Plan indicated Resident 110 had an indwelling urinary catheter. The Care Plan's interventions indicated to monitor, record, and report to the physician for signs and symptoms of UTI such as blood-tinged urine, cloudiness, foul smelling urine, and deepening urine color. During a concurrent interview and record review on 2/26/2025 at 10:04 a.m., with Registered Nurse (RN) 2, Resident 110's Orders dated 1/1/2025 through 2/26/2025 were reviewed. RN 2 stated Resident 110 did not have an order to monitor for signs and symptoms of infection related to Resident 110's indwelling urinary catheter. RN 2 stated Resident 110 should have had an order for monitoring to ensure the licensed nurses were prompted to be aware of any changes in Resident 110's urine output that would require notification to Resident 110's physician. During an interview on 2/28/2025 at 9:18 a.m., with the Director of Nursing (DON), the DON stated Resident 110 was required to have monitoring, every shift, of her indwelling urinary catheter output. The DON stated Resident 110's urinary output should be monitored for cloudiness, foul odor, hematuria (bloody urine), and sediments, which would be indication of an infection. The DON stated without this necessary monitoring, if an infection were to occur, there could be a delay in Resident 110's treatment. During a review of the facility's policy and procedure (P&P) titled, Catheter Care, Urinary, dated 1/2018, the P&P indicated to observe the resident's urine output for unusual appearance such as color and blood. The P&P indicated to observe for other signs and symptoms of urinary tract infection and report the findings to the physician immediately. 2. During a review of Resident 66's Admission Record, dated 2/27/2025, the admission record indicated Resident 66 was initially admitted to the facility on [DATE] and readmitted on [DATE]. The admission record indicated Resident 66 had the following diagnoses which included dementia (a progressive state of decline in mental abilities), paraplegia (loss of movement and/or sensation, to some degree, of the legs), type 2 diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), neuromuscular dysfunction of the bladder (when the nerves and muscles of the bladder [the organ that stores and empties urine] do not work properly), and chronic pain. During a review of Resident 66's Minimum Data Set (MDS - a resident assessment tool), dated 12/26/2025, the MDS indicated Resident 66's cognitive skills (ability to think, remember and reason) were intact. The MDS indicated Resident 66 used a wheelchair for mobility (the ability to move). The MDS further indicated Resident 66 was independent with eating (requires no assistance from a helper) and required supervision (helper provides verbal cues and/or touching assistance as resident completes the activity) related to toileting, bathing and personal hygiene. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 66's' H&P, dated 8/1/2024, the H&P indicated Resident 66 had the mental capacity to understand and make decisions. During a review of Resident 66's care plan, titled Condom Catheter, initiated on 10/27/2021, the care plan indicated Resident 66's condom catheter was due to impaired mobility related to paraplegia and neuromuscular dysfunction of the bladder. The care plan indicated Resident 66 used the condom catheter when he felt the urge to urinate. The care plan indicated Resident 66 was at risk for infections and related complications. The care plan interventions indicated to check tubing for kinks every shift and as needed, monitor for signs and symptoms of discomfort on urination and frequency, monitor, record, and report to medical doctor for signs and symptoms of pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, foul smelling urine and urinary frequency. During a review of Resident 66's Order Summary Report, dated 2/27/2025, the order summary report indicated there was no active order for a condom catheter. During an observation on 2/24/2025 at 10:20 a.m., in Resident 66's room, Resident 66's condom catheter collection bag was observed lying on the floor amongst the clutter on his floor. During a concurrent observation, interview, and record review on 2/27/2025 at 8:17 a.m., with Licensed Vocational Nurse (LVN) 7, observed Resident 66's condom catheter collection bag lying on the floor without a dignity bag. Resident 66's condom collection bag was overly full and bloated with urine. Resident 66 was observed picking up the condom catheter collection bag from the floor, opening the bag and pouring the urine from the collection bag into two separate urinals (a container used to collect urine). Observed Resident 66 place the collection bag back on the floor and hang both urinals on the trash can located next to his bed. Resident 66's urine was observed to be cloudy and a dark amber color. Resident 66 had a white residue that covered the inside of the urine collection bag and the tubing. LVN 7 stated she was not aware Resident 66 was wearing a condom catheter and the information was not reported to her from the nurse on the prior shift. LVN 7 stated she thought Resident 66 used a urinal to void urine. LVN 7 stated she does not know how long Resident 66 had been wearing a condom catheter. LVN 7 reviewed Resident 66's doctor's orders to see when the condom catheter was ordered. LVN 7 stated there was no active order for the condom catheter. LVN 7 stated there should have been a doctor's order for the condom catheter so that Resident 66's urine could be monitored and documented in the medical records. LVN 7 stated Resident 66 did have a care plan initiated for the condom catheter. LVN 7 stated the care plan indicated to check the Resident 66's urine color and sediment (crystals, bacteria, or blood exited through the urine). LVN 7 stated she was not following Resident 66's condom catheter care plan. LVN 7 stated the condom catheter collection bag should not have been placed on the floor because the floor because Resident 66 could catch an infection. LVN 7 stated the bag should have been covered for privacy so that Resident 66 would not feel embarrassed. During an interview on 2/26/2025 at 9:07 a.m. with the Director of Nursing (DON), the DON stated Resident 66 should have had an order for the condom catheter, but it had been canceled. The DON stated the condom catheter needed an order so that the nurses could keep track of when the catheter needed to be changed and to document and report the urine output. The DON stated Resident 66 prefers to empty his own urine collection bag, but he needed to be educated on how to use it. The DON stated the certified nursing assistants (CNAs) should have been reporting Resident 66's urine output to the charge nurse and ensuring his urine collection bag was emptied, covered, and off of the floor. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER California Post-Acute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 3615 E. Imperial Hiwy Lynwood, CA 90262	

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/27/2025 at 1 p.m., with the Infection Preventionist Nurse (IPN), the IPN stated the nursing staff should have been monitoring Resident 66's condom catheter urine output. The IPN stated Resident 66's dark, amber color urine with sediments could have been a sign that the urine was old or Resident 66 could have had an infection. The IPN stated the CNAs should have reported the urine to the charge nurse and the charge nurse should have reported the to the Registered Nurse (RN) Supervisor and notified the doctor. During a review of the facility's P&P titled Physician Orders, dated December 2016, the P&P indicated monthly physician orders must be renewed every month. During a review of the facility's P&P titled Physician Notification, dated December 2016, the P&P indicated a physician will be notified when there is a change of condition. During a review of the facility's policy and procedure (P&P) titled, Catheter Care, Urinary, dated January 2018, the P&P indicated, The purpose of this procedure is to prevent catheter-associated urinary tract infections. The P&P indicated to the following: 1. Maintain an accurate record of the resident's daily output, per facility policy and procedure. 2. Check the resident frequently to be sure he or she is not lying on the catheter and to keep the catheter and tubing free of kinks. 3. Use standard precautions when handling or manipulating the drainage system 4. Be sure the catheter tubing and drainage bag are kept off the floor. 5. Empty the bag regularly using a separate, clean collection container for each resident. 6. Check the urine for unusual appearance (i.e., color, blood, etc.) 3. During an observation on 2/2/2025 at 12:33 p.m. in Resident 4's room, Resident 4's foley catheter bag (bag that collects urine) was not covered with a privacy bag. Resident 4's foley catheter bag displayed Resident 4's urine. During an observation on 2/28/2025 at 12:33 p.m. in Resident 4's room, Resident 4's foley catheter bag was not covered with a privacy bag. Resident 4's foley catheter bag displayed Resident 4's urine. During a review of Resident 4's Admission Record, the admission record indicated Resident 4 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses of neuromuscular dysfunction of the bladder ([neurogenic bladder] a condition where the nerves controlling bladder function are damaged, leading to impaired bladder muscle activity and resulting in problems like urinary incontinence and lack of awareness of bladder fullness) and benign prostatic hyperplasia [(BPH] is a noncancerous enlargement of the prostate gland that causes frequent urination, weak urine stream, and difficulty in starting to urinate). During a review of Resident 4's H&P dated 1/21/2024, the H&P indicated Resident 4 had the capacity to understand and make decisions. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 4's MDS, dated [DATE], the MDS indicated Resident 4's cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making was intact. The MDS indicated Resident 4 required maximal assistance (helper does more than half the effort) for upper body dressing, shower/bathing and personal hygiene. The MDS indicated Resident 4 required set up assistance for eating. During an interview on 2/24/2025 at 11:58 a.m. with Resident 4, Resident 4 stated his foley bag did not get covered. Resident 4 stated staff did not insist on covering his foley catheter bag and they did not tell him why it should be covered. During an interview on 2/28/2025 at 12:42 p.m. with Treatment Nurse (TN) 1, TN 1 stated all foley catheter bags must be covered with a privacy bag. TN 1 stated the privacy bag covered the urine in the foley catheter bag. TN 1 stated it was important to cover the foley catheter bag with a privacy bag because it provided privacy and dignity to residents. During an interview on 2/28/2025 at 2:11 p.m. with the Director of Nursing (DON), the DON stated all nursing staff that enter a resident's room must assess foley catheter bags and make sure they covered. The DON stated foley catheter bags must be covered at all times. The DON stated a resident with a foley catheter bag that is not covered with a privacy bag would feel embarrassed and create dignity issues.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48131 Based on observation, interview, and record review, the facility failed to place oxygen signage at the doorway indicating oxygen was in use for one of two sampled residents (Resident 36) receiving oxygen therapy. This deficient practice had the potential to place all residents' and staff's safety at risk. Findings: During a review of Resident 36's Admission Record, dated 2/27/2024, the admission record indicated Resident 36 was initially admitted to the facility on [DATE] and readmitted on [DATE]. The admission record indicated Resident 36 diagnoses included acute respiratory failure with hypoxia (when the lungs suddenly fail to adequately provide oxygen to the body, resulting in a dangerously low level of oxygen in the blood), congestive heart failure (CHF- a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), end stage renal disease (ESRD - irreversible kidney failure), and dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed). During a review of Resident 36's History and Physical (H&P), dated 11/21/2024, the H&P indicated Resident 36 had the capacity to understand and make decisions. During a review of Resident 36's Minimum Data Set (MDS - a resident assessment tool), dated 1/23/2025, the MDS indicated Resident 36's cognition (ability to think, remember, and reason) was moderately impaired. The MDS indicated Resident 36 could eat independently (resident completes the activity by himself with no assistance) and was dependent (helper does all the effort) for toileting, bathing and personal hygiene. During a review of Resident 36's Order Summary Report dated 2/27/2025, the order summary report indicated an active order on 2/22/2025 for oxygen at two liters (unit of volume) per minute (LPM) via nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) as needed for shortness of breath to keep oxygen saturation (O2 sat - a measurement of how much oxygen the blood is carrying, normal O2 sat - 95% to 100%) equal or more than 92 percent (%). The order indicated may titrate to adjust the flow of oxygen to meet the resident's needs) oxygen flow to two to four LPM. During an observation on 2/24/2025 at 10:51 a.m , observed Resident 36 lying in bed receiving oxygen at two LPM via nasal cannula. Resident 36 did not have oxygen signage placed outside of the doorway or in the room. During an interview on 2/26/2025 at 8:47 a.m., with Licensed Vocational Nurse (LVN 9), LVN 9 stated the facility's infection preventionist nurse (IPN) was responsible for posting the oxygen sign outside of Resident 36's doorway when the resident was initially placed on supplemental oxygen. LVN 9 stated Resident 36 had an oxygen sign but sometimes the sign would fall off of the doorway. LVN 9 stated it was important to make sure an oxygen sign was on the doorway when there was oxygen running so that no one would smoke and cause an explosion in the resident's room. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/27/2025 at 3:11 p.m. with the Director of Nursing (DON), the DON stated the facility was looking for a better way to ensure the oxygen signage did not fall off of the doorways of the residents' rooms. The DON stated nursing staff was responsible for making sure the oxygen signage was on the doorway of Resident 36's room. The DON stated if the oxygen signage falls off, the nursing staff should find out where the sign belongs and replace it immediately. The DON stated the oxygen signage was important to let everyone know there was oxygen in the room because oxygen is a fire risk. During a review of the facility's policy and procedure (P&P) titled, Oxygen Administration, Nasal Cannula, dated August 2017, the P&P indicated an Oxygen sign must be visibly posted. The P&P indicated to post the Oxygen sign and explain to the resident, his/her roommate and all other visitor the regulations regarding the use of smoking materials near oxygen.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48131 47679 Based on observation, interview, and record review, the facility failed to administer pain medication as ordered and effectively manage severe pain for two of six sampled residents (Residents 117 and 99) by: 1. Failing to ensure Resident 117 was reassessed for inadequate pain relief. 2. Failing to administer pain medication for Resident 117's severe pain as ordered by the physician. 3. Failing to follow Resident 117's care plan goal to maintain comfort and manage resident's pain. 4. Failing to administer Norco (an opioid medication used to treat pain) to Resident 99, which was available in the emergency kit ([e-kit], small supply of medication that can be used when pharmacy services are unavailable), while waiting for the Norco to be delivered to the facility by the pharmacy. 5. Failing to effectively manage Resident 99's chronic back pain. These deficient practices allowed Resident 117 to suffer with severe pain unnecessarily and resulted in Resident 117's and Resident 99's pain being ineffectively managed which left both residents feeling frustrated with their pain management treatment. Findings: A.) During a review of Resident 117's Admission Record ([Face Sheet] - front page of the chart that contains a summary of basic information about the resident), dated 2/27/2025, the admission record indicated Resident 117 was admitted to the facility on [DATE]. The admission record indicated Resident 117 had the following diagnoses which included hemiplegia (total paralysis [loss of the ability to move and feel in all or part of the body] of the arm, leg, and trunk on the same side of the body), cardiomyopathy (disease affecting the heart muscle), low back pain, and acute kidney failure (a sudden loss of kidney function). During a review of Resident 117's Minimum Data Set (MDS - a resident assessment tool), dated 1/23/2025, the MDS indicated Resident 117's cognitive skills (ability to think, remember and reason) were intact. The MDS indicated Resident 117 had impairment on one side of his upper and lower extremities and used a wheelchair for mobility (the ability to move). The MDS further indicated Resident 117 received hospice care (compassionate care for people who are near the end of life provided at the person's home or within a health care facility) and required moderate assistance (helper does less than half the effort) related to toileting and personal hygiene. During a review of Resident 117's' History and Physical (H&P), dated 1/21/2025, the H&P indicated Resident 117 had the mental capacity to understand and make decisions. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 117's care plan with a focus of chronic pain, initiated on 10/7/2024, the care plan indicated Resident 117's chronic pain was due to acute kidney injury (AKI - same as acute kidney failure), and a fracture (a break in the bone) to the left clavicle (collarbone). The care plan indicated Resident 117 would verbalize adequate relief of pain. The care plan interventions included to administer pain medication as ordered, anticipate the resident's need for pain relief and respond immediately to any complaint of pain. The care plan indicated to evaluate the effectiveness of pain interventions, review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results. The care plan indicated to identify and record previous pain history and management of that pain and the impact on function. The care plan indicated to identify previous responses to analgesia including side effects and impact on function. The care plan intervention indicated to notify physician if interventions were unsuccessful or if current complaint of pain was a notable change from resident's past experience of pain. During a review of Resident 117's care plan with a focus of hospice care, initiated on 1/17/2025, the care plan indicated Resident 117 was under hospice care with expected deterioration (becoming worse) due to decline/terminal (a condition expected to end in death) illness related to end stage heart failure (the most severe stage of heart disease in which the heart is too weak to pump blood effectively). The care plan indicated Resident 117 would be comfortable, and pain would be managed through his terminal status daily. The care plan interventions included to administer and document prescribed analgesics (medications to relieve pain), evaluate and document evidence of response to pain-relief measures. During a review of Resident 117's Order Summary Report, dated 2/27/2025, the order summary report indicated an active order with a start date of 10/4/2024, to monitor and rate pain, provide nonpharmacological (does not involve the use of drugs) interventions (nursing actions that are intended to benefit the resident) prior to the administration of pain medication if resident complained of pain every shift with a pain scale (a tool used to measure a resident's level of pain) of 0 - no pain, 1-3 - mild pain, 4-6 - moderate pain, and 7-10 - severe pain. During a review of Resident 117's Order Summary Report, dated 2/27/2025, the order summary report indicated an active order with a start date of 10/4/2024 for Acetaminophen (Tylenol - a medication to relieve mild to moderate pain) 650 milligrams (MG - metric unit of measurement). The order summary report indicated to give one tablet by mouth every six hours as needed for general discomfort. During a review of Resident 117's Order Summary Report, dated 2/27/2025, the order summary report indicated an active order with a start date of 10/15/2024 for Hydrocodone-Acetaminophen (Norco - a medication to relieve moderate to severe pain) Oral Tablet 5-325 MG. The order summary report indicated to give one tablet by mouth every 6 hours as needed for severe pain (7-10). During a review of Resident 117's Order Summary Report, dated 2/27/2025, the order summary report indicated an active order with a start date of 10/5/2024 for Methocarbamol (a muscle relaxant used to treat muscle pain and stiffness) Oral Tablet 500 MG. The order summary report indicated to give one tablet by mouth two times a day for pain. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 117's Order Summary Report, dated 2/27/2025, the order summary report indicated an active order with a start date of 1/18/2025 for Morphine Sulfate (a medication used to treat moderate to severe pain) Solution 20 MG/milliliter (ML - metric unit of measurement, used to measure fluid volume of a medication). The order summary report indicated to give 0.25 ML sublingually (under the tongue) every two hours as needed for mild pain. During a review of Resident 117's Order Summary Report, dated 2/27/2025, the order summary report indicated an active order with a start date of 1/18/2025 for Morphine Sulfate Solution 20 MG/ML. The order summary report indicated to give 0.5 ML sublingually every two hours as needed for moderate pain. During a review of Resident 117's Order Summary Report, dated 2/27/2025, the order summary report indicated an active order with a start date of 1/18/2025 for Morphine Sulfate Solution 20 MG/ML. The order summary report indicated to give 1 ML sublingually every two hours as needed for severe pain. During a review of Resident 117's Medication Administration Record (MAR), for the month of February 2025, the MAR indicated Resident 117 did not receive any medication to relieve pain on 2/6/2025, 2/7/2025, 2/11/2025, 2/15/2025, 2/16/2025, 2/17/2025, 2/18/2025, 2/19/2025, 2/21/2025, 2/22/2025 and 2/23/2025. During a review of Resident 117's Pain Assessment on the MAR dated 2/24/2025, the pain assessment indicated Resident 117's pain was rated at a level of 5 on the day shift. During a review of Resident 117's Pain Assessment on the MAR dated 2/25/2025, the pain assessment indicated Resident 117's pain was rated at a level of 5 on the day shift. During a review of Resident 117's Pain Assessment on the MAR dated 2/26/2025, the pain assessment indicated Resident 117's pain was rated at a level of 5 on the day shift. During a concurrent observation and interview on 2/24/2025 at 11:24 a.m., with Resident 117, Resident 117 was observed lying in bed on his back, awake and alert. Resident 117 stated he was not getting enough pain medication to relieve his pain. Resident 117 stated he had constant pain, and the pain was not controlled with the pain medication he was receiving. Resident 117 stated his pain rated at a 10/10 on the pain scale of 1 to 10. Resident 117 stated he previously had back surgery which caused him to have severe pain in his lower back. Resident 117 stated he was paralyzed on his left side from a stroke and had severe pain in his left shoulder and left leg. Resident 117 stated the pain in his left shoulder and left leg was rated a 10/10 on the pain scale. Resident 117 stated that he received pain medication earlier that morning on 2/24/2025, but the medication did not relieve his pain. Resident 117 stated he had informed the nurses of his pain on several occasions and the pain medication he was receiving was not relieving his pain. Resident 117 stated he decided to sign up for hospice, so he would be able to get more medication to relieve his pain. Resident 117 stated he regretted signing up for hospice because he continued to have unrelieved pain. Resident 117 stated he would like to go back to his previous facility because the previous facility kept his pain under control. During an interview on 2/25/2025 at 11:15 a.m., with Resident117, Resident 117 stated his pain was at a 10/10 on the pain scale. He says his pain is in his lower back and he is always in pain. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/25/2025 at 11:38 a.m., with Resident 117, Resident 117 stated his pain was in his lower back and was rated at a 10/10 on the pain scale. During an interview on 2/25/2025 at 4:15 p.m., with Resident 117, Resident 117 stated he was having left shoulder pain that was 10/10 on the pain scale. During an interview on 2/26/2025 at 4:03 p.m., with Resident 117, Resident 117 stated that he continued to have pain in his back and shoulder that was 10/10 even though he was given pain medication. During an interview on 2/27/2025 at 12 p.m., with Resident 117, Resident 117 stated his pain was at a 10/10 like it always is. Resident 117 stated he received pain medications, but the medication did not relieve his pain. During a telephone interview on 2/27/2025 at 12:15 p.m., with the Hospice Nurse (HN 1), HN 1 stated Resident 117 was on hospice to keep him as comfortable as possible and to provide pain management. HN 1 stated she would prefer Resident 117 to have zero pain. HN 1 stated she did not ask Resident 117 what his pain level was but used the facial scale to determine his pain level, even though Resident 117 is alert and oriented and able to verbalize his pain. HN 1 stated Resident 117 receives Norco but if the Norco is not effective Resident 117 can also have morphine for a higher level of pain. HN 1 stated Resident 117 should be reassessed 20 minutes after administering the Norco and if the Norco is not effective, he should be offered the morphine to relieve his pain. During a concurrent observation , interview, and record review on 2/27/2025 at 1:33 p.m., with HN 1, Licensed Vocational Nurse (LVN 7) and Resident 117, Resident 117 was observed in his wheelchair in the hallway outside of his room. Resident 117's left leg was observed shaking uncontrollably. Resident 117 stated his pain level was now at 8 because the nurse had just given him pain medication. Resident 117 stated the pain medication only lasts for 15 minutes which is why his left leg began shaking. Resident 117 stated he informed both HN 1 and LVN 7 of his pain earlier that morning but was not given anything for the pain. Resident 117 stated he informed the nurses his pain was a level 10 all the time and he had constant pain. Resident 117 stated his pain level was at 100 the day before (2/26/2027) and the medication he was given did not relieve his pain. HN 1 stated, He is a drug seeking resident, just look at him. Does he look like he is in pain to you? LVN 7 stated she asked Resident 117 if he had pain during her med pass and Resident 117 did not inform her that he was in any pain. Resident 117 stated to LVN 7, I have pain all the time, every day and the pain is always at a level 10! LVN 7 stated Resident 117's pain was not being managed effectively. During a concurrent interview and record review on 2/27/2025 at 1:54 p.m., with the Hospice Physician (HMD), Resident 117's February 2025 MAR was reviewed. The HMD stated he felt it would be best to place Resident 117 on a longer acting pain medication since the pain medication he was currently receiving was only working for a brief period of time. The HMD stated the nurses may not be getting back to the resident to reassess his pain in time. The HMD stated Resident 117 may also need to have his pain medication dosage or the frequency of his medication adjusted to manage his pain, however, he could not assess whether the pain medications were working because the nurses were not giving the pain medications as ordered. The HMD stated upon reviewing the MAR for the month of February 2025, Resident 117's pain was not being managed properly. The HMD stated Resident 117's pain should have been assessed and documented and if the current pain regimen was not working, the nurses should have notified the doctor. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/27/2025 at 3:21 p.m., with the Director of Nursing (DON), the DON stated the main reason Resident 117 was on hospice was for comfort, dignity and end of life. The DON stated the nurses should follow the doctors' orders and administer the appropriate pain medication based on the resident 117's pain level. The DON stated Resident 117 could become frustrated if the nurses are not listening to his request for pain medication. The DON stated once she heard about Resident 117's pain, she went to assess his pain for herself, and Resident 117 informed her his pain was 10/10. B.) During a review of Resident 99's Admission Record, the Admission Record Face Sheet indicated Resident 99 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included acute myocardial infarction (heart attack), low back pain, and type two diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 99's MDS, dated [DATE], the MDS indicated Resident 99's cognition (process of thinking) was moderately impaired. The MDS indicated Resident 99 required maximal assistance (helper does more than half the effort) with oral hygiene, upper body dressing, and personal hygiene. The MDS indicated Resident 99 took opioid medication in the facility. During a review of Resident 99's History and Physical (H&P), dated 10/19/2024, the H&P indicated Resident 99 had the capacity to understand and make decisions. During a review of Resident 99's Order Recap Report, dated 6/1/2024 through 2/28/2025, the Order Recap Report indicated to give: a. Norco 5-325 mg by mouth, every six hours, as needed for chronic lower back pain. The order date was 2/12/2025. b. Tylenol 500 mg, by mouth, every six hours, as needed for pain. The order date was 9/22/2024. During an interview on 2/24/2025 at 10:26 a.m., with Resident 99, Resident 99 stated he had chronic back pain that required Norco to effectively manage his pain. Resident 99 stated the licensed nurses told him he ran out of Norco and had to wait for more to be delivered. Resident 99 stated the licensed nurses gave him Tylenol (medication to treat pain) instead but Tylenol would not relieve all his pain. Resident 99 stated he felt frustrated the facility could not ensure his Norco was readily available when he had pain. During a concurrent observation and interview on 2/24/2025 at 10:40 a.m. with Licensed Vocational Nurse LVN 5 in Resident 99's room, LVN 5 administered Tylenol to Resident 99. LVN 5 stated Resident 99 received Norco on 2/23/2025 at 8 p.m. and the it dose was the last dose in Resident 99's bubble pack (a card holding medicinal tablets or capsules that are individually packaged in a clear plastic case sealed to the card). LVN 5 stated the facility was waiting for Resident 99's physician to sign the prescription so the pharmacy could deliver more Norco for Resident 99 to the facility. LVN 5 stated Norco was available in the e-kit, which she could have accessed and administer a dose from there. LVN 5 stated she did not give Norco to Resident 99 because Resident 99 had incidents of sedation (excessive sleepiness) after taking Norco. LVN 5 stated Resident 99 was awake, and she should have accessed the e-kit. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER California Post-Acute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 3615 E. Imperial Hiwy Lynwood, CA 90262	

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 99's MAR, dated 2/1/2025 through 2/28/2025, the MAR indicated Resident 99 received Tylenol 500mg on 2/24/2025 at 10:45 a.m., 2/25/2025 at 2:34 a.m., and 2/25/2025 at 9:58 p.m. During a concurrent interview and record review on 2/28/2025 at 8:59 a.m., with the Director of Nursing (DON), the facility's Packing Slip Proof of Delivery, dated 2/26/2025 was reviewed. The DON stated Resident 99's Norco 5-325mg was delivered to the facility on [DATE] at 4:31 a.m. The DON stated Resident 99's Norco was unavailable from 2/23/2025 through 2/26/2025, while the facility was waiting for the Norco to be delivered. The DON stated Resident 99 had a history of chronic back pain and Norco was more effective in treating Resident 99's pain than Tylenol. The DON stated while the facility was waiting for Resident 99's Norco to be delivered, the licensed nurses should have accessed the medication e-kit for the Norco and administered to Resident 99. The DON stated because Resident 99 was administered Tylenol on multiple occasions, instead of Norco, Resident 99's pain was not effectively managed, therefore the licensed nurses failed to provide Resident 99 comfort. During a review of the facility's policy and procedure (P&P) titled, Pain Management Program, dated 1/2019, the P&P indicated the pain management program was based on a facility-wide commitment to resident comfort. During a review of the facility's P&P titled, Emergency Pharmacy Service and Emergency Kits, undated, the P&P indicated, Medications are not borrowed from other residents. The ordered medication is obtained either from the emergency box or from the provider pharmacy. The P&P indicated, When an emergency or starter dose of a medication is needed, the nurse unlocks the container/cabinet [and] breaks the container seal and removes the required medication. During a review of the facility's policy and procedure (P&P) titled, Pain Management Program, dated January 2019, the P&P indicated the pain management program was based on a facility-wide commitment to resident comfort. The P&P indicated pain management was defined as the process of alleviating the resident's pain to a level that was acceptable to the resident and based on his or her clinical condition. The P&P indicated strategies for prevention and management of pain may include assessing resident's potential for pain, recognizing the onset, presence and duration of pain, treating the underlying causes of pain, and developing and implementing both non-pharmacological and pharmacological interventions/approaches to pain management, monitor appropriately for effectiveness and/or adverse consequences. Cross Reference F755

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48131 Based on observation, interview, and record review, the facility failed to ensure the hemodialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) access site (an arteriovenous (AV) shunt - an access site formed by the joining of a vein and an artery in the arm to provide hemodialysis) was assessed upon return to facility for one of two sampled residents (Resident 36). Findings: During an observation on 2/24/2025 at 10:51 a.m., in Resident 36's room, Resident 36 was observed with an AV fistula in his left arm. Resident 36's AV fistula had a cotton ball soaked with a reddish drainage that was sitting on top of the gauze dressing. The gauze dressing was also observed oozing reddish drainage. During an observation on 2/24/2025 at 11:27 a.m., in Resident 36's room, Resident 36's left arm was observed still wrapped in the thin gauze dressing with reddish drainage seeping through the dressing and the cotton ball sitting on top of the dressing. During a review of Resident 36's Admission Record, dated 2/27/2024, the admission record indicated Resident 36 was initially admitted to the facility on [DATE] and readmitted on [DATE]. The admission record indicated the following diagnoses which included acute respiratory failure with hypoxia (when the lungs suddenly fail to adequately provide oxygen to the body, resulting in a dangerously low level of oxygen in the blood), congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), end stage renal disease (ESRD - irreversible kidney failure), and dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed). During a review of Resident 36's History and Physical (H&P), dated 11/21/2024, the H&P indicated Resident 36 had the capacity to understand and make decisions. During a review of Resident 36's Minimum Data Set (MDS - a resident assessment tool), dated 1/23/2025, the MDS indicated Resident 36's cognition (ability to think, remember, and reason) was moderately impaired. The MDS indicated Resident 36 received hemodialysis, could eat independently (resident completes the activity by himself with no assistance) and was dependent (helper does all the effort) for toileting, bathing and personal hygiene. During a review of Resident 36's Order Summary Report dated 2/27/2025, the order summary report indicated an active order for AV shunt site: Left arm - Monitor for signs and symptoms of bleeding every shift on 9/15/2024. During a review of Resident 36's Order Summary report dated 2/27/2025, the order summary report indicated an active order for Dialysis - every day shift on Monday, Wednesday and Friday for renal failure on 9/11/2024. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/26/2025 at 9 a.m., with Licensed Vocational Nurse (LVN) 9, LVN 9 stated when Resident 36 returned from hemodialysis, his AV-shunt dressing should have been cleaned and assessed for any drainage or bleeding. LVN 9 stated Resident 36 could have hemorrhaged (bleeding) from his AV-shunt because it was not assessed after he returned to the facility. During an interview on 2/26/2025 at 9:38 a.m., with the Treatment Nurse (TN), the TN stated a LVN should have assessed Resident 36's AV-shunt when he returned to the facility to ensure there was no bleeding. TN stated if fresh blood was observed on Resident 26's the AV-shunt dressing, the nurse should have reinforced the dressing by putting another dressing on top of the old dressing to add pressure and stop any bleeding. The TN 1 stated by not applying extra pressure to Resident 36's AV shunt, the resident's shunt could have continued to bleed. During an interview on 2/27/2025 at 3 p.m., with the Director of Nursing (DON), the DON stated assessing the AV shunt after a resident returned from hemodialysis was important because the AV shunt can continue to bleed. The DON stated if Resident 36's AV shunt had any signs of bleeding, the AV shunt dressing should have been reinforced. The DON stated, if Resident 36's AV shunt had continued bleeding, it would have been an emergency because Resident 36 could have bled out. During a review of the facility's policy and procedure (P&P) titled, Hemodialysis, Care of Residents, dated June 2023, the P&P indicated, The facility provides residents with safe, accurate, and appropriate care, assessments and interventions to improve resident outcomes for resident outcomes for residents on hemodialysis. The P&P indicated care following dialysis treatment: 1. Check graft site for bleeding every 4 hours or twice during the shift after the resident returns, or per physician's order. 2. If the dressing becomes wet, dirty, or not intact, the dressing shall be changed by a licensed nurse trained in this procedure.

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F 0745

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide medically-related social services to help each resident achieve the highest possible quality of life.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 47858

Based on interview and record review, the facility failed to ensure to follow up on a resident's transfer to a locked nursing facility (a nursing home that has a secure area for residents who need extra supervision or protection, commonly due to dementia [a progressive state of decline in mental abilities] or behavioral issues) after the transfer was requested by the resident's responsible party (RP) on 12/13/2024 for one out of one sampled residents (Resident 97).

This failure resulted in a two-month delay in Resident 97's transfer to a locked skilled nursing facility to better manage Resident 97's behaviors and psychiatric (mental) condition.

Findings:

During a review of Resident 97's Admission Record, the Admission Record indicated Resident 97 was admitted to the facility on [DATE]. Resident 97's diagnoses included schizophrenia (a mental illness that is characterized by disturbances in thought), Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities), dementia, and an immunocompromised disease (having an impaired immune system).

During a review of Resident 97's Minimum Data Set ([MDS], a resident assessment tool), dated 12/25/2024, the MDS indicated Resident 97's cognitive skills (ability to think and reason) for daily decision making was severely impaired. The MDS indicated Resident 97 required set up or clean up assistance for toileting, oral hygiene, and dressing, and required clean-up assistance when performing personal hygiene.

During a concurrent interview and record review on 2/27/2025 at 12:40 p.m. with the Social Services Assistant (SSA), Resident 97's Interdisciplinary (IDT, group of different disciplines working together towards a common goal of a resident) Meeting Note, dated 12/13/2024, was reviewed. The IDT note indicated the Social Services Designee (SSD) was to follow up with Resident 97's Responsible Party (RP 1) revocation of Resident 97's hospice (compassionate care for people who are near the end of life provided at the person's home or within a health care facility) services to allow for the transfer of Resident 97 to locked facility, as requested by RP 1. The SSA stated she did not have knowledge of the IDT conference held on 12/13/2024 and that was why she did not follow up on the status of the transfer for Resident 97. The SSA stated the former SSD had resigned in December 2024 and did not make any endorsements regarding Resident 97's planned transfer to a locked facility. The SSA stated RP 1 had the right to have her request for her father's transfer to a locked facility respected and honored.

During an interview on 2/28/2025 at 10:30 a.m. with the Director of Nursing (DON), the DON stated the facility should have followed up on the status of the revocation of hospice services to facilitate Resident 97's transfer to a locked facility. The DON stated that the facility should have initiated measures to transfer Resident 97 to a more appropriate psychiatric facility regardless of the lack of follow up or knowledge of the discussion in the IDT meeting on 12/13/2024.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/28/2025 at 1:46 p.m. with RP 1, RP 1 stated she recalled the discussion with the facility about her father's transfer to a locked facility and stated the facility never updated her with the status of her father's transfer to locked or psychiatric facility. During a review of the facility's SSD Job Description, dated 10/19/2015, the SSD Job Description indicated the SSD was to support patient/resident and family members to assist in their understanding of placement and facility issues in addition to referring them to the appropriate Social Service agencies when the facility does not provide the needed services. The job description indicated the SSD was to work with the interdisciplinary team to promote and protect resident rights and the psychosocial well-being of all patients/residents. During a review of the facility's Policy and Procedure (P&P), titled, Exercising Resident Rights, dated 11/2017, the P&P indicated the facility protected and promoted the rights of each resident and ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

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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** 46832 Based on observation, interview and record review, the facility failed to: 1. Reorder Resident 62's Arginaid (a powder or liquid supplement that contains arginine and antioxidants to help with wound healing) medication timely. 2. Ensure Resident 62's ProHeal (a liquid protein supplement used to manage wounds and other conditions that require additional protein) medication dosage was clarified by Resident 62's physician. 3. Ensure Resident 4 received oxybutynin chloride (to treat symptoms of an overactive bladder, such as incontinence (loss of bladder control) or a frequent need to urinate) 5 milligrams ([mg] metric unit of measurement, used for medication dosage and/or amount), on 2/21/2025 and 2/22/2025. 4. Reorder Resident 4's medication timely and caused Resident 4 to miss two days of medication. 5. Ensure nursing staff followed medication parameters (specific instructions that you can measured) when administering medication to Resident 39. 6. Reorder Resident 99's Norco (an opioid medication used to treat pain) timely. 7. Ensure Licensed Vocational Nurse (LVN) 9 documented on Resident 99's Medication Administration Record (MAR, a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) after administering Norco on 2/26/2025. These deficient practices had the potential to cause medication errors for Resident 4, Resident 62, and Resident 99. Findings: a. During a review of Resident 62's Admission Record, the admission record indicated Resident 62 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included ulcer of the left lower extremity (an open sore on the leg that takes more than two weeks to heal), acute kidney failure, hypertension and benign prostatic hyperplasia. During a review of Resident 62's Minimum Data Set (MDS- a resident assessment tool), dated 12/24/2024, indicated Resident 62's cognitive skills (ability to think and reason) was intact. The MDS also indicated Resident 62 was dependent on staff with activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) such as toileting needs, showering and upper/lower body dressing. During a review of Resident 62's physician orders, the physician order indicated Arginald Oral Packet (Nutritional Supplements) Give 1 packet by mouth two times a day for dietary supplement. with a start date of 12/19/2024. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 62's physician orders, the physician order indicated ProHeal Oral Protein two times a day for supplement with a start date of 8/14/2024. During a concurrent interview and record review, on 2/25/2025, at 8:26 a.m., with Licensed Vocational Nurse 3 (LVN 3), LVN 3 was observed prepping for medication administration for Resident 62. LVN 3 verified physician order for ProHeal for Resident 62. LVN 3 stated the physician order did not clarify the amount of ProHeal Resident 62 should had received. LVN 3 stated Resident 62 had received 30ml per manufacturer's instructions on the bottle since 8/14/2024. LVN 3 stated the physician's order should had been clarified and withheld the medication. LVN 3 stated the risk of administering a medication without a dosage could result in overdosing and delay of wound healing. During a concurrent interview and record review, on 2/25/2025, at 8:32 a.m., with LVN 3, LVN 3 verified Resident 62's physician order for Arginaid. LVN 3 stated Arginaid was not in stock at the facility. LVN 3 stated the medication should had been reordered. LVN 3 stated the risk of not having the medication on hand at the facility could result in a delay in wound healing and care. During an interview, on 2/27/25, at 2:30 p.m., with the Director of Nursing (DON), the DON stated the protocol for an unknown medication dosage was to call the physician and clarify the order. The DON stated the licensed staff should have contacted Resident 62's physician for clarification of the dosage amount to be given. The DON stated the risk of administering a medication with an unknown dosage could result in administering the wrong dosage. 45009 b. During a review of Resident 4's Admission Record, the admission record indicated Resident 4 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses of neuromuscular dysfunction of the bladder ([neurogenic bladder] a condition where the nerves controlling bladder function are damaged, leading to impaired bladder muscle activity and resulting in problems like urinary incontinence and lack of awareness of bladder fullness) and benign prostatic hyperplasia [(BPH] is a noncancerous enlargement of the prostate gland that causes frequent urination, weak urine stream, and difficulty in starting to urinate). During a review of Resident 4's History and Physical (H&P) dated 1/21/2024, the H&P indicated Resident 4 had the capacity to understand and make decisions. During a review of Resident 4's MDS, dated [DATE], the MDS indicated Resident 4's cognitive skills for daily decision making was intact. The MDS indicated Resident 4 required maximal assistance (helper does more than half the effort) for upper body dressing, shower/bathing and personal hygiene. The MDS indicated Resident 4 required set up assistance for eating. During a review of Resident 4's Order Summary Report, dated 3/1/2024, the order summary report indicated Resident 4 had an order for oxybutynin chloride 5 mg one time a day. During a review of Resident 4's Medication Administration Record (MAR) dated 2/1/2025 - 2/28/2025, the MAR indicated on 2/21/20225 and 2/22/2025 Resident 4 did not receive oxybutynin chloride 5 mg. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/24/2025 at 11:31 a.m. with Resident 4, Resident 4 stated he did not receive oxybutynin a few times (unable to recall when). Resident 4 stated he became upset because he did not receive his medication and that medication helped him with bladder spasm prevention. Resident 4 stated he felt unimportant to have nurses know he was low on medication but did not bother to reorder. During an interview on 2/27/2025 at 2:20 p.m. with Licensed Vocational Nurse (LVN) 8, LVN 8 stated Resident 4 did not receive oxybutynin chloride 5 mg on 2/21/2025 and 2/22/2025 because the facility did not have the medication. LVN 8 stated the medication had not been reordered. LVN 8 stated a nurse must reorder medication when there is five pills left. LVN 8 stated it was important to have residents' medication available to keep the resident's medical condition under control. LVN 8 stated he informed Resident 4 his medication was not available and the resident became very upset. During an interview on 2/28/2025 at 1:10 p.m. with the DON, the DON stated all nurses must reorder medications when there was 3 to 5 pills left. The DON stated all medications must be available at all times to ensure all residents' needs are met. The DON stated charge nurses are supposed to notice how low the medication is during medication administration and reorder the medication. The DON stated it was important to have mediations available to manage the indications for that medication. The DON stated if medications are not available to administer, symptoms for what mediation is for would not be controlled. 47679 c. During a review of Resident 39's Admission Record, the admission record indicated Resident 39 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses of heart failure (progressive heart disease that affects pumping action of the heart muscles, causes fatigue and shortness of breath) and cardiomyopathy acquired or hereditary disease of heart muscle, this condition makes it hard for the heart to deliver blood to the body and can lead to heart failure). During a review of Resident 39's H&P dated 10/3/2024, the H&P indicated Resident 39 had the capacity to understand and make decisions. During a review of Resident 39's MDS, dated [DATE], the MDS indicated Resident 39's cognitive skills for daily decision making was intact. The MDS indicated Resident 39 required supervision for oral hygiene, toileting hygiene, and personal hygiene. The MDS indicated Resident 39 required set up assistance for eating, shower/bathing and dressing. During a review of Resident 39's Order Summary Report, dated 10/30/2019, the order summary report indicated Resident 39 had an order for clonidine tablet 0.1 mg, give 1 tablet by mouth, every 12 hours for hypertension (high blood pressure). The order summary report indicated medication parameter was to hold medication if systolic blood pressure (pressure in your arteries when your heart contracts and pumps blood) was less than 120. During a review of Resident 39's MAR dated 2/1/2025 - 2/28/2025, the MAR indicated Resident 39 was to receive clonidine tablet 0.1 mg for hypertension. The MAR indicated medication parameter were to hold medication if systolic (top number of the blood pressure reading) blood pressure (BP) was less than 120. The MAR indicated medication parameters were not followed and medication was administered to Resident 39. The MAR indicated on: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. 2/3/2025 at 9:00 a.m. - Resident 39's systolic BP was 116. 2. 2/4/2025 at 9:00 a.m. - Resident 39's systolic BP was 109. 3. 2/10/2025 at 9:00 p.m. - Resident 39's systolic BP was 114. 4. 2/17/2025 at 9:00 a.m. - Resident 39's systolic BP was 113. During an interview on 2/28/2025 at 1:21 p.m. with the DON, the DON stated medication parameters served as guidelines for licensed nurses to follow when administering medications. The DON stated it was important to follow medication parameters to manage symptoms, prevent further escalation of symptoms and potentially cause an emergency. The DON stated if medication parameters are not followed signs and symptoms could continue and get worse. d. During a review of Resident 99's Admission Record, the admission record indicated Resident 99 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included acute myocardial infarction (heart attack), low back pain, and type two diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 99's MDS, dated [DATE], the MDS indicated Resident 99's cognition was moderately impaired. The MDS indicated Resident 99 required maximal assistance (helper does more than half the effort) with oral hygiene, upper body dressing, and personal hygiene. The MDS indicated Resident 99 took opioid medication in the facility. During a review of Resident 99's H&P, dated 10/19/2024, the H&P indicated Resident 99 had the capacity to understand and make decisions. During a review of Resident 99's Order Recap Report, dated 6/1/2024 through 2/28/2025, the Order Recap Report indicated to give: a. Norco 5-325 milligrams (mg, unit of measurement), by mouth, every six hours, as needed for chronic lower back pain. The order date was 2/12/2025. b. Tylenol 500 mg, by mouth, every six hours, as needed for pain. The order date was 9/22/2024. During an interview on 2/24/2025 at 10:26 a.m., with Resident 99, Resident 99 stated he had chronic back pain that required Norco to effectively manage his pain. Resident 99 stated the licensed nurses told him he ran out of Norco and had to wait for more to be delivered. Resident 99 stated the licensed nurses gave him Tylenol (medication to treat pain) instead but would not relieve all his pain. Resident 99 stated he felt frustrated the facility could not ensure his Norco was readily available when he had pain. During a concurrent observation and interview on 2/24/2025 at 10:40 a.m. with LVN 5 in Resident 99's room, LVN 5 administered Tylenol to Resident 99. LVN 5 stated Resident 99 received Norco on 2/23/2025 at 8 p. m. and the dose was the last in Resident 99's bubble pack (a card holding medicinal tablets or capsules that are individually packaged in a clear plastic case sealed to the card). LVN 5 stated the facility was waiting for Resident 99's physician to sign the prescription so the pharmacy could deliver more Norco for Resident 99 to the facility. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
California Post-Acute Care	3615 E. Imperial Hiwy Lynwood, CA 90262

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 2/28/2025 at 8:54 a.m. with the DON, Resident 99's Controlled Drug Record for Norco, dated 2/12/2025 through 2/23/2025 was reviewed. The DON stated the Controlled Drug Record indicated to reorder the medication when 14 doses of Norco remained. The DON stated the process of refilling a controlled medication included faxing the medication sticker to the pharmacy, the pharmacy would request the physician's signature, then the medication would be delivered to the facility. The DON stated reordering the Norco with 14 doses left would allow ample time for the pharmacy to process the order and delivery the medication before the bubble pack was finished. The DON stated Resident 99's Norco should have been reordered from the pharmacy on 2/19/2025 to ensure another Norco bubble pack was delivered to the facility prior to the last dose given on 2/23/2025. During a concurrent interview and record review on 2/28/2025 at 8:59 a.m. with the DON, the facility's Fax to the pharmacy, dated 2/25/2025, was reviewed. The DON stated the facility requested a refill for Resident 99's Norco on 2/25/2025. The DON stated Resident 99's bubble pack of Norco was finished on 2/23/2025. The DON stated Resident 99's Norco was not reordered timely to ensure adequate stock to administer to treat Resident 99's pain. During a concurrent interview and record review on 2/28/2025 at 9:01 a.m., with the DON, the facility's Packing Slip Proof of Delivery, dated 2/26/2025, was reviewed. The DON stated Resident 99's Norco 5-325mg was delivered to the facility on [DATE] at 4:31 a.m. The DON stated Resident 99's Norco was unavailable from 2/23/2025 through 2/26/2025, while the facility was waiting for the Norco to be delivered. The DON stated Resident 99 had a history of chronic back pain and Norco was the most effective in treating Resident 99's pain. The DON stated due to Resident 99's Norco being unavailable, Resident 99 was administered Tylenol (a medication to treat pain) instead, which resulted in Resident 99's pain being ineffectively managed. During a concurrent interview and record review on 2/26/2025 at 11:26 a.m., with LVN 4, Resident 99's Controlled Drug Record for Norco, dated 2/26/2026, was reviewed. LVN 4 stated a new bubble pack of Norco was delivered on 2/26/2025 and LVN 9 administered one dose of Norco to Resident 99 at 9:35 a.m. During a concurrent interview and record review on 2/26/2025 at 11:28 a.m., with LVN 9, Resident 99's MAR, dated 2/26/2025, was reviewed. LVN 9 stated the MAR indicated Resident 99's last administration of Norco was 2/25/2025 at 9:54 a.m. LVN 9 stated she administered Norco to Resident 99 on 2/26/2025 at 9:355 a.m. but she did not document on Resident 99's MAR. LVN 9 stated after she removed the Norco from the bubble pack, she documented on the Controlled Drug Record, administered the Norco to Resident 99, but before she could document on Resident 99's MAR she was pulled to something else. LVN 9 stated, I got distracted and did not document on Resident 99's MAR. LVN 9 stated she was responsible for immediately documenting on Resident 99's MAR after administering the Norco to Resident 99. During an interview on 2/28/2025 at 9:04 a.m., with the DON, the DON stated when a resident was administered a controlled medication, the licensed nurse was responsible to check and compare the medication on hand to the active order, remove the medication from the bubble pack, document on the Controlled Drug Record, administer the medication, and document the administration on the MAR. The DON stated the documentation on the MAR was the proof the licensed nurse administered the medication and communicated to the next licensed nurse when the medication could be administered next. The DON stated because LVN 9 did not document immediately on Resident 99's MAR, Resident 99 was at risk of double administration of Norco if he were to request from a different licensed nurse. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Pain Management Program, dated 1/2019, the P&P indicated the pain management program was based on a facility-wide commitment to resident comfort. A review of the facility's P&P, titled Specific Medication Administration Orders, dated 1/2022, the P&P indicated Medications are administered in accordance with written orders of the prescriber. During a review of the facility's policy and procedure (P&P) titled, Controlled Medications, undated, the P&P indicated, When a controlled medication is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and the medication administration record (MAR): date and time of administration, amount administered, [and the] signature of the nurse administering the dose, completed after the medication is actually administered. The P&P indicated, Schedule Two controlled medications are reordered when a seven-day supply remains to allow time for transmittal of the required original written prescription to the provider pharmacy. During a review of the facility's P&P, titled Medication Administration- Guidelines dated 1/2022, the P&P indicated If a dose seems excessive considering the resident's age and condition, or a medication order seems to be unrelated to the resident's current diagnoses or conditions, the nurse calls the provider pharmacy for clarification prior to the administration of the medication or if necessary, contacts the prescriber for clarification. This interaction with the pharmacy and/or prescriber and the resulting order clarification are documented in the nursing notes and elsewhere in the medical record as appropriate.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47679 Based on interview and record review, the facility failed to provide the correct indication of use and monitoring for two of five sampled residents' (Residents 277 and 81) medication by failing to: 1. Ensure the correct indication of use for Resident 277's use of pregabalin (anticonvulsant [medication to prevent or treat seizures] and can be used to treat nerve and muscle pain). This deficient practice resulted in the licensed nurses administering pregabalin to prevent seizures instead of the treatment for diabetic neuropathy (complication when high blood sugar levels over time damage the blood vessels that nourish and protect the nerves). This deficient practice had the potential to result in the mismanagement of Resident 277's neuropathy pain. 2. Monitor for signs and symptoms of bleeding for Resident 277's use of enoxaparin (anticoagulant [medication used to treat blood clots from forming in the blood vessels and the heart]) and for Resident 81's use of apixaban (anticoagulant medication). This deficient practice had the potential to result in Residents 277 and 81 suffering from undetected hemorrhage (release of blood from a broken blood vessel, either inside or outside of the body). Findings: 1. During a review of Resident 277's Admission Record (Face Sheet), the Face Sheet indicated Resident 277 was admitted to the facility on [DATE] with diagnoses that included bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), type two diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing), and sepsis (a life-threatening blood infection). During a review of Resident 277's Minimum Dat Set ([MDS], a resident assessment tool), dated 2/20/2025, the MDS indicated Resident 277's cognition (process of thinking) was moderately impaired. The MDS indicated Resident 277 required moderate assistance (helper does less than half the effort) with toileting, bathing, upper body dressing, and personal hygiene. During a review of Resident 277's History and Physical (H&P), dated 2/15/2025, the H&P indicated Resident 277 had the capacity to understand and make decisions. During a review of Resident 277's Order Recap Report, dated 2/1/2025 through 2/28/2025, the Order Recap Report indicated to give pregabalin 50 milligrams (mg, a unit of measurement), by mouth, two times a day for seizures. The order date was 2/14/2025. During an interview on 2/26/2025 at 8:21 a.m., with the Minimum Data Set Nurse (MDSN), the MDSN stated when a resident was initially admitted to the facility, their hospital discharge paperwork was reviewed and information such as diagnoses, and medication indications of use were inputted into the resident's medication record. The MDSN stated she did not know if Resident 277 had seizures and if pregabalin was used to prevent seizures. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/28/2025 at 9:28 a.m., with the Director of Nursing (DON), the DON stated she clarified with Resident 277's physician regarding the use of pregabalin for seizures. The DON stated Resident 277 was taking pregabalin, prior to her admission the facility, to treat diabetic neuropathy. The DON stated administering pregabalin for the wrong indication placed Resident 277 at risk for unmanaged pain control due to the licensed nurses assessing Resident 277 for seizures and not for pain. During a review of the facility's policy and procedure (P&P) titled, Medication Therapy, dated 12/2017, the P&P indicated, Each resident's medication regimen shall include only those medications necessary to treat existing conditions and address significant risks. 2a. During a review of Resident 277's Order Recap Report, dated 2/1/2025 through 2/28/2025, the Order Recap Report indicated to inject enoxaparin 40mg subcutaneously (in the fatty tissue), every 24 hours for anticoagulation. During a review of Resident 277's Care Plan, dated 2/21/2025, the Care Plan indicated Resident 277 received enoxaparin for anticoagulation therapy and had staff interventions to monitor, document, and report signs and symptoms of bleeding. During a concurrent interview and record review on 2/26/2025 at 10 a.m., with Registered Nurse (RN) 2, Resident 277's Order Recap Report, dated 2/1/2025 through 2/28/2025, was reviewed. RN 2 stated Resident 277 did not have an order to monitor for signs and symptoms of bleeding related to enoxaparin. RN 2 stated Resident 277 was at risk of bleeding and Resident 277 should be monitored for any kind of bleeding, which could be an indication of a more serious medical condition to be reported to her physician. 2b. During a review of Resident 81's Admission Record (Face Sheet), the Face Sheet indicated Resident 81 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety disorder (a mental health condition that involves excessive fear, worry, and dread), and encephalopathy (general condition where brain function is impaired). During a review of Resident 81's MDS, dated [DATE], the MDS indicated Resident 81's cognition was intact. The MDS indicated Resident 81 was dependent on staff's assistance with toileting, bathing, and lower body dressing. The MDS indicated Resident 81 received anticoagulant medication. During a review of Resident 81's History and Physical (H&P), dated 1/28/2024, the H&P indicated Resident 81 had the capacity to understand and make decisions. During a review of Resident 81's Order Recap Report, dated 6/1/2024 through 2/28/2025, the Order Recap Report indicated to give apixaban 5 mg, by mouth, every 12 hours, for blood clot. The order date was 1/27/2025. During a concurrent interview and record review on 2/26/2025 at 10:03 a.m., with RN 2, Resident 81's Order Recap Report, dated 6/1/2024 through 2/28/2025, was reviewed. RN 2 stated Resident 81 did not have an order to monitor for signs and symptoms of bleeding related to apixaban. RN 2 stated Resident 81 was at risk of bleeding and Resident 81 should be monitored for any kind of bleeding, which could be an indication of a more serious medical condition to be reported to her physician. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/28/2025 at 9:21 a.m., with the Director of Nursing (DON), the DON stated all residents on an anticoagulant medication should be monitored every shift for signs and symptoms of bleeding. The DON stated Resident 277 and 81 received anticoagulant medication in the facility and the licensed nurses were responsible for documenting every shift whether bleeding was seen or not. The DON stated monitoring for any signs of bleeding was essential to intervene before the bleeding became a medical emergency. During a review of the facility's policy and procedure (P&P) titled, Anticoagulation Therapy Management, dated 7/2017, the P&P indicated, Throughout anticoagulant therapy, monitor the resident for signs and symptoms of bleeding. If signs and symptoms of bleeding are noted, 'Hold' anticoagulant medication and notify physician immediately.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47679 Based on interview and record review, the facility failed to provide monitoring for two of five sampled residents (Resident 81 and 277) who received psychotropic medications (medication that affect the brain and alters mood, thoughts, emotions, and behaviors) by failing to: 1. Monitor adverse reactions and effectiveness of Resident 277's use of quetiapine (antipsychotic medication [medications that affect the mind, emotions, and behavior]). 2. Monitor adverse reactions and effectiveness of Resident 81's use of Trazodone (an antidepressant [a medication used to treat depression, which is a mood disorder that causes a persistent feeling of sadness and loss of interest]) and Seroquel (an antipsychotic medication). These deficient practices had the potential to result in undetected adverse reactions associated with psychotropic medications and Resident 277 and 81's behaviors being mismanaged. Findings: 1. During a review of Resident 277's Admission Record (Face Sheet), the Face Sheet indicated Resident 277 was admitted to the facility on [DATE] with diagnoses that included bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), type two diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing), and sepsis (a life-threatening blood infection). During a review of Resident 277's Minimum Dat Set ([MDS], a resident assessment tool), dated 2/20/2025, the MDS indicated Resident 277's cognition (process of thinking) was moderately impaired. The MDS indicated Resident 277 required moderate assistance (helper does less than half the effort) with toileting, bathing, upper body dressing, and personal hygiene. The MDS indicated Resident 277 received antipsychotic medication. During a review of Resident 277's History and Physical (H&P), dated 2/15/2025, the H&P indicated Resident 277 had the capacity to understand and make decisions. During a review of Resident 277's Order Recap Report, dated 2/1/2025 through 2/28/2025, the Order Recap Report indicated to give quetiapine 500 milligrams (mg, unit of measurement), by mouth, two times a day for bipolar depression as manifested by restlessness, cursing, and calling nurses names. The order date was 2/20/2025. During a review of Resident 277's Care Plan, dated 2/21/2025, the Care Plan indicated Resident 277 used quetiapine related to bipolar depression and had staff interventions to monitor, document, and report any adverse reactions of the psychotropic medication and to monitor, record, and document the occurrence of target behavior symptoms. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 2/26/2025 at 10:10 a.m., with Registered Nurse (RN) 2, Resident 277's Order Recap Report, dated 2/1/2025 through 2/28/2025, was reviewed. RN 2 stated Resident 277 did not have an order to monitor for adverse reactions nor the effectiveness of Resident 277's quetiapine use. RN 2 stated the licensed nurses were responsible for monitoring for any adverse reactions related to quetiapine so Resident 277's physician would be aware and determine the next course of action. RN 2 stated Resident 277 exhibited behaviors that were treated with quetiapine. RN 2 stated monitoring and documenting the occurrence of those behaviors were essential in communicating to Resident 277's physician whether the quetiapine was effective or not. RN 2 stated consistent documentation of the effectiveness of Resident 277's quetiapine would allow Resident 277's physician to decide whether the medication would need to be increased or possibly decreased. 2. During a review of Resident 81's Admission Record (Face Sheet), the Face Sheet indicated Resident 81 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety disorder (a mental health condition that involves excessive fear, worry, and dread), and encephalopathy (general condition where brain function is impaired). During a review of Resident 81's MDS, dated [DATE], the MDS indicated Resident 81's cognition was intact. The MDS indicated Resident 81 was dependent on staff's assistance with toileting, bathing, and lower body dressing. The MDS indicated Resident 81 received anticoagulant medication. During a review of Resident 81's History and Physical (H&P), dated 1/28/2024, the H&P indicated Resident 81 had the capacity to understand and make decisions. During a review of Resident 81's Order Recap Report, dated 6/1/2024 through 2/28/2025, the Order Recap Report indicated to: a. Give Trazodone 50 mg, by mouth, at bedtime for depression as manifested by verbalization of sadness. The order date was 6/19/2024. b. Give Seroquel 100mg, by mouth, one time a day, for psychosis (a mental health condition characterized by a loss of contact with reality) as manifested by auditory hallucinations (hearing sounds or voices that are not real) of commanding voices. During a review of Resident 81's Care Plan, dated 11/27/2024, the Care Plan indicated Resident 81 used Seroquel 100mg related to psychosis and with staff interventions to monitor, document, and report any adverse reactions of the psychotropic medication and to monitor, record, and document the occurrence of target behavior symptoms. During a review of Resident 81's Care Plan, dated 2/5/2025, the Care Plan indicated Resident 81 used Trazodone 50mg related to depression with staff interventions to monitor, document, and report any adverse reactions of the psychotropic medication and to monitor, record, and monitor every shift and tally by hashmarks the occurrence of behavior. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 2/26/2025 at 10:16 a.m., with RN 2, Resident 81's Order Recap Report, dated 6/1/2024 through 2/28/2025, was reviewed. RN 2 stated Resident 81 did not have an order to monitor for adverse reactions nor the effectiveness of Resident 81's Seroquel and Trazodone use. RN 2 stated the licensed nurses were responsible for monitoring for any adverse reactions related to Seroquel and Trazodone. RN 2 stated Resident 81 exhibited behaviors that were treated with Seroquel and Trazodone. RN 2 stated monitoring and documenting the occurrence of those behaviors were essential in communicating to Resident 81's physician whether the treatments were effective or not. RN 2 stated consistent documentation of the effectiveness of Resident 81's Seroquel and Trazodone would allow Resident 81's physician to decide whether the medication dosages would need to be adjusted. During an interview on 2/28/2025 at 9:28 a.m., with the Director of Nursing (DON), the DON stated residents on psychotropic medications had to be monitored for adverse reactions of the medications and the occurrences of their manifested behaviors treated by the medications. The DON stated Resident 277 and 81 should have been monitored for adverse reactions and in the event any symptoms occurred, the licensed nurses would notify their physician and implement any new orders. The DON stated monitoring and documenting the number of behavior occurrences was the main tool Resident 277 and 81's physician would use to determine if a gradual dose reduction ([GDR], a stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose of if the dose or medication can be discontinued) was appropriate. During a review of the facility's policy and procedure (P&P) titled, Psychoactive Medication Assessment, dated 7/2017, the P&P indicated, The facility will use a psychoactive medication assessment to document information collected for the resident.

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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** 46832 Based on observation, interview, and record review, the facility failed to: 1. Ensure a medication error rate of less than 5 percent (%) for one of three sampled residents (Resident 62). This deficient practice had the potential to result in inconsistent medication administration and further skin breakdown. Findings During a review of Resident 62's Admission Record, the admission record indicated Resident 62 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included ulcer of the left lower extremity (an open sore on the leg that takes more than two weeks to heal), acute kidney failure, hypertension and benign prostatic hyperplasia. During a review of Resident 62's Minimum Data Set (MDS- a resident assessment tool), dated 12/24/2024, indicated Resident 62's cognitive skills (ability to think and reason) was intact. The MDS also indicated Resident 62 was dependent on staff with activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) such as toileting needs, showering and upper/lower body dressing. During a review of Resident 62's physician orders, the physician order indicated Arginaid (a medication used for wound healing) Oral Packet (Nutritional Supplements) Give 1 packet by mouth two times a day for dietary supplement.' with a start date of 12/19/2024. During a review of Resident 62's physician orders, the physician order indicated ProHeal (a medication used for wound healing) Oral Protein two times a day for supplement' with a start date of 8/14/2024. During a medication administration observation, on 02/25/2025, at 8:20 a.m., there were a total of two medication errors out of 28 opportunities. These medication administration errors resulted to a medication error rate of 7.14%. During a concurrent interview and record review, on 2/25/2025, at 8:26 a.m., with Licensed Vocational Nurse 3 (LVN 3), LVN 3 was observed prepping for medication administration for Resident 62. LVN 3 verified physician order for ProHeal for Resident 62. LVN 3 stated the physician order did not clarify the amount of ProHeal Resident 62 should had received. LVN 3 stated Resident 62 had received 30 milliliters (mL- metric unit of measurement, used for medication dosage and/or amount) per manufacturer's instructions on the bottle since 8/14/2024. LVN 3 stated the physician's order should have been clarified and the medication withheld. LVN 3 stated the risk of administering a medication without a dosage could result in overdosing and delay of wound healing. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review, on 2/25/2025, at 8:32 a.m., with LVN 3, LVN 3 verified Resident 62's physician order for Arginaid. LVN 3 stated Arginaid was not in stock at the facility. LVN 3 stated the medication should had been reordered. LVN 3 stated the risk of not having the medication on hand at the facility could result in a delay in wound healing and care. During a review of the facility's policy and procedures (P&P), titled Medication Administration- Guidelines, dated 1/2022, the P&P indicated the nurse should call the provider pharmacy prior to the administration of the medication or, if necessary, contact the prescriber for clarification if a dose needs clarification.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 46832 Based on observation and interview, the facility failed to: 1. Ensure a medication bottle had a legible label in Station B's medication cart. 2. Ensure insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) pens were labeled in Station A's medication storage room. This deficient practice had the potential to result in medication errors. Findings: During a concurrent observation and interview, on 2/26/2025, at 9:06 a.m., with Registered Nurse 2 (RN 2) in Station A's medication storage room, RN 2 observed one opened and one unopened Fiasp FlexTouch (a pre-filled, disposable insulin pen containing insulin aspart, a rapid-acting insulin) insulin pens in the medication refrigerator. RN 2 stated there was no label to indicate which resident the medication belonged to. RN 2 stated the risk of having unlabeled medication in the refrigerator could result in administering to the wrong resident and medication errors. During a concurrent observation and interview, on 2/26/2025, at 11:13 a.m., with Licensed Vocational Nurse 4 (LVN 4), LVN 4 observed a medication bottle with an illegible label in the medication cart. LVN 4 stated the label was not intact. LVN 4 stated the medication would not be safe to give. LVN 4 stated the risk of storing a medication with an illegible label could result in medication errors. During a review of the facility's policy and procedures (P&P), titled Medication Administration- General Guidelines, dated 1/2022, the P&P indicated FIVE RIGHTS- Right resident, right drug, right dose, right route and right time, are applied for each medication being administered. and Medication- label, container and contents are checked for integrity, and compared against the medication administration record (MAR) by reviewing the 5 Rights.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 45009 Based on observation, interview, and record review, the facility failed to ensure dietary staff served omelets as indicated on the menu for 124 residents. This deficient practice resulted in the residents being served scrambled eggs instead of an omelet for breakfast on 2/27/2025. Findings: During an observation on 2/27/2025 at 7:46 a.m. in the kitchen, Dietary [NAME] (DC) 2 scooped scrambled eggs onto a plate and poured salsa on top of the eggs. During an interview on 2/27/2025 at 7:50 a.m. with DC 2, DC 2 stated on 2/27/2025, she served residents scrambled eggs for breakfast. DC 2 stated she cooked her daily meals based on the facility's dietary menus. DC 2 stated scrambled eggs were on the breakfast menu for 2/27/2025. During a concurrent interview and record review on 2/28/2025 at 2:33 p.m. with the Dietary Manager (DM), the menu dated 2/27/2025 was reviewed. The menu indicated residents were supposed to receive an omelet for breakfast. The DM stated cooks must follow the menus when cooking for residents. The DM stated she was not aware that scrambled eggs were served instead of an omelet. The DM stated an omelet was beaten eggs folded in half and it was different than scrambled eggs. The DM stated she must be informed of all food changes and the dietary cook did not notify her of the omelet substitution. The DM stated she must be notified of all food changes because she must notify the dietician (an expert on diet and nutrition) and find out if the food item changes had the same nutritional value, same number of calories, and protein. The DM stated she must be informed of food substitutions because she had to inform the residents. The DM stated it was important to follow the menus because they were developed to provide a nutritional value to residents. During a review of the facility's Policy and Procedure (P&P) titled Menu Planning, dated 2023, the P&P indicated all menu changes, and the reason for the change are to be noted on the back of menu sheet. The P&P indicated the DM and dieticians are the only ones that could make permanent food changes from the menu. The P&P indicated the DM must get the dieticians approval for any food changes. The P&P indicated menu changes should also be noted on the menus on the resident's board and on any other menus which may be posted.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45009 Based on observation, interview, and record review, the facility failed to ensure a safe and sanitary food storage practice in the kitchen that affected 146 residents out of 146 sampled residents when: 1. The refrigerator contained food items with no in date (the date when the food was placed in the refrigerator) and no use by date (date the food item must be consumed by), and an unlabeled juice pitcher with no in date and use by date. 2. The freezer had food that was not labeled with an in date and a use by date. 3. The dry storage room had food items that were not labeled with a use by date, empty cans and empty cracker packages on the food rack. 4. The dietary staff did not ensure pasteurized eggs (eggs that have been heated to kill harmful bacteria without cooking them) were available for residents. 5. Dietary Aide (DA) 1 did not remove their gloves when moving to another task. 6. The dietary staff did not have oranges and apples available for residents. These failures had the potential to result in harmful bacteria growth and cross contamination that could lead to foodborne illness in residents that are medically compromised. Findings: 1. During the initial kitchen tour on 2/24/2025 at 8:39 a.m., in the kitchen, food items and drinks in the refrigerator did not have a use by date. 2. During the initial kitchen tour on 2/24/2025 at 8:45 a.m., in the kitchen, the food in the freezer did not have a use by date. 3. During the initial kitchen tour on 2/24/2025 at 8:46 a.m., in the dry storage room, the food items did not have a use by date. The dry storage room had an empty juice can and a used cracker wrapper on the food rack. During an interview on 2/27/2025 at 8:11 a.m. with the Dietary Manager (DM), the DM stated all food items in the kitchen must be labeled with a received date, open date and a use by date. The DM stated if food items are not labeled correctly, dietary staff would not know how long food items had been there and when it should be taken out. The DM stated once a food product has been opened, the expiration date changes. The DM stated there should not be any empty cans or empty cracker wrappers in the storage room for infection prevention. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4. During the initial kitchen tour on 2/24/2025 at 9:24 a.m., in the walk-in refrigerator, observed two boxes of 12 cartons of liquid pasteurized eggs. During an interview on 2/24/2025 at 9:26 a.m. with the DM, in the walk-in refrigerator, the DM stated the facility only had liquid pasteurized eggs. The DM stated it was hard to get to get shelled eggs because they were very expensive. During an interview on 2/27/2025 at 8:05 a.m. with Dietary [NAME] (DC) 1, DC 1 stated the facility received eggs on 2/25/2025. DC 1 stated it had been over one month that the facility did not have shelled eggs. DC 1 stated during that time all residents received scrambled eggs only. DC 1 stated many residents requested fried eggs but received scrambled eggs. DC 1 stated dietary staff were supposed to provide food requested by the residents but could not provide fried eggs because the facility only had liquid eggs. During an interview on 2/27/2025 at 8:39 a.m. with the DM, the DM stated the facility did not have shelled egg and only had liquid eggs. The DM stated there were residents that requested fried eggs for breakfast but did not receive them. The DM stated the facility could not provide fried eggs to residents when they requested them because there was only liquid eggs. The DM stated it was important to have shelled eggs available for residents because food preferences make them happy. 5. During an observation on 2/26/2025 at 12:19 p.m. in the kitchen, Dietary Aide (DA) 1 was observed making a sandwich while wearing gloves. DA 1 did not remove the gloves when he walked to the dry storage room to get food items. DA 1 came back with ham and continued making the sandwich. DA 1 walked to the trash can and touched the trash lid and returned to finish making the sandwich. DA 1 did not remove his gloves. During an interview on 2/27/2025 at 9:00 a.m. with the DM, the DM stated dietary staff must remove their gloves before they move to another task. The DM stated dietary staff must change their gloves for infection control. The DM stated this practice could potentially cause a cross contamination and could cause residents to get sick. 6. During an observation on 2/27/2025 at 8:48 a.m. in the walk in refrigerator, there was one apple observed in the apple bin. The orange bin was empty. During an interview on 2/27/2025 at 8:50 a.m. with the DM in the refrigerator, the DM stated the facility should have 10 pounds of oranges and 10 pounds of apples available for residents. The DM stated it was important to have apples and oranges available for residents because this was their home and food was important to them. The DM stated when a resident requested fresh fruit, the facility should be able to give them an apple or an orange. During a review of the facility's Policy and Procedure (P&P) titled Labeling and Dating of Foods, dated 2023, the P&P indicated all food items in the storeroom, refrigerator, and freezer need to be labeled and dated. The P&P indicated food delivered to the facility needs to be marked with received date. The P&P indicated newly opened food items will need to be labeled with an open date and a used by date. The P&P indicated all prepared food must be covered, labeled and dated. The P&P indicate produce must be dated with received date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of facility's P&P titled Storage of Food and Supplies, dated 2023, the P&P indicated the storeroom (dry storage room) would be clean at all times. During a review of facility's P&P titled Glove Use Policy, dated 2023, the P&P indicated appropriate use of gloves is essential in preventing food borne illness. The P&P indicated gloves needed to be changed before beginning a different task.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 47679 Based on interview and record review, the facility failed to retain Medication Regimen Review ([MRR], thorough evaluation of the medication regimen of a resident) documentation for all the residents in the facility prior to December 2024. This deficient practice had the potential to result in the facility not carrying out the recommendations made from the consulting pharmacist and attending physicians. Findings: During a concurrent interview and record review on 2/25/2025 at 3:30 p.m., with the Director of Nursing (DON), the facility's MRR dated, December 2024 and January 2025, were reviewed. The DON stated she was unable to locate the MRR recommendations and responses from the residents' physicians starting from before December 2024. The DON stated she could request the recommendations from the consulting pharmacists but would not be able to obtain the responses from the residents' physicians. During an interview on 2/28/2025 at 9:32 a.m. with the DON, the DON stated residents' records should be retained in-house for at least five years. The DON stated she was hired and started as the DON in January 2025 and could not locate the MRR prior to December 2024. The DON stated the MRR was important documents to retain because the MRR contained recommendations from the consulting pharmacists and the documentation whether the residents' physicians agreed, and a new order was placed or disagreed with the recommendations with a rationale. The DON stated without the complete MRR documentation, the facility was unable to ensure recommendations were carried out and if the appropriate adjustments to medications were made. During a review of the facility's policy and procedure (P&P) titled, General Record Policies, dated 11/2021, the P&P indicated, Clinical records, electronic, and/or manual, will be kept for each resident admitted for care.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48131 Based on observation, interview, and record review, the facility to failed ensure the oxygen nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) was labeled and dated for one of two sampled residents (Resident 36). This deficient practice placed Resident 36 at risk infection. Findings: During an observation on 2/24/2025 at 10:51 a.m , while in Resident 36's room, observed Resident 36 lying in bed receiving oxygen via nasal cannula at two LPM. Observed Resident 36's nasal cannula was not dated or labeled. During a review of Resident 36's Admission Record, dated 2/27/2024, the admission record indicated Resident 36 was initially admitted on [DATE] and readmitted on [DATE]. The admission record indicated the following diagnoses which included acute respiratory failure with hypoxia (when the lungs suddenly fail to adequately provide oxygen to the body, resulting in a dangerously low level of oxygen in the blood), and congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). During a review of Resident 36's History and Physical (H&P), dated 11/21/2024, the H&P indicated Resident 36 had the capacity to understand and make decisions. During a review of Resident 36's Minimum Data Set (MDS - a resident assessment tool), dated 1/23/2025, the MDS indicated Resident 36's cognition (ability to think, remember, and reason) was moderately impaired. The MDS indicated Resident 36 eats independently (resident completes the activity by himself with no assistance) and was dependent (helper does all the effort) for toileting, bathing and personal hygiene. During a review of Resident 36's Order Summary Report dated 2/27/2025, the order summary report indicated Resident 36 had an active order on 2/22/2025 for oxygen at two liters (unit of volume) per minute (LPM) via nasal cannula as needed for shortness of breath. During an interview on 2/27/2025 at 1:11 p.m., with the Infection Preventionist Nurse (IPN), the IPN stated all oxygen tubing should be dated and labeled weekly by the charge nurse. The IPN stated if the oxygen tubing is not changed the tubing can become dirty with a build up of mucus and cause irritation to the nose. The IPN stated it was important to ensure Resident 36's oxygen tubing was changed because dirty oxygen tubing could lead to infection. The IPN stated oxygen tubing with no label or date should be changed, then labeled and dated. During an interview on 2/27/2025 at 3:07 p.m., with the Director of Nursing (DON), the DON stated oxygen nasal cannulas should be changed and dated every week for infection control and to ensure proper function of the nasal cannula. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedures (P&P) titled, Guidelines for Changing of Disposable Respiratory Equipment, dated August 2017, the P&P indicated the purpose of the policy was to decrease hospital acquired infections. The P&P indicated to change nasal cannulas every seven days or as often as necessary. The P&P indicated to label respiratory equipment with resident's name, room number, and date changed.