STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055064	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cottonwood Canyon Healthcare Center	1391 Madison Avenue El Cajon, CA 92021

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. 39449 Based on interview and record review, the facility failed to ensure call lights were answered in a timely manner for a confidential group. This failure resulted in resident's suffering a lack of dignity when the confidential group voiced anger and frustration over call light incidences with the facility staff. The facility census was 86. Cross reference F851 Findings: On 12/10/24 at 10 A.M., a confidential group meeting was conducted. Three out of seven in attendance indicated complaints regarding the facility call light response time. According to the confidential group, the facility call light response depended on the shift, when staff were busy and there were times, staff took break all at the same time. The confidential group stated there were times they waited an hour for staff to answer call lights any time of the day. According to the confidential group the facility was understaffed and there were times, residents waited for an hour to get medications including pain medications. On 12/10/24, a record review of Resident Council Minutes on call light from September to November 2024 was conducted and indicated the following: 9/19/24 - call lights - ongoing concern 10/17/24 - call lights - on going concerns 11/29/24 - call lights are taking too long On 12/11/24 at 10:08 A.M., and interview was conducted with the Activity Director (AD). The AD stated when resident council have concerns, they go to department leaders. The AD stated call light response concerns were given to the Director of Staff Development (DSD). The AD stated the resident council stated call light response was a concern on all shifts. The AD stated the call light response concerns were ongoing. The AD stated there was no improvement on call light response. (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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/12/24 at 11:18 A.M., a concurrent interview and record review was conducted with the DSD. The DSD stated she received call light response concerns a few weeks ago. The DSD stated residents complained call light response took 30 minutes or more. The DSD stated she conducted in-services and follow up with residents and employees but call light response concerns were still ongoing. The DSD stated call light response was everyone's responsibility to make sure call light was answered timely. On 12/12/24 at 12:20 P.M., an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated the acceptable call light response time should be between less than five (5) minutes and longest call light response time should be 30 minutes. The ADON stated employees should respond to call light in a timely manner because residents would be upset. The ADON stated when residents wait for their pain medications, residents would yell and become agitated. The ADON stated when residents would wait for incontinent care (providing assistance in cleaning and changing residents when soiled), residents would be prone to infection and would be emotional and not feel comfortable. Per the undated facility policy titled, Answering the Call Light indicated, .the purpose of this procedure is to ensure timely responses to the resident's requests and needs .1. Answer the resident call system immediately .

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 36471 Based on observation, interview and record review, the facility failed to offer written and follow-up initiation of the advance directives for seven of 20 sampled residents (Residents 10, 29, 77, 36, 237, 61 and 62). This failure resulted in staff not knowing residents' directives regarding care and the residents' legal health care agent. Findings: 1. Resident 10 was admitted to the facility on [DATE] with diagnoses which included paranoid schizophrenia (a severe mental disorder that may interfere with a resident's ability to think, manage emotions, make decisions, and relate to others) per the Admission Record. Per the same document, Resident 10 was responsible for herself and had five emergency contacts. A review of Resident 10's medical record was conducted. Per the Physician Orders for Life-Sustaining Treatment (POLST), dated 7/29/24, under Section D, there was no information about the advance directive. Per the history and physical, dated 8/1/24, Resident 10 can make needs known but can not make medical decisions because Resident 10 has diagnosis of schizophrenia, which was not consistent with the facility's Admission Record. Upon further review of Resident 10's medical record, there was no evidence that the facility offered or had follow-up about Resident 10's advance directives. 2. Resident 29 was admitted to the facility on [DATE] with diagnoses which included cerebral infarction (blood flow to the brain was blocked) per the Admission Record. Per the same document, Resident 29 had two agents (DPOA- durable power of attorney) to manage Resident 29's care. A review of Resident 29's medical record was conducted. Per the Physician Orders for Life-Sustaining Treatment (POLST), dated 8/7/24, under Section D, there was no information about the advance directive. Upon further review of Resident 29's medical record, there was no evidence that the facility offered or had follow-up about Resident 29's advance directives. 3. Resident 77 was admitted to the facility on [DATE] with diagnoses which included protein malnutrition (not enough nutrients in the body) per the Admission Record. Per the same document, Resident 77 was responsible for himself. A review of Resident 77's medical record was conducted. Per the Physician Orders for Life-Sustaining Treatment (POLST), dated 11/14/24, under Section D, there was no information about the advance directive. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Upon further review of Resident 77's medical record, there was no evidence that the facility offered advance directives to Resident 77. On 12/12/24 at 2:45 P.M., an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated Resident 10, Resident 29, and Resident 77's medical records had no evidence that the advance directive was offered, followed up, or filed. The ADON further stated it was important to have the advance directive to ensure a resident's wishes were honored when a resident can no longer make decisions. Per the facility's policy and procedure, dated 9/22, titled Advance Directives, .the facility staff will offer assistance in establishing advance directives .the Nursing staff will document in the medical record the offer . 46235 4. Resident 36 was admitted to the facility on [DATE] with diagnoses including chronic osteomyelitis (bone infection) according to the facility's Admission Record. During an observation on 12/9/24 at 9:23 A.M., Resident 36's room door was closed with a sign on the wall which indicated enhanced barrier precaution (an approach when healthcare workers wore gowns and gloves during high contact with residents to reduce transmission of organisms). Resident 36 was sitting on a motorized wheelchair in his room and stated he was admitted to the facility with a wound. During a review of Resident 36's medical records, there was a Physician Order for Life-Sustaining Treatment (POLST- written order which outlines a resident's treatment preferences) dated, 8/26/24 but no advance directive. Section D of the POLST which pertained to advance directive was left blank. 5. Resident 237 was admitted to the facility on [DATE] with diagnoses including chronic pulmonary edema (fluid buildup in the lungs making it difficult to breathe) according to the facility's Admission Record. During an observation on 12/9/24 at 10:08 A.M., Resident 237 was in bed in his room with oxygen on via nasal cannula (small, flexible tube with two prongs that sit inside the nostrils to deliver oxygen). Resident 237 stated he still felt short of breath with the use of oxygen. Resident 237's medical records were reviewed. A POLST for Resident 237 dated 11/20/24 did not have information in section D regarding advance directive. There was no advance directive in Resident 237's medical records. An interview and joint record review was conducted on 12/11/24 at 9:36 A.M. with the ADON. The ADON stated Resident 237's POLST was left blank regarding advance directives. 6. Resident 62 was admitted to the facility on [DATE] with diagnoses including acute respiratory failure with hypoxia (a condition where the lungs fail to adequately exchange oxygen, leading to low oxygen in the blood) according to the facility's Admission Record. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/9/24 at 3:55 P.M. Resident 62 was observed yelling out, Ahh repeatedly while in bed in his room. Resident 62 was asked if he needed help, Resident 62 stated he wanted his doctor but did not state the reason. During a review of Resident 62's medical records, a POLST form dated 2/23/24 did not indicate if resident 62 had an advance directive. There was no advance directive found in resident 62's medical record or documentation that it was discussed with the resident or the resident's representative. An interview and joint record review was conducted on 12/11/24 at 9:36 A.M. with the ADON. The ADON stated Resident 62 had a durable power of attorney (legal decision maker) and the POLST was left blank regarding advance directives. 7. Resident 61 was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction (paralysis and weakness affecting one side of the body due to a stroke) according to the facility's Admission Record. Resident 61 was observed in bed in his room on 12/10/24 at 3:37 P.M. Resident 61 had a one-to-one certified nurse assistant (CNA) sitting at bedside. When Resident 61 was asked how he was doing, Resident 61 stated he was doing okay. A review of Resident 61's medical record was conducted. A POLST form dated 2/21/23 did not have boxes checked regarding advance directive. There was no advance directive in Resident 61's medical record or documentation that it was discussed with the resident or the resident's representative. During an interview on 12/10/24 at 8:10 A.M. with the Social Service Director (SSD), the SSD stated the POLST, and advance directives were followed up by the medical records staff. During an interview on 12/11/24 at 9:36 A.M. with the ADON, the ADON stated the charge nurse checked upon residents' admission for advance directives. The ADON stated medical records staff uploaded advance directives in the resident's medical records. The ADON further stated section D of resident's POLST should be completed for staff to know who can medically decide for the residents' care. An interview was conducted on 12/12/24 at 2:24 P.M. with the Director of Nursing (DON). The DON stated it was her expectation for nursing staff to check resident's hospital records for an advance directive or check with the resident's family. The DON stated social services was responsible for verifying the advance directive and then medical records staff will upload the forms in the resident's medical record. The DON further stated it was important to find out if a resident had an advance directive to provide proper care for the resident in the event of an emergency. A review of the facility's policy and procedure (P&P) titled, Advance Directives, dated September 2022 was reviewed. The P&P indicated, .Prior to or upon admission of a resident, the social services director or designee inquires of the resident, his/her family members and/or his her legal representative, about the existence of any written advance directives .The resident or representative is provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so .

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from medications that restrain them, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36471 Based on interview and record review, the facility failed to ensure a resident had an authorized responsible party to sign the informed consent for the use of the psychotropic medication (medications that affect brain activities associated with mental processes and behaviors) for one of five sampled residents reviewed for unnecessary medications (Resident 10). This failure may result in a conflict that impacts the decision-making process for Resident 10. Findings: Resident 10 was admitted to the facility on [DATE] with diagnoses which included paranoid schizophrenia (a severe mental disorder that may interfere with a resident's ability to think, manage emotions, make decisions, and relate to others) per the Admission Record. Per the same document, Resident 10 was responsible for herself and had five emergency contacts. A review of Resident 10's medical record was conducted. Per the Physician Orders for Life-Sustaining Treatment (POLST), dated 7/29/24, under Section D, there was no information about the advance directive. Upon further review of Resident 10's medical record, there was no evidence that Resident 10 had an advance directive. Per the history and physical, dated 8/1/24, Resident 10 can make needs known but can not make medical decisions because Resident 10 has schizophrenia, which was not consistent with the facility's Admission Record. Per the Order Summary Report, Resident 10 was taking Buspirone Hydrochloride (a medication that acts on the brain) 15 milligrams three times a day for anxiety (excessive worrying), beginning on 7/29/24, and Olanzapine 10 milligrams at bedtime for schizoaffective disorder (a mental health condition that was marked by a mix of schizophrenia symptoms) beginning 10/17/24. Per the Informed Consent dated 6/15/24, Resident 10 consented to the Buspirone. Per the Informed Consent, dated 7/29/24, Resident 10's sister-in-law verbally consented that Resident 10 may receive the olanzapine medication. On 12/12/24 at 8:23 A.M., an interview and joint record review were conducted with the Assistant Director of Nursing (ADON). The ADON stated Resident 10 was diagnosed with paranoid schizophrenia on 11/24/23, and because of that medical diagnosis, Resident 10 was not fit to make medical decisions for herself. The ADON further stated Resident 10 had five emergency contacts, the brother, sister-in-law, two sisters, and the case manager, who were involved with Resident 10's care. However, none of them were Resident 10's representatives for health care decisions. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/12/24 at 11:54 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated informed consent should have been signed by the resident or the responsible party. The DON further stated that Resident 10 could not sign the informed consent and that the facility had to find Resident 10's representative to help with health care decisions. Per the undated, policy and procedure titled Psychoactive/Psychotropic Medication Use, .The prescribing clinician will obtain informed consent from the resident (or, as appropriate, the resident representative) for the use of a psychotropic medication .

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47466 Based on interview and record review, the facility failed to ensure an advanced beneficiary notice (ABN-waiver of liability) was offered in one of six residents (Resident 39) reviewed for discharge . This failure had the potential for Resident 39 to not have options with regards to Resident 39's discharge placement or location and care. Findings: A review of the facility's Admission Record indicated Resident 39 was admitted to the facility on [DATE] with diagnoses that included primary hypertension (high blood pressure) and osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage). A record review of the Physician's Order Summary dated 12/2/24 indicated Resident 39 had an order for discharge for 12/3/24 to home with home health and durable medical equipment (DME). An interview on 12/12/24 at 11:02 A.M., with the Business Office Manager (BOM) was conducted. The BOM stated Resident 39 exhausted her Medicare (government insurance) benefits, but we did not offer an ABN when Resident 39 was discharged . BOM stated it was the Social Service Director's responsibility to do an ABN. An interview on 12/12/24 at 2 P.M., with the Social Service Director (SSD) was conducted. The SSD stated I did not do or offer an ABN for Resident 39. The SSD stated I should have offered an ABN for Resident 39 and her family for them to have options regarding her discharge placement and care. A record review of the SSD progress notes dated 12/3/24 indicated, Resident 39's daughter had called the facility and spoke to SSD regarding Resident 62's care at home. Resident 39's daughter indicated, she may not be able to lift Resident 39 from bed to wheelchair and had concerns with Resident's 39's DME and caregiver. A record review of the Discharge summary note dated 12/4/24 indicated Resident 39 was discharged to home at 4:30 P.M. and was picked up by private transport. An interview on 12/12/24 at 2:36 P.M., with the ADON was conducted. The ADON stated it was important for the facility to offer an ABN to provide an option for Resident 39 and her family to ensure a safe discharge and to prevent possible transfer to the acute. A review of the facility's policy and procedure titled, Admission, Transfer and Discharge, dated October 2022 did not provide guidance regarding ABN.

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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** 36471 Based on observation, interview, and record review, the facility failed to ensure comprehensive resident-centered care plans were developed and implemented for two of 20 sampled residents (Resident 29 and 62) when: 1. Resident 29 was not assisted in repositioning while in bed, and nail care was not performed. 2. Resident 62's pressure ulcer was not care planned. These failures had the potential to affect resident's care needs. Findings: 1. Resident 29 was admitted to the facility on [DATE] with diagnoses which included cerebral infarction (blood flow to the brain was blocked) per the Admission Record. A review of Resident 29's medical record was conducted. Per the Care Plan, under Focus [problem], Resident 29 was at risk for skin breakdown related to activity intolerance, impaired mobility, incontinence, and bedbound. In addition, the care plan indicated under Interventions/Tasks, the staff should assist in turning and repositioning Resident 29 as indicated or tolerated. Per the Care Plan, the facility's focus problem included Resident 29's nail trimming refusal. The care plan's intervention included staff would re-approach Resident 29 to the extent possible. On 12/11/24 at 8:43 A.M., Resident 29 was observed in bed, flat on her back, with eyes closed. On 12/11/24 at 10:25 A.M., Resident 29 was observed in bed, flat on her back, and awake. Resident 29 stated, I'm not comfortable. Resident 29 also showed both of her hands. It was observed that Resident 29's left fingers were trimmed. However, Resident 29's right hand was observed with half-inch long nails. Resident 29 could move the index finger and the thumb, but the middle, ring, and pinky fingers were bent, pointing inward, and the nails dug through the palm. On 12/11/24 at 11:53 A.M., an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated that a room assignment had been changed, and the assigned CNA for Resident 29 had left. CNA 1 further stated she took over the care for Resident 29 around 9:30 A.M. On 12/11/24 at 2:02 P.M., Resident 29 was observed in bed flat on her back. On 12/11/24 at 2:16 P.M., an interview and joint observation was conducted with CNA 1. CNA 1 stated she had not helped reposition Resident 29 in bed and would do it now. CNA 1 further stated she was unfamiliar with Resident 29's care and unsure when was the last time Resident 29's right fingernails were trimmed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/11/24 at 2:21 P.M., an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated residents should have been repositioned for about two to three hours or as tolerated. The ADON further stated that staff should have assisted Resident 29 with repositioning. The ADON stated Resident 29's right fingernails were long and should have been trimmed. On 12/11/24 at 2:27 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated she was aware of Resident 29's history of refusal, but nail care and repositioning should have been done. Per the facility's policy and procedure, dated 2/2018, titled Fingernails/Toenails, Care of, .Nail cares daily cleaning and regular trimming .Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin . Per the facility's policy and procedure, dated 5/2013, titled Repositioning, .Repositioning is critical for a resident who is immobile or dependent upon staff for repositioning . 46235 2. Resident 62 was admitted to the facility on [DATE] with diagnoses including disc degeneration (loss of cushioning in spine), lumbar region (lower back) with lower extremity pain according to the facility's Admission Record. On 12/9/24 at 3:55 P.M. Resident 62 was observed yelling out, Ahh repeatedly while in bed in his room. Resident 62 was asked if he needed help, Resident 62 stated he wanted his doctor but did not state the reason. An interview was conducted on 12/11/24 at 9:03 A.M. with certified nurse assistant (CNA) 17. CNA 17 stated Resident 62 was dependent with activities of daily living (ADL-basic tasks of everyday life). CNA 17 stated Resident 62 was started on enhanced barrier precaution (EBP-an approach when healthcare workers wore gowns and gloves during high contact with residents to reduce transmission of organisms) due to a wound on Resident 62's left foot. During an interview and joint record review on 12/11/24 at 9:36 A.M. with the ADON, the ADON reviewed Resident 62's care plans. The ADON stated there was a care plan regarding EBP but there was no care plan for Resident 62's left foot wound. The ADON stated it was important to have a care plan regarding Resident 62's wound for staff to know how to care for the resident. An interview was conducted on 12/12/24 at 2:24 P.M. with the Director of Nursing (DON). The DON stated it was expected for residents to have individualized care plans. The DON further stated it was important to have individualized care plans for staff to provide better care for the residents. A review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, dated March 2022 was conducted. The P&P indicated, .The interdisciplinary team (IDT), [team members with various areas of expertise who work together toward the goals of their residents] in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered plan for each resident .The comprehensive, person-centered care plan includes measurable objective and timeframes .describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39449 Based on observation, interview and record review, the facility failed to provide treatment and care according to professional standards of practice for two of 20 sampled residents when: 1. A physician's order to elevate both feet on a pillow was not provided (Resident 64), 2. A physician's order for route of medication was not followed. In addition treatment for jejunostomy tube site (JT- a tube inserted into the small intestine to help with nutrition and hydration) was not provided (Resident 286). These failures had the potential to place residents at risk for further medical complications. Findings: 1. Resident 64 was admitted to the facility on [DATE] with diagnoses to include hemiplegia (complete weakness of one side of the body) and hemiparesis (partial weakness of one side of the body) following a stroke and muscle weakness per the Admission Record. The following observations were conducted: 12/9/24 at 10:11 A.M. no pillows under both feet 12/10/24 at 11:04 A.M. no pillows under both feet 12/11/24 at 11:04 A.M. no pillows under both feet 12/11/24 at 3:08 P.M. no pillows under both feet 12/12/24 at 8:48 A.M. no pillows under both feet A review of Resident 64's Medication Administration Record (MAR) for December 2024 indicated elevate both feet with pillow marked with a check and licensed nurses' initials as complete. A review of the physician's History and Physical Examination dated 11/5/21 indicated Resident 64 could make needs known but could not make medical decisions. A review of the physician's Order Summary dated 9/15/24 indicated, elevate bilateral (both) feet with pillow every shift. On 12/12/24 at 9:06 A.M., a concurrent observation and interview was conducted with LN 21. Resident 64 was observed without a pillow under both feet. (continued on next page)

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	055064	A. Building B. Wing	12/12/2024

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Cottonwood Canyon Healthcare Center	1391 Madison Avenue El Cajon, CA 92021

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/12/24 at 11:31 A.M., concurrent interview and record review was conducted with the Director of Staff Development (DSD). The DSD stated Resident 64's physician order to elevate both feet should have been implemented to prevent foot drop. The DSD stated Resident 64's physician order should have been done by the licensed nurse. The DSD stated licensed nurses should inform the CNAs of Resident 64's physician order. On 12/12/24 at 11:59 A.M., a concurrent interview and record review was conducted with the ADON. The ADON stated it was the licensed nurses' responsibility and should check during their rounds. The ADON stated Resident 64's physician was not followed and should have notified the doctor. The facility did not provide policy and procedure regarding following physician's orders. 47466 2. A review of the facility's Admission Record indicated Resident 286 was admitted to the facility on [DATE] with diagnoses that included morbid obesity and malignant neoplasm (cancer) of the body of the stomach. An interview on 12/9/24 at 9:35 A.M., with Resident 286 was conducted. Resident 286 stated she arrived Thursday night 12/2/24. Resident 286 stated no one has done the treatment to her jejunostomy tube site (JT- a tube inserted into the small intestine to help with nutrition and hydration) and other LNs administered her medications by mouth instead of through her JT. A review of Resident 286 Minimum data set (MDS- a federally mandated assessment tool) dated 12/12/24 indicated a BIMS (brief interview for mental status) score of 15 which meant Resident 286's cognition was intact. An interview on 12/10/24 2:45 P.M., with LN 31 was conducted. LN 31 stated she had admitted Resident 286 and did not accurately transcribe the physician's order for Resident 286's JT site. A record review of the physician's Order Summary dated 12/5/24 indicated cleanse J-tube site with normal saline, pat dry and cover with dry dressing daily and PRN (as needed), and all medications should be administered via JT. An interview on 12/10/24 at 3:35 P.M., with the treatment nurse (TN) was conducted. The TN stated she had done Resident 286 treatment on her JT site but did not follow physician's order to apply a dry dressing. The TN stated she should have notified Resident 286's physician for JT site treatment. An interview and record review on 12/10/24 at 4:11 P.M., with licensed nurse (LN). LN 11 was conducted. LN 11 stated, she could not find the treatment order for the JT site on both the electronic medication and treatment administration record (EMAR/ETAR). In addition, LN 11 stated Resident 286's medications should be administered via JT. A record review of the Resident 286 skin care plan dated 12/5/24 indicated interventions/task, administer medication as ordered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 2/12/24 2:27 P.M., with the ADON was conducted. The ADON stated, it is important to follow the physician's orders, based on Resident 286 health issues, if they were worsening, avoiding complications in the end. A review of the facility's policy titled, Administering Medications through an Enteral Tube dated November 2018, .1)Verify that there is a physician's medication order .Dressings dry and /clean .1)Verify that there is a Physician's order for this procedure .3) check the treatment record .Medication and Treatment orders .9) Orders for medication must include .d) route of administration .

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39449 Based on observation, interview and record review, the facility failed to arrange an appointment for audiology (measure and evaluate hearing) for one of one residents reviewed for Vision and Hearing (Resident 59). This failure resulted in Resident 59 not having access to hearing aids to maintain his hearing. Findings: Resident 59 was readmitted to the facility on [DATE] per the facility Admission Record. A review of Resident 59's Brief Interview of Mental Status (BIMS, an assessment tool) dated 10/19/24 indicated 12 out of a possible 15 which meant moderately impaired mental cognition. A review of the physician's History and Physical Examination dated 8/12/24 indicated Resident 59 has the capacity to understand and make decisions. A review of the physician's order dated 8/9/24 indicated audiology evaluation and treatment. A review of the social services progress notes there was no documentation to indicate Resident 59 was seen by an audiologist (ear specialist). A review of Resident 59's appointments indicated audiology appointments on 8/29/24 and 9/26/24 were cancelled. On 12/9/24 at 9:38 A.M., a concurrent observation and interview was conducted with Resident 59. Resident 59 was in bed with head of his elevated. Resident 59 stated he could not walk. Resident 59 was hard of hearing and stated he had procedure on his ears a long time ago. On 12/11/24 at 9:44 A.M., an interview was conducted with CNA 21. CNA 21 stated Resident 59 could not walk and did not asked to get out of bed. CNA 21 stated Resident 59 required two-person hoyer lift (device used for transferring residents) for transfers. On 12/11/24 at 3:10 P.M., a concurrent interview and record review was conducted with the Social Service Director (SSD). The SSD stated she remembered making the audiology appointment for Resident 59 but did not see any progress notes related to the audiology consult. On 12/11/24 at 3:50 P.M., an concurrent interview and record review was conducted with the Unit Clerk. The Unit Clerk stated Resident 59 had a audiology consult on 8/29/24 but was cancelled because Resident 59 was bed bound and could not transfer to wheelchair. The Unit Clerk stated the clinic where Resident 59 was scheduled to go was small and could not accommodate a patient on a gurney. The Unit Clerk stated Resident 59's appointment was rescheduled on 9/26/24 but Resident 59 had refused physical therapy and could not tolerate a sitting position. The Unit Clerk stated he was not sure whether the DON and ADON were aware. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/12/24 at 8:10 A.M., a concurrent interview with the SSD, Social Service Assistant (SSA) and Unit Clerk was conducted. The SSD stated they did not follow up Resident 59's audiology consult scheduled for 8/29/24 and 9/26/24. The SSA stated Resident 59 had an ENT consult and was not aware of an audiology consult. The Unit Clerk stated Resident 59 was able to sit in a wheelchair at that time. The Unit Clerk stated the audiology clinic was small and could not accommodate a resident on a gurney and Resident 59 required an audiology clinic that could accommodate gurney transport. The SSD stated she should have followed up on Resident 59's audiology consult. On 12/12/24 at 12:15 P.M., a concurrent interview and record review was conducted with the ADON. The ADON stated the audiology consult was not done. The ADON stated the Unit Clerk's role was to coordinate appointment schedule and transportation, the social services coordinate with the physician, physical therapist, nursing, DON/ADON to make sure the implementation of the appointment and transportation and notify the physician if the physician order was not done. The ADON stated Resident 59 was not able to communicate properly because Resident 59 had hearing difficulty. Per the facility policy titled Referrals, Social Services, dated December 2008 indicated, .1. Social services shall coordinate most resident referrals .3. Social services will collaborate with the nursing staff or other pertinent disciplines to arrange for services that have been ordered by the physician .4. Social services will document the referral in the resident's medical record .6. Social services will help arrange transportation to outside agencies, clinic appointment, etc., as appropriate .

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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** 39449 Based on observation, interview and record review, the facility failed to ensure professional standards of practice when: 1. Physician's order for oxygen was not followed (Resident 16), 2. There was no order for oxygen (Resident 237). As a result, Resident 16 was provided with more oxygen than what was ordered. In addition this failure had the potential to affect Resident 237's respiratory status. Findings: 1. Resident 16 was admitted on [DATE] to the facility with diagnoses to include chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing) per the Admission Record. On 12/9/24 at 3: 15 P.M., an observation was conducted with Resident 16's oxygen (air) level at five liters per minute. A review of Resident 16's physician orders dated 11/3/24 indicated oxygen at four liters per minute via nasal cannula (tube place in resident's nose which provides oxygen) continuous and monitor oxygen saturation, if oxygen saturation (oxygen level in blood) is 92%, start oxygen at four liters per minute. A review of Resident 16's Medication Administration Record (MAR) for December 2024 indicated Resident 16's oxygen level was above 92 percent (%). In addition Resident 16's oxygen level was documented at four liters per minute. On 12/12/24 8:53 A.M., concurrent observation of Resident 16's oxygen concentrator (a medical device used to provide oxygen) was conducted with LN 21. The oxygen concentrator was observed at five liters per minute. LN 21 stated the physician's orders indicated Resident 16's physician order for oxygen was four liters per minute. LN 21 stated Resident 16's physician order for oxygen was documented as four liters per minute instead of the actual five liters per minute in the MAR. LN 21 stated Resident 16's physician order for oxygen was not followed. LN 21 stated it was important to follow Resident 16's physician orders for oxygen because Resident 16 had COPD and she could have become confused [NAME] have difficulty breathing. On 12/12/24 at 12:12 P.M., a concurrent interview and record review was conducted with the ADON. The ADON stated Resident 16's physician's order for oxygen was four liters per minute. The ADON stated the licensed nurses and respiratory technician should have checked the oxygen level. Per the undated facility policy and procedure titled, Oxygen Administration indicated .Review the physician's orders . (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	46235 2. Resident 237 was admitted to the facility on [DATE] with diagnoses including chronic pulmonary edema (fluid buildup in the lungs making it difficult to breathe) according to the facility's Admission Record. During an observation on 12/9/24 at 10:08 A.M., Resident 237 was in bed in his room with oxygen on via nasal cannula (small, flexible tube with two prongs that sit inside the nostrils to deliver oxygen). Resident 237 stated he still felt short of breath with the use oxygen. During an interview and joint observation on 12/10/24 at 9:50 A.M. with the Treatment Nurse (TN), the TN observed Resident 237's oxygen level. The TN stated Resident 237's oxygen was set at five and half liters (L). The TN stated she did not know what the physician's order was for Resident 237's oxygen. An interview and joint record review was conducted with the assistant director of nursing (ADON) on 12/11/24 at 9:36 A.M. The ADON reviewed Resident 237's physician's orders and stated there was an order for oxygen dated 12/10/24 which indicated, .titrate [adjust] O2 [oxygen] sat [saturation- percentage of oxygen in the blood] 2-5 liters via nc [nasal cannula] . The ADON stated Resident 237 did not have a physician's order for oxygen until 12/10/24 and Resident 237 had been using oxygen prior to 12/10/24. The ADON further stated it was important to have a physician's order for Resident 237's oxygen to have the right route and dosage which was the same as with medication orders. The Director of Nursing (DON) was interviewed on 12/12/24 at 2:24 P.M. The DON stated it was her expectation to have physician's orders for residents' use of oxygen. The DON stated it was important to have a physician's order to provide continuity of care and for staff to know the resident's needs. The DON further stated physician's orders should be complete for staff to know how to administer the oxygen, provide the right amount and prevent a change in resident's condition. The facility's policy and procedure (P&P) titled, Medication and Treatment Orders, dated July 2016 was reviewed. The P&P indicated, .Orders for medications and treatments will be consisted with principles of safe and effective order writing .Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state .Drug and biological orders must be recorded on the physician's order sheet in the resident's chart . During a review of the undated facility P&P titled, Oxygen Administration, the P&P indicated, .The purpose of this procedure is to provide guidelines for safe oxygen administration .Preparation .Verify that there is a physician's order for this procedure .

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46235 Based on observation, interview and record review, the facility failed to ensure one of two residents reviewed (Resident 9), received Trauma Informed Care (TIC- an intervention and organizational approach that focuses on how trauma may affect an individual's life and his or her response to behavioral health). This failure resulted in the facility's inability to identify possible triggers that could result in re-traumatization (the reactivation of trauma symptoms via thoughts, memories, or feelings related to the past torture experience). Findings: Resident 9 was admitted to the facility on [DATE] with diagnoses including post-traumatic stress disorder (PTSD- a mental and behavioral disorder that can develop because of exposure to a traumatic event) and suicidal ideations [thoughts of ending one's own life] according to the facility's Admission Record. During observation of Resident 9 on 12/9/24 at 11:53 A.M., Resident 9 was in bed in his room with eyes closed. During observation and interview of Resident 9 on 12/10/24 at 3:08 P.M., Resident 9 was lying in bed in his room. Resident 9 stated he could not sleep at night due to noise. Resident 9 stated he has had traumatic events in the past. Resident 9 stated he was molested by a stranger when he was eight years old. Resident 9's roommate was observed yelling out and Resident 9 stated the yelling did not bother him and then Resident 9 closed his eyes. An interview was conducted on 12/11/24 at 9:03 A.M. with certified nurse assistant (CNA) 17. CNA 17 stated Resident 9 was independent with activities of daily living (ADL-basic selfcare task). CNA 17 stated she did not know why Resident 9 slept a lot. CNA 17 stated she was not aware of Resident 9's past traumatic event. CNA 17 did not know what PTSD meant. A joint record review and interview was conducted with the ADON on 12/11/24 at 9:36 A.M. The ADON reviewed Resident 9's care plans and stated Resident 9 had a care plan for PTSD related to Resident 9's mother's death which inconsistent with Resident 9's statement. The ADON stated the previous social service director identified Resident 9's PTSD during an interview on admission. The ADON stated it was important for staff to know about resident's PTSD because the resident could become depressed and irritated. The ADON further stated staff should know what triggered the resident. During an interview with CNA 18 on 12/11/24 at 11:05 A.M., CNA 18 stated PTSD meant a resident has had a traumatic event. CNA 18 stated it was important for staff to know if a resident had PTSD because if the trauma was triggered, the resident's behavior may change and feel sad or agitated. CNA 18 stated she was not aware of any resident in the facility with PTSD. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 12/11/24 at 11:10 A.M. with the Director of Staff Development (DSD - a licensed nurse certified for staff training). The DSD checked the 2024 in-service binder and stated there was no in-service training regarding trauma informed care or PTSD. The DSD stated residents with PTSD had events in the past that might trigger the resident to act a certain way emotionally and physically. The DSD stated she knew of one resident with the diagnosis of PTSD and CNAs should have knowledge of this diagnosis by checking the resident's Kardex (information for CNAs) in the resident's electronic medical record. The DSD provided another resident's name which was not Resident 9. The DSD stated all staff should know if a resident had the diagnosis of PTSD to know how to approach and provide better care for the resident. An interview was conducted on 12/11/24 at 3:55 P.M. with CNA19. CNA 19 stated he had been assigned to Resident 9. CNA 19 stated it was important to know if a resident had PTSD because anything may trigger a bad reaction. CNA 19 further stated he was not aware of Resident 9's diagnosis of PTSD. A joint record review and interview on 12/12/24 at 10:03 A.M. with CNA 20 was conducted. CNA 20 checked the Kardex for Resident 9. CNA 20 stated there was no information on the Kardex that Resident 9 had PTSD. CNA 20 stated it was important to know if the resident had PTSD to better understand the resident when mad or sad. An interview was conducted with the Director of Nursing (DON) on 12/12/24 at 2:24 P.M. The DON stated upon admission residents were assessed for prior trauma. The DON stated this information was important to identify triggers when a resident exhibited a behavior or was acting out. The DON further stated all staff should be aware of resident's diagnosis to understand the resident and provide better care for the resident. The facility's policy and procedure (P&P) titled, Trauma Informed Care and Culturally Competent Care, dated August 2022 was reviewed. The P&P indicated, .To address the needs of trauma survivors by minimizing triggers and/or re-traumatization .All staff are provided in-service training about trauma and trauma-informed care .Assessment involves an in-depth process of evaluating the presence of symptoms, their relationship to trauma, as well as the identification of triggers . Identify and decrease exposure to triggers that may re-traumatize the resident .

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36471 Based on interview and record review, the facility failed to ensure the Medication Regimen Review (MRR- a thorough evaluation of the resident's current medications) was completed monthly for one of five sampled residents selected for an unnecessary medication review (Resident 10). As a result, there was a potential for Resident 10 to receive unnecessary medications and medication irregularities to go unattended. Findings: Resident 10 was admitted to the facility on [DATE] with diagnoses which included paranoid schizophrenia (a severe mental disorder that may interfere with a resident's ability to think, manage emotions, make decisions, and relate to others) per the Admission Record. Resident 10's medical record and the facility's MRR were reviewed. There was no evidence that the MRR was conducted monthly for Resident 10. On 12/12/24 at 9:49 A.M., a joint interview and record review was conducted with the Assistant Director of Nursing (ADON). The ADON stated Resident 10 did not have an MRR in October and November 2024. The ADON further stated the MRR should have been done monthly. On 12/12/24 at 2:34 P.M., an interview was conducted with the Pharmacy Consultant (PC). The PC stated the MRR should be done monthly, and he should have an MRR for Resident 10. The PC could not provide evidence of October and November 2024 MRR for Resident 10. Per the facility's policy and procedure, dated 5/2019, titled Medication Regimen Reviews, The consultant pharmacist reviews the medication regimen of each resident at least monthly .

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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** 36471 Based on interview and record review, the facility failed to ensure one of five selected sampled residents (Resident 10) reviewed for psychotropic (a drug or substance that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior) had specific behavior monitoring in place for the use of antipsychotic (a class of drugs that treat symptoms of mental disorder by altering brain function). This failure had the potential to result in unnecessary use of psychotropic medication. Findings: Resident 10 was admitted to the facility on [DATE] with diagnoses which included paranoid (a pattern of behavior where someone feels distrustful, suspicious, and fearful of others), schizophrenia (a severe mental disorder that may interfere with a resident's ability to think, manage emotions, make decisions, and relate to others) per the Admission Record. A review of Resident 10's medical record was conducted. Per the Order Summary Report, dated 10/17/24, Resident 10 was taking Olanzapine 10 milligrams at bedtime for schizoaffective disorder (a mental health condition that was marked by a mix of schizophrenia symptoms). The same document, dated 10/21/24, indicated OLANZAPINE- Target Behavior (lack of motivation) . On 12/12/24 at 9:13 A.M., an interview was conducted with Certified Nursing Assistant (CNA) 16. CNA 16 stated she was occasionally assigned to Resident 10, and Resident 10 had no issues with lack of motivation. On 12/12/24 at 9:29 A.M., an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated the facility was monitoring Resident 10's lack of motivation for the use of Olanzapine. The ADON further stated that Resident 10 was hearing voices that caused Resident 10 to have lack the motivation to do things. On 12/12/24 at 11:26 A.M., an interview was conducted with CNA 2. CNA 2 stated she was very familiar with Resident 10. Resident 10 had many episodes of hallucinations and seeing people that were not there. Resident 10 likes to smoke and did not have episodes of lack of motivation. On 12/12/24 at 2:34 P.M., an interview was conducted with the Pharmacy Consultant (PC). The PC stated Resident 10 had antipsychotic medication, and the behavior monitoring should be what the resident was experiencing. The PC further stated the facility had to describe the behaviors and monitor specific behaviors, such as visual or auditory (hearing) hallucinations. The PC stated that lack of motivation was inappropriate behavior monitoring for Resident 10. Per the facility's undated policy and procedure, titled Psychoactive/Psychotropic Medication Use, .the resident's symptoms and therapeutic goals must be clearly and specifically identified and documented .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36471 Based on observation, interview, and record review, the facility failed to ensure opened dressings were labeled with an open date, and expired food was removed from the walk-in refrigerator in the kitchen. These failures placed residents at risk of acquiring foodborne illness. Findings: On [DATE] at 7:54 A.M., a joint observation and interview were conducted with the Director of Dietary Services (DDS). Inside the walk-in refrigerator were opened, undated gallons of mayonnaise and Asian artisan dressings, and an opened tub of cottage cheese with a USED BY (the last date recommended for the use while at peak quality) date of [DATE]. The DDS stated the kitchen staff should have written the date when the food was opened and should have used the food before the used-by date or should have discarded the food item. The DDS further stated it was important to have foods labeled, dated, and discarded to ensure that the food served in the kitchen was safe and palatable for the residents. Per the facility's undated policy and procedure titled Food Receiving and Store, .7. Refrigerated foods are labeled, dated and monitored so they are used by their use-by date, frozen, or discarded .

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	055064	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cottonwood Canyon Healthcare Center	1391 Madison Avenue El Cajon, CA 92021

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36471 Based on observation, interview and record review, the facility failed to ensure four of 20 residents reviewed had accurate and complete medical records when: 1. Resident 66's treatment record was incomplete, 2. Resident 23's post dialysis note was incomplete and did not indicate reassessment after dialysis site bleeding, 3. Resident' 36 and Resident 63's Diabetic Administration Record was incomplete. This failure did not provide an accurate representation of the care provided to the residents and had the potential for residents to not receive the appropriate care. Findings: 1. Resident 66 was admitted to the facility on [DATE] with diagnoses which included End Stage Renal Disease (ESRD- kidney failure) per the Admission Record. A review of Resident 66's medical record was conducted. Per the Order Summary Report, dated 12/1/24, the staff was to monitor Resident 10's dialysis site for bleeding and infection every shift. Per the December 2024 Treatment Administration Record (TAR), the monitoring for the dialysis site was blank on 12/2/24, 12/3/24, 12/9/24, and 12/10/24. On 12/12/24 at 11:54 A.M., a joint interview and record review was conducted with the Director of Nursing (DON). The DON stated dialysis site should have been monitored per the physician's order, and the licensed nurses should initial the TAR to indicate the site was monitored. The DON further stated if it was not signed, it was not done. The facility could not provide policy and procedure for Treatment Administration Records. Per the facility's policy and procedure, dated 11/2022, titled Documentation of Medication Administration Record, .Documentation of medication administration includes .initials, signature and title . 39449 2. Resident 23 was admitted to the facility on [DATE] with diagnoses to include end stage kidney disease per the facility Admission Record. A review of Resident 23's Brief Interview of Mental Status dated 9/30/24 (BIMS, an assessment tool) indicated 13 out of a possible 15 for intact mental cognition. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 23's physician History and Physical Examination dated 9/12/24 indicated Resident 23 had the capacity to understand and make decisions. On 12/9/24 at 11:34 A.M., an observation and interview and conducted with Resident 23. Resident 23 was observed in bed with a raised/bulging arterio-venous (AV-connection of blood vessels used for dialysis [process to filter waste from blood]) shunt on his left upper arm. Resident 23 stated his dialysis schedule was Tuesdays, Thursdays and Saturdays. Resident 23 stated last Saturday, 12/7/24 around 1:30 P.M., he came from dialysis and when he bent his arm to eat his AV started to bleed. Resident 23 stated he pressed the call light and waited for a long time for a staff to respond. Resident 23 stated the male employee pressed his arm and went out. Resident 23 stated his AV shunt was still bleeding and he had to clamp the AV shunt himself and was used to clamping his AV shunt. Resident 23 stated the male nurse did not return for one hour. A review of Resident 23's physician order dated 6/26/24 indicated the following: Hemodialysis (a machine which filters wastes, salts and fluid when kidneys were no longer healthy to this work adequately) on Tuesday, Thursday and Saturday. Hemodialysis- remove dressing on left upper arm after four hours from dialysis treatment on Tuesday, Thursday and Saturday. Assess and document site for signs of bleeding, swelling, redness, drainage or pain at site. If active bleeding, utilize the dialysis emergency kit at bedside. A review of the facility's document titled, Nursing Hemodialysis Communication Observation and Assessment-Facility Post -Dialysis indicated on 12/7/24 at 1:54 P.M., Resident 23 returned to the facility. Resident 23 was noted to have bleeding to dialysis site, pressure applied, arm elevated, dressing intact. No bleeding noted after pressure applied. At four-hour post removal noted at 5:54 P.M. and no bleeding noted. On 12/11/24 at 5: 57 P.M., an interview was conducted with LN 12. LN 12 stated last Saturday, Resident 23 came back from dialysis and a CNA informed me Resident 23 had bleeding on his left upper arm (LUA) AV shunt. LN 12 stated he applied pressure, elevate his arm and came back 20 minutes later to check Resident 23's LUA AV shunt. LN 12 stated Resident 23 had no more bleeding, and no clamps was applied to Resident 23's LUA AV shunt. On 12/12/24 at 10:20 A.M., a concurrent interview and record review was conducted with LN 12. LN 12 stated he returned 20 minutes after he applied pressure to Resident 23's LUA AV shunt. LN 12 stated he returned three times to Resident 23 to check Resident 23's LUA AV shunt was still bleeding. LN 12 stated he checked Resident 23's LUA AV shunt at around 1:54 P.M., after 20 minutes and at 5:54 P.M. LN 12 stated he did not document the second time he checked Resident 23's LUA AV shunt. On 12/12/24 at 11:05 A.M., a concurrent interview and record review was conducted with the DSD. The DSD stated LN 12 should have reassessed Resident 23 and documented in a timely manner. On 12/12/24 at 12:05 P.M., a concurrent interview and record review was conducted with the ADON. The ADON stated every time Resident 23 came back from dialysis, LNs should assess, document in progress notes and communicate with the team. The ADON stated if you did not document it, you did not do it. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Per the facility policy entitled Hemodialysis Catheters- Access and Care of, dated February 2023, indicated . Documentation .The nurse should document in the resident's medical record every shift as follows: .5. Observations post-dialysis . 46235 3a. Resident 36 was admitted to the facility on [DATE] with diagnoses including chronic osteomyelitis (bone infection) and diabetes (too much sugar circulating in the blood) according to the facility's Admission Record. During an observation on 12/9/24 at 9:23 A.M., Resident 36's room door was closed with a sign on the wall which indicated enhanced barrier precaution (EBP-an approach when healthcare workers wore gowns and gloves during high contact with residents to reduce transmission of organisms). Resident 36 was sitting on a motorized wheelchair in his room and stated he was admitted to the facility with a wound. Resident stated he took insulin for his diabetes. A review of Resident 36's physician's orders for December 2024 was conducted. The physician's orders indicated an order date on 8/26/24 for Insulin Lispro .Inject as per sliding scale .subcutaneously (under the skin) before meals and at bedtime . The physician's order did not indicate when to check Resident 36's blood sugar. An interview and joint record review of Resident 36's Diabetic Administration Record (DAR) with licensed nurse (LN) 11 was conducted on 12/12/24 at 9:51 A.M. LN 11 stated Resident's 36's DAR for December 2024 had no blood sugar result for 12/4/24 at 11 A.M. and on 12/5/24 at 11 A.M. LN 11 also checked Resident 36's DAR for November 2024 and stated there were no blood sugar results for 11/1/24 at 8 P.M., 11/5/24 at 11 A.M., 11/7/24 at 11 A.M., 11/9/24 at 11 A.M., 11/28/24 at 11 A.M. and 11/29/24 at 11 A.M. LN 11 stated the DAR was not clicked during medication pass which was a problem because staff and the physician will not know if the resident's blood sugar was high or low, and if the resident needed insulin coverage. LN 11 further stated the resident's medical records should have accurate and complete information for the physician to decide when to discontinue the resident's blood sugar finger sticks or adjust insulin doses. 3b. Resident 63 was admitted to the facility on [DATE] with diagnoses including type 2 diabetes mellitus with diabetic neuropathy (type of nerve damage) according to the facility's Admission Record. A review of Resident 63's physician's orders for December 2024 was conducted. The physician's orders indicated an order date on 10/7/24 for Insulin Lispro .Inject as per sliding scale .subcutaneously (under the skin) before meals and at bedtime . The physician's order did not indicate when to check Resident 63's blood sugar. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview and joint record review of Resident 63's DAR with LN 11 was conducted on 12/12/24 at 9:51 A. M. LN 11 reviewed Resident 63's DAR for December 2024. LN 11 stated there was no documentation on Resident 63's DAR for 12/4/24 at 6:30 A.M. and 11:30 A.M., 12/5/24 at 11:30 A.M. and on 12/10/24 at 8 P.M. LN 11 reviewed Resident 63's DAR for November 2024 and stated there was no documentation for 11/2/24 at 6:30 A.M., 11/3/24 at 6:30 A.M., 11/7/24 at 11:30 A.M., 11/9/24 AT 11:30 A.M., 11/28/24 at 11:30 A.M. and on 11/29/24 at 11:30 A.M. LN 11 stated the DAR was not clicked during medication pass which was a problem because staff and the physician will not know if the resident's blood sugar was high or low, and if the resident needed insulin coverage. LN 11 further stated the resident's medical records should have accurate and complete information for the physician to decide when to discontinue the resident's blood sugar finger sticks or adjust insulin doses. An interview was conducted with the Director of Nursing (DON) on 12/12/24 at 2:24 PM. The DON stated she expected resident's diabetic administration records to be complete and accurate. The DON stated medication administration should also be followed according to physician's orders. The DON stated if it was not documented, it was not done. The DON stated it was important to document resident's blood sugar results and insulin administration to prevent glycemic (change in blood sugar in the blood) reactions. The DON further stated if the blood sugar was not documented, the physician would not see trends and monitor the effectiveness of the medication which may need an adjustment. A review of the facility's policy and procedure (P&P) titled, Obtaining a Fingerstick Glucose Level, dated December 2024 was conducted. The P&P indicated, .The purpose of this procedure is to obtain a blood sample to determine the resident's blood glucose level .The person performing this procedure should record the following information in the resident's medical record .The date and time the procedure was performed . The name and title of the individual(s) who performed the procedure . During a review of the facility's P&P titled, Documentation of Medication Administration, dated November 2022 the P&P indicated .A nurse documents .all medications administered to each resident . Administration of medication is documented immediately after it is given . Documentation of medication administration includes, as a minimum . initials, signature and title of the person administering the medication .

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 39449 Based on interview and record review, the facility failed to maintain staffing based on payroll data on quarterly schedule to Centers for Medicare & Medicaid Services (CMS-government agency overseeing nursing health facilities) for one of four fiscal quarters (4th quarter of 2024 [07/01/24 to 09/30/24]). This failure in excessively low weekend staffing resulted in not meeting staffing requirements by CMS. Cross Reference F550 Findings: A review of the facility [NAME] Report PBJ (Payroll-based journal) Staffing Data Report for Quarter 4 2024 July 1 to September 30, 2024 indicated the metric (method of measuring) for excessively low weekend staffing was triggered which meant the facility submitted PBJ reports with excessively low weekend staffing. On 12/12/24 at 5: 44 P.M., a concurrent interview and record review was conducted with the DON, Staffing Coordinator and Human Resource (HR)/Payroll Personnel was conducted. The HR/Payroll stated facility corporate submitted quarterly but it triggered because the facility had one day of low staffing in July 2024. The DON stated we had a lot of registry in July 2024. The DON stated her expectation was to meet CMS requirements for staffing. A review of the CMS Electronic Staffing Data Submission Payroll-Based Journal; Long-Term Care Facility Policy Manual, dated June 2022, indicated .The Centers for Medicare and Medicaid Services (CMS) has long identified staffing as one of the vital components of a nursing home's ability to provide quality of care . The data, when combined with census information, can then be used to not only report on the level of staff in each nursing home, but also to report on employee turnover and tenure, which can impact the quality of care delivered .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36471 Based on observation, interview, and record review, the facility failed to ensure infection control practices were followed when an expired disinfectant (kills or inactivates germs) wipes were removed from the cart, and a resident with a wound infection was not placed on Enhanced Barrier Precaution (EBP-infection control measure to prevent spread of infection) timely. These deficient practices could potentially spread infectious diseases in the facility. Findings: 1. On [DATE] at 9:46 A.M., an observation and interview was conducted with the Treatment Nurse (TN). Before the wound care observation, the TN stated she sanitized all her equipment with the wipes and placed the wipes back in the cart. After the wound care treatment, the TN rolled the used table and scissors out of the resident's room to the treatment cart in the hallway. The TN then got the wipes inside the treatment cart and showed that the expiration date was [DATE]. The TN stated she should not use the wipes since they were expired. The TN walked to the next medication cart and grabbed another wipes container. The TN then showed that the expiration date of the wipes was unreadable. The TN stated she could not use the wipes because she could not read the year the wipes expired. The TN stated she should not use expired wipes to ensure the equipment was sanitized. On [DATE] at 8:44 A.M., an interview was conducted with the Infection Preventionist (IP). The IP stated expired wipes should have been taken off use to ensure the efficacy of the wipes and prevent the spread of germs. Per the facility's policy and procedure, dated ,d+[DATE], titled Cleaning and Disinfection of Environmental Surfaces, .Manufactures' instructions will be followed for proper use of disinfecting (or detergent) products including: manufacture expiration date . 47466 2. A review of the facility's Admission Record indicated Resident 62 was admitted to the facility originally on [DATE] but was readmitted on [DATE] with diagnoses that included muscle weakness and Acute respiratory failure with hypoxia (low oxygen level). An observation on [DATE] on Resident 62's room was conducted. Resident 62 had Enhanced Barrier Precaution(EBP-infection control measure to prevent spread of infection) signage and PPEs (personal protective equipment) in a clear plastic cubicle outside his room by the door. An interview on [DATE] at 9 A.M., with licensed Nurse (LN) LN 11 was conducted. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LN 11 stated Resident 62 was on EBP due to a wound on his foot and was being treated daily by the treatment nurse. A record review of Resident 62's Physician's order summary dated [DATE] indicated Resident 62 had treatment to his left lateral foot wound and was on low air loss mattress to maintain skin integrity. An interview on [DATE] at 2 P.M., with the IP (Infection Preventionist Nurse) was conducted. The IP stated we did not place Resident 62 on EBP until [DATE] and did not notify Resident 62's physician. The IP stated it was important to have Resident 62 on EBP to protect Resident 62 from the spread of infection and could have affected his health condition and or decline. An interview on [DATE] at 2:46 P.M., with the Assistant Director of Nursing (ADON) was conducted. The ADON stated it was important to have Resident 62 on EBP to prevent the spread of infection and avoid worsening of the wound that could affect Resident 62's health condition. A review of the facility's policy titled Enhanced Barrier Precautions dated [DATE], indicated .Policy Interpretations and Implementations . #5. EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds .