STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055070	A. Building B. Wing	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seacrest Post-Acute Care Center	1416 West 6th Street San Pedro, CA 90732

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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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44898 Based on observation interview and record review the facility failed to ensure one of 16 reviewed residents (Resident 29) personal items were returned to Resident 29 after being laundered. This failure resulted in Resident 29's blankets being lost, missing, and received a blanket that did not belong to him. Findings: During a review of Resident 29's, Admission Record, the Admission Record indicated Resident 29 was admitted to the facility on [DATE] with diagnoses including hypertension (HTN-high blood pressure), bladder cancer (a type of cancer that starts in the cells lining of the bladder), Alzheimer's (a disease characterized by a progressive decline in mental abilities) dementia (a progressive state of decline in mental abilities), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), dysphagia (difficulty swallowing), and need for assistance with personal care. During a review of Resident 29's Minimum Data Set (MDS-a resident assessment tool), dated 2/2/2025, the MDS indicated, Resident 29 had the ability to express ideas and wants. The MDS indicated Resident 29 had the ability to make self understood. The MDS indicated Resident 29 usually had the ability to understand others. The MDS indicated Resident 29 needed partial to moderate assistance from nursing staff with inserting and removing dentures into and from the mouth and managing dentures soaking and rinsing with use of equipment. The MDS indicated Resident 29 was dependent on nursing staff for putting on and taking off footwear. The MDS indicated Resident 29 needed substantial to maximal assistance from nursing staff with toileting, showering, dressing, lying, sitting, standing, walking, and transferring to the toilet chair and bed. During a review of Resident 29's Clothing and Possessions List, dated 7/5/2024, the Clothing and Possession List indicated Resident 29 had one blanket. During an interview on 2/26/2025 at 10:46 a.m., with Resident 29's family member (FM) Resident 29's FM stated she brought a blanket to Resident 29 and put Resident 29's name on the blanket and after the blanket was washed, the blanket got lost. FM stated when the blanket was returned Resident 29, he received two blankets that do not belong to him. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a current observation and interview on 2/27/2025 at 12:29 p.m., with Certified Nursing Assistant (CNA) 4, in Resident 29's room. Resident 29 had two blankets in his closet one with another resident's initials (G.V.G.) labeled on the blankets and another blanket with another resident's name. CNA 4 stated she heard in the huddle Resident 29's blankets were missing. CNA 4 stated she was told to return Resident 29's blankets back to him if she found his blankets in another residents' room and not to use Resident 29's blankets on other residents. CNA 4 stated she does not know if Resident 29's blankets were found. CNA 4 stated she goes to every resident's room and makes sure the name of the resident was written on personal stuff. CNA 4 stated she will report to the charge nurse any lost or missing property. CNA 4 stated when laundry comes, she gives the residents their blankets according to the name written on the belonging. During an interview on 2/27/2025 at 1:16 p.m., with Licensed Vocational Nurse (LVN) 6, LVN 6 stated Resident 29's family complained about Resident 29's blankets missing. LVN 6 stated all of Resident 29's blankets were labeled with his name. LVN 6 stated staff were to return items to Resident 29 with the resident's name on it. LVN 6 stated the blankets should be washed and returned to the right resident. During an interview on 2/27/2025 at 2:09 p.m., with Housekeeper (HK) 1, HK 1 stated she separates the clothing that was labeled with resident's name and returns it back to the residents. HK 1 stated when a resident has a blanket, it will be labeled and returned to that resident. HK 1 stated sometimes the laundry staff will mix resident's blankets and place residents blankets in the closet for donations. HK 1 stated the CNAs and registry staff distribute those blankets that are for donations to everybody. During a concurrent observation and interview on 2/28/2025 at 12:44 p.m., with Registered Nurse Supervisor (RNS) in Resident 29's room. RNS pulled two blankets from Resident 29's closet with initials G.V.G. RNS stated this blanket does not belong to Resident 29 and could be a blanket that was donated to the facility. RNS stated Resident 29's missing blanket should have been reported to Social Services (SS) so that Resident 29's items are replaced or reimbursed. During an interview on 2/28/2025 at 1:18 p.m., with Social Services (SS), SS stated she was informed by nursing staff that Resident 29's blankets were missing. SS stated when items go missing, she makes a report and will call the family and notify them of the missing item. SS stated she will ask for a receipt and ask them if they want reimbursement or replacement. During a review of the facility's policy and procedure (P&P) titled, Personal Property, revised 8/2022, the P&P indicated, Residents are permitted to retain and use personal possessions, including furniture and clothing, as space permits, unless doing so would infringe on the rights or health and safety of other residents Resident belongings are treated with respect by facility staff, regardless of perceived value . The facility promptly investigates any complaints of misappropriation or mistreatment of resident property.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49889 Based on observation, interview and record review, facility failed to ensure call light was within reach for one of five reviewed residents (Resident 139). This failure had the potential to put Resident 319's safety at risk and not meet his personal needs. Findings: During a review of Resident 319's Admission Record, the Admission Record indicated, Resident 319 was admitted to the facility on [DATE] with diagnoses including multiple myeloma (blood cancer), difficulty walking, muscle weakness, dementia (a progressive state of decline in mental abilities). During a review of Resident 319's History & Physical (H&P) dated 11/27/24, the H&P indicated, Resident 319 does not have the capacity to understand and make decision. During a review of Resident 319's Minimum Data Set (MDS- a resident assessment tool) dated 12/3/24, the MDS indicated Resident 319's cognition (ability to think, understand, learn, and remember) is severely impaired. The MDS indicated that Resident 319 needs substantial/maximal assist (helper does more than half the effort) with Activities of Daily Living (ADLs- activities such as toileting and personal hygiene a person performs daily). During an observation on 2/25/24 at 11:25 a.m., in Resident 319's room, Resident 319's call light was wrapped around the siderail of his bed with the siderail in down position Resident 319 was not able to reach his call light. During a concurrent observation and interview on 2/26/25 at 9:05 a.m., with the Director of Staff Development (DSD) in Resident 319's room. Observed Resident 319's call light was wrapped around the siderail of his bed with the siderail in down position. The DSD stated Resident 319 was not able to reach his call light. The DSD stated call light should be within reach. DSD stated the call light provides help and support that is needed and that is how Resident 139 communicates with the staff. The DSD stated there could be a medical emergency or resident could fall out bed. During an interview on 2/27/25 at 5:07 p.m., with the Director of Nursing (DON), the DON stated the call light is a devise to help residents call for assistance and should be within reach for the resident. The DON stated residents could fall and hurt themselves when call lights were not within reach. During a review of the facility's policy & procedure (P&P) titled Answering the Call Light dated 9/2022, indicated Staff need to be sure that the call light is plugged in and functioning at all times. Staff need to ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor.

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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** 49889 Based on observation, interview, and record review, the facility failed to develop and/or implement an individualized person-centered plan of care with measurable objectives, timeframe, and interventions to meet the resident's needs for one of four reviewed residents (Resident 38). This failure had the potential to negatively affect the delivery of necessary care and services to Resident 38. Findings: During a review of Resident 38's Admission Record, the Admission Record indicated, Resident 38 was admitted to the facility on [DATE] with the diagnoses including ovarian cancer (a growth of cells that forms in the ovaries [female organ that produce eggs]), type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) hypertension (HTN-high blood pressure). During a review of Resident 38's Minimum Data Set (MDS - a resident assessment tool) dated 2/04/2025, the MDS indicated Resident 38's cognition (ability to think, understand, learn, and remember) was intact. The MDS also indicated that Resident 38 needs substantial/maximal assistance (helper does more than half the work) with Activities of Daily Living (ADLs- activities such as toileting, bathing and dressing a person performs daily). During a review of Resident 38's History & Physical (H&P) dated 5/08/2024 the H&P indicated, Resident 38 was able to exercise her own rights. During a review of Resident 38's Change of Condition ([COC] a sudden, clinically important deviation from a patient's baseline in physical, cognitive (ability to think, understand, learn, and remember) behavioral, or functional status which without immediate intervention, may result in complications or death) dated 2/1/2025, the COC indicated Resident 38 had a right leg swelling with redness, skin warm to touch with complain of pain 5 out 10 scale (pain screening tool using numerical value to assess the level of pain ranging from 4 to 6-moderate pain). Resident 38 was prescribed Bactrim DS (medication to treat infection) oral tablet 800-160 milligram (mg-unit of measurement) give one tablet by mouth two times a day for cellulitis (a skin infection that causes swelling and redness) and do a venous doppler (an ultra sound that uses sound waves to examine blood flow) on the right lower extremity. During a review of Resident 38's Physician Order Summary Report dated 2/28/2025, the Physician Order Summary Report indicated Resident 38 has orders for Restorative Nursing Assistant ([RNA] assist residents in regaining or maintaining their functional abilities) to perform ambulation using platform walker five times a week. The Physician Order Summary Report also indicated Resident 38 had order for Triamcinolone Acetonide 1% (treats inflammatory skin conditions) apply to right lower leg every day shift for superficial cellulitis (skin infection) for 30 days started on 2/14/2025. (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 38's RNA Treatment Administration Record (RNA TAR) dated 2/2025, the RNA TAR indicated Resident 38 did not participate in RNA treatments for 16 days in the month of February. A. Resident 38 refused treatment on February 6, 10, 11,12,13,14,18,19,20,25, and 26. B. Resident 38 was not available for RNA treatment on February 7, 9, 17, 21, and 24. During a review of Resident 38's Care Plan dated 2/27/2025, the care plan indicated Resident 38 is non-compliant with RNA program orders. Resident participates at times but has multiple out on passes, appointments, and additional reasons why not to participate when time allows. The Care Plan goals indicated for Resident 38 to participate in RNA program per medical doctor (MD) order and will allow some services within her allotted time prior to departing the facility. The Care Plan interventions indicated to educate Resident 38 on risk and benefits of refusal of services and report observations of decline. RNA to supervise patient using recumbent cycle for 20 min 5 times a week. RNA to perform ambulation using platform walker five times a week once a day as tolerated. Offer RNA service early morning prior to pick up times. Offer RNA services once resident returns from appointment. During a concurrent observation and interview on 2/25/25 at 11:55 a.m. in Resident 38's room. Resident 38's right shin had redness. Resident 38 stated she wears a brace that fits in her right shoe when she walks. Resident 38 stated about 3 weeks ago when she took off her brace, she noticed some redness and swelling on her right shin and ever since then she has not been doing her RNA exercises. During an interview on 2/27/24 at 12:27 p.m., with RNA 1, RNA 1 stated Resident 38 just started refusing to walk in February because she says that her right leg has pain and does not want to try and walk. During a concurrent interview and record review on 2/27/25 at 2:39 p.m. with the Director of Nursing (DON), Resident 38's RNA TAR dated 2/1/2025 and care plan for noncompliant with RNA program dated 2/27/2025 were reviewed. The DON stated that care plans need to be specific, measurable, attainable, realistic and time bound. The DON stated that Resident 38 had been refusing care for about three weeks and that Resident 38's care plan should have been initiated on the reason of Resident 38 refusal when the concern was identified. The DON stated she does not think Resident 38's care plan was appropriate for Resident 38's identified concerns (right leg pain). During a review of the facility's policy and procedure (P&P) titled Care Plans, Comprehensive Person-Centered dated 3/2022, the P&P indicated, 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.

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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** 49130 Based on interview and record review, the facility failed to provide care in accordance with professional standards of practice for one of five reviewed residents (Resident 22) investigated for use of unnecessary psychotropic (any medication capable of affecting the mind, emotions, and behavior) drug, by failing to ensure a medical diagnosis or indication was documented to support administration of Seroquel (generic name - quetiapine, a medication used to treat schizophrenia [a mental illness that is characterized by disturbances in thought]. This failure had the potential to place Resident 22 at risk for significant adverse consequences (unwanted, uncomfortable, or dangerous effects that a drug may have) from the use of unnecessary psychotropic drug, which could result to impairment or decline in the resident's mental, physical condition, functional, and psychosocial status. Findings: During a review of Resident 22's Admission Record, the Admission Record indicated Resident 22 was admitted to the facility on [DATE] with diagnoses including sepsis (a life-threatening blood infection) due to Escherichia Coli (E.coli - a micro bacterium), acute cystitis (inflammation of the bladder) without hematuria (blood in the urine), encephalopathy (altered brain function), unspecified schizophrenia, hypo-osmolality (low levels of electrolytes, protein and nutrients in blood) and hyponatremia (low sodium level in blood) and vascular dementia (a progressive state of decline in mental abilities), mild, with agitation. During a review of Resident 22's Minimum Data Set (MDS-resident assessment tool), dated 1/30/2025, the MDS indicated Resident 41's cognition (ability to think, understand, learn, and remember) was moderately impaired. The MDS indicated, Resident 22 needed setup assistance from facility staff for Activities of Daily Living (ADLs) such as eating, supervision level assistance for oral and personal hygiene, moderate assistance for upper body dressing, maximal assistance for toileting, showering and lower body dressing, and was dependent on facility staff for putting on/taking off footwear. The MDS did not indicate Resident 22 with diagnoses of any psychiatric (mental) /mood disorders such as schizophrenia, anxiety (emotion characterized by feelings of tension, worried thoughts), depression or bipolar disorder (sometimes called manic-depressive disorder, mood swings that range from the lows of depression to elevated periods of emotional highs). During a review of Resident 22's Physician Order Summary Report, dated 2/1/2025, the order summary report indicated but not limited to the following physician order: 1.Seroquel oral tablet 25 mg (quetiapine fumarate), give 1 tablet by mouth at bedtime for delirium (a serious disturbance in a person's mental abilities that results in a decreased awareness of one's environment and confused thinking), order date 1/24/2025, start date 1/24/2025. During a review of Resident 22's Physician Order Summary Report, dated 2/27/2025, the Physician Order Summary report indicated but not limited to the following physician order: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1.Seroquel oral tablet 25 milligram ([mg] a unit of measurement for mass) (quetiapine fumarate), give 1 tablet by mouth at bedtime for schizophrenia manifested by (m/b) hallucination (sights, sounds, smells, tastes, or touches that a person believes to be real but are not real) informed consent obtained by medical doctor (MD) from responsible party. Risk and benefits explained, order date 2/1/2025, start date 2/1/2025. During a review of Medication Regimen Review report (MRR - a monthly evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences associated with medication), dated 2/11/2025, the review indicated the consultant pharmacist failed to identify Resident 22 was receiving quetiapine without a corresponding medical diagnosis of a psychiatric disorder. The consultant pharmacist instead indicated Resident 22 was taking an atypical antipsychotic medication with a potential to cause type II adult-onset diabetes (a disorder characterized by difficulty in blood sugar control and poor wound healing) and hyperlipidemia (high levels of fat particles in the blood). During a review of Resident 22's Medication Administration Record (MAR), dated 1/24/2025 to 1/31/2025, the facility administered quetiapine 25 mg daily at 9:00 p.m. for a total of eight times. During a review of Resident 22's MAR, dated 2/1/2025 to 2/26/2025, the facility administered quetiapine 25 mg daily at 9:00 p.m. for a total of six times. During a concurrent interview and record review on 2/28/25 at 10:26 a.m. with Quality Assurance Licensed Vocational Nurse (QA LVN), the MDS dated [DATE], progress notes dated 2/1/2025, interdisciplinary team ([IDT] team members from different departments working together with a common purpose to set goals and make decisions that ensure residents receive the best care) meeting notes dated 1/28/2025, and hospital admission records sent on 1/23/2025 were reviewed. The MDS did not indicate diagnosis of schizophrenia. The progress notes indicated, Resident was seen and examined by psychiatrist on 2/1/2025, ordered to clarify indication of Seroquel 25mg. Doctor on call made aware and agreed. Resident's daughter made aware. Risk and benefits were discussed and verbalized understanding. The IDT notes indicated, IDT held care plan meeting with resident and resident's daughter. Psych regimen reviewed as resident's daughter provided verbal consent for resident to continue Seroquel medication. THE IDT notes indicated Resident 22 daughter verbalized she is new to it, she started having delirium (a serious disturbance in person's mental abilities that results in a decreased awareness of one's environment and confused thinking) once she started the dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidneys have failed) it's only been like three weeks, but I think it's affecting her brain they told me it's called schizophrenia' .time. The hospital admission records' section of psychiatric review of systems indicated, No anxiety, depression, or insomnia. QA LVN stated, Resident 22 was receiving quetiapine for Schizophrenia because of hallucinations. QA LVN stated the MDS did not indicate diagnosis of schizophrenia or other psychiatric disorders. QA LVN stated the IDT meeting notes indicated the meeting was held with Resident 22 and Resident 22's daughter. QA LVN stated Resident 22 should not be on quetiapine without a corresponding diagnosis. QA LVN stated quetiapine would be considered as an unnecessary drug for Resident 22 and placed her at risk for altered mental status, allergy, shortness of breath, respiratory distress, dizziness, vomiting, hypotension (low blood pressure) and fever. QA LVN stated Resident 22 also had dementia and stated the administration of quetiapine without medical diagnosis could affect Resident 22's function negatively. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/28/2025 at 12:46 p.m. with QA LVN, QA LVN stated the Medical Records Supervisor (MR) entered the admission order for quetiapine and diagnosis of schizophrenia in Resident 22's facility admission record, per Director of Nursing (DON) instructions. QA LVN stated it was not a right practice for MR to enter medical diagnosis of schizophrenia because medical diagnosis should have been entered by a physician after Resident 22 was evaluated. QA LVN stated she was not able to provide psychiatrist evaluation notes related to Resident 22's diagnosis of schizophrenia. During a review of the facility's policy and procedure (P&P) titled, Psychotropic Medication Use, dated 7/2022, the P&P indicated, Residents will not receive medications that are not clinically indicated to treat a specific condition. The P&P indicated, Psychotropic medication management includes a. indications of use. Residents who have not used psychotropic medication are not prescribed or given these medications unless the medication is determined to be necessary to treat a specific condition that is diagnosed and documented in the medical record. During a review of the facility's P&P titled, Medication Regimen Reviews, dated 05/2019, the P&P indicated, an 'irregularity' refers to the use of medication that is inconsistent with accepted pharmaceutical services standards of practice . not supported by medical evidence .It may also include the use of medication without indication, without adequate consequences. During a review of the facility's document titled, Job Description Unit/Shift Nursing Supervisor, the documented indicated, The primary purpose of your job position is to assist .in accordance with current applicable federal, state and local standards, guidelines and regulations .quality patient care can be maintained at all times. Cross reference F758

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44898 Based on observation, interview, and record review the facility failed to ensure denture care was done for one of 16 reviewed residents (Resident 29). This failure resulted in Resident 29's dentures not being cleaned and stored properly in a denture container. Findings: During a review of Resident 29's, Admission Record, the Admission Record indicated Resident 29 was admitted to the facility on [DATE] with diagnoses including hypertension (HTN-high blood pressure), bladder cancer (a type of cancer that starts in the cells lining of the bladder), Alzheimer's (a disease characterized by a progressive decline in mental abilities) dementia (a progressive state of decline in mental abilities), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), dysphagia (difficulty swallowing), and need for assistance with personal care. During a review of Resident 29's Care Plan, titled Oral/Dental Care, dated 3/8/2023, the Care Plan indicated goal of adequate oral/dental hygiene will be maintained. The Care Plan indicated Resident 29 will be provided good mouth care. During a review of Resident 29's Minimum Data Set (MDS-a resident assessment tool), dated 2/2/2025, the MDS indicated, Resident 29 had the ability to express ideas and wants. The MDS indicated Resident 29 had the ability to make self-understood. The MDS indicated Resident 29 usually had the ability to understand others. The MDS indicated Resident 29 needed partial to moderate assistance from nursing staff with inserting and removing dentures into and from the mouth and managing dentures soaking and rinsing with use of equipment. The MDS indicated Resident 29 was dependent on nursing staff for putting on and taking off footwear. The MDS indicated Resident 29 needed substantial to maximal assistance from nursing staff with toileting, showering, dressing, lying, sitting, standing, walking, and transferring to the toilet chair and bed. During a review of the facility's in-service, titled Dentures and Oral Care, dated 2/13/2024, the in-service indicated a summary lecture on denture cup with water storage, denture tablets provided by the families and the facility, providing daily oral care after meals, and as needed, oral care process and preventing bad breath and decaying gum issues. During an interview on 2/26/2025 at 10:46 a.m., with Resident 29's family member (FM), Resident 29's FM stated she had an issue with oral care and dentures not being cleaned and placed in denture cups. During a concurrent observation and interview with Certified Nursing Assistant (CNA) 4, in Resident 29's room observed Resident 29 had a sign on his wall that indicated Please remove lower dentures and disinfect with tablets at night. CNA 4 stated Resident 29 has lower dentures placed on the wall of his bed. CNA 4 stated dentures are cleaned in the sink before and after eating. CNA 4 stated Resident 29 does not have a denture cup, or the tablets used for cleaning the dentures at the bedside. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 2/27/2025 at 1:01p.m., with Licensed Vocational Nurse (LVN) 6, in Resident 29's room, Resident 29 did not have a denture container at the bedside and did not have denture tablets used for cleaning at the bedside. LVN 6 stated Resident 29 should have a denture container at the bedside for his lower denture. LVN 6 stated CNAs were responsible for providing oral and denture care. LVN 6 stated CNAs' remove Resident 29's lower denture at night and brush the lower denture. LVN 6 stated dental hygiene has not been documented on 2/27/2025 and should have been documented after it was done. LVN 6 stated she did not see any denture tablets at the bedside and stated she did not see any denture cleaning tablets in the facility's utility room. LVN 6 stated the facility ran out of the denture tablets. LVN 6 stated CNAs are supposed to take dentures out to clean them then take the dentures to the sink and wash them in warm water, place the dentures on a towel to dry and apply dental paste and apply dentures. LVN 6 stated dentures should be placed in a container at bedside when the resident is not using them. During a concurrent observation and interview on 2/28/2025 at 12:44 p.m., with Registered Nurse Supervisor (RNS), in Resident 29's room, RNS stated all nursing staff were responsible for making sure dentures were cleaned. RNS stated she follows up with the CNAs to make sure resident's dentures were being cleaned and to make sure resident have a denture cup. RNS stated CNAs had an in-service for dentures and oral care. RNS stated she failed to check if Resident 29's dentures were cleaned. RNS stated Resident 29 does not have denture tablets at the bedside to clean dentures. RNS stated the family, or the facility supplies the resident with tablets for denture cleaning. During a review of the facility's policy and procedure (P&P) titled, Dentures, Cleaning and Storage, dated revised 3/2028, the P&P indicated, The purposes of this procedure are to cleanse and freshen the resident's mouth, to clean the resident's dentures, to prevent infections of the mouth, to protect the resident's dentures from breakage when dentures are out of the resident's mouth, and to store dentures at bedtime .Store dentures whenever they are not in the resident's mouth .The following equipment and supplies will be necessary when performing this procedure .Toothpaste or denture cleaner .Disposable denture cup/container (with cover) .Clean the dentures by brushing them with a denture cleaner or toothpaste .Rinse dentures thoroughly. Fill the denture cup one-half (1/2) full of fresh water and one-half (1/2) full of mouthwash. Place dentures into the denture cup. Take the denture cup and emesis basin to the bedside table. Leave dentures in the cup until the resident is ready to replace them in his or her mouth .Leave the denture cup, with the cleaning solution, on the resident's bedside stand. Put it within easy reach of the resident. Be sure the denture cup is properly labeled with the resident's name and room number.

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	055070	A. Building B. Wing	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seacrest Post-Acute Care Center	1416 West 6th Street San Pedro, CA 90732

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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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49889 Based on observation, interview, and record review the facility failed to ensure two of two reviewed residents (Residents 20 and 319) intravenous catheter (IV - a flexible tube that is inserted into vein to deliver fluids or medications) was maintained in accordance with professional standard of practice. The facility failed to: a.Ensure Resident 20's IV catheter was removed in a timely manner after Resident 20's IV therapy was completed. b.Ensure Resident 318/'s IV site was changed Rotated when Resident 318's IV site was not changed for 14 days. This failure had the potential to cause an infection at the insertion site. Findings: During a review of Resident 20's Admission Record, the Admission Record indicated, Resident 20 was admitted on [DATE] and readmitted on [DATE] with the diagnoses including chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), takotsubo syndrome (causes chest pain, shortness of breath, symptoms mimic a heart attack), sepsis (a life-threatening blood infection). During a review of Resident 20's History & Physical (H&P) dated 1/29/2025 the H&P indicated, Resident 20 was alert and oriented to name place but not situation. During a review of Resident 20's Minimum Data Set (MDS - a resident assessment tool) dated 1/20/2025, the MDS indicated Resident 20's cognition (ability to think, understand, learn, and remember) was moderately impaired. The MDS also indicated that Resident 20 was dependent (helper does all the work) with Activities of Daily Living (ADLs- activities such as toileting, bathing and personal hygiene a person performs daily). During a review of Resident 20's IV administration record dated 2/4/2025 indicated, Resident 20 was given one liter of sodium chloride (NS-normal saline IV solution) started on 2/4/2025, completed on 2/5/25. During a review of Resident 20's Care plan titled Resident 20 has the following IV access and is at risk for infection or other complications such as pain, phlebitis (inflammation of the vein), and embolism (blood clot) dated 2/4/2025 indicated a goal for Resident 20 to be free from complications of IV therapy (signs of infection, phlebitis, and embolism). The Care Plan interventions indicated to rotate IV site every 72 hours and as needed for soilage and complications (signs of infection, phlebitis, and embolism) and monitor for signs and symptoms of infection or other complications such as pain, phlebitis, and embolism. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 318's Admission Record, the Admission Record indicated, Resident 318 was admitted on [DATE] with the diagnoses including osteomyelitis (bone infection) left ankle and foot, asthma (a chronic lung condition), and muscle weakness. During a review of Resident 318's H&P dated 2/19/25 the H&P indicated, Resident 318 does not have the capacity to understand and make decisions for himself. During a review of Resident 318's Physician Order Summary Report dated 2/27/2025, Physician Order Summary Report indicated Resident 318 had order for ceftriaxone (antibiotic- treats bacterial infection) 2 grams, give one time a day for osteomyelitis until 3/18/2025. Resident 318 also had order to rotate IV site every 72 hours and as needed for soilage and complications (sign of infection, edema, phlebitis). During a review of Resident 318's Care plan titled Resident 318 has an IV antibiotic and is at risk for infection or other complications such as pain, phlebitis, and embolism dated 2/20/2025, The Care Plan goal indicated resident will be free from complications. The Care Plan interventions indicated to change IV peripheral (catheter placed in a vein near the surface of the skin) heplock (a way to access a vein without having an IV running) every three days may extend with medical doctors (MD) order. Change IV peripheral hep lock gauze dressing every day. During an observation on 2/25/2024 at 12:15 p.m. in Resident 20's room, observed Resident 20 had an IV heplock in her right wrist with no date and time label on the dressing. During an observation on 2/25/2024 at 1:26 p.m., in Resident 318's room, observed Resident 318 had an IV in his left forearm wrapped with kerlix (gauze dressing) with no date and time label on the dressing. During a concurrent observation and interview on 2/26/2025 at 8:35 a.m., with Registered Nurse Supervisor (RNS) in Resident 20's room, Resident 20 had an IV catheter in her right wrist. RNS stated Resident 20 was not receiving IV therapy at this time. RNS stated IV catheter should have been removed after Resident 20's IV therapy was completed on 2/5/2025. RNS stated IV sites are a potential source for infection. During a concurrent observation and interview on 2/26/2025 at 8:45 a.m., with RNS in Resident 318's room, Resident 318 had an IV catheter in his left forearm wrapped with a kerlix dressing with no time or date on the dressing. RNS unwrapped IV site, IV site was dated 2/14/2025 and was placed at the general acute care hospital (GACH). RNS stated IV site should be rotated every 72 hours. RNS stated you can leave IV site in longer than 72 hours but we would have to monitor and document daily to ensure there are no signs and symptoms of infection, IV line was flushing well and no infiltration (leakage of medication or solution from the catheter into the surrounding tissues instead of the vein). RNS stated IV sites are a potential source for infection. During an interview on 2/27/2025 at 5:07 p.m., with the Director of Nursing (DON), the DON stated the IV site needs to be rotated every 72 hours because veins are fragile. The DON stated IV catheters must be removed after the course of therapy was completed. The DON stated it could lead to infection and complications because there is an opening in the skin. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy & procedure (P&P) titled Peripheral IV Catheter (PIVC) and Site Selection, the P&P indicated to select PICV's based on prescribed therapies, duration of treatments, availability of peripheral access sites, diagnosis, and potential complications. Use PICV's for duration of less than four days when criteria are met for compatibility of therapy.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49130 Based on observation, interview, and record review, the facility failed to ensure the Licensed Vocational Nurse (LVN) 4 was trained and had knowledge of conducting a blood pressure (BP) check for one of ten reviewed residents (Resident 368) prior to determining whether hydralazine (a medication used to treat hypertension [high blood pressure]) should be administered per parameters ordered by physician. This failure had the potential for medication errors, hypertension, hypotension (low blood pressure) and hospitalization for Resident 368. Findings: During a review of Resident 368's Admission Record, dated 2/27/2025, the Admission Record indicated, Resident 368 was admitted to the facility on [DATE] with diagnoses including but not limited to, essential (primary) hypertension, end stage renal disease (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 368's Physician Order Summary Report, dated 2/27/2025, the Physician Order Summary Report indicated but not limited to the following physician orders: Hydralazine (a medication used to treat high blood pressure) hydrochloride (HCl) oral tablet 50 milligram ([mg] a unit of measurement for mass), give 1 tablet by mouth three times a day for hypertension Hold if systolic blood pressure (SBP) less than (<) 100, order date 2/24/2025, start date 2/25/2025. Pregabalin (a medication used to treat pain) 25 mg, give 1 capsule by mouth three times a day for neuropathy (nerve pain), order date 2/24/2025, start date 2/25/2025. Amlodipine besylate (a medication used to treat high blood pressure) oral tablet 10 mg, give 1 tablet by mouth one time a day for hypertension, hold if SBP < 100, order date 2/24/2025, start date 2/25/2025. Clonidine (a medication used to treat high blood pressure) HCl oral tablet 0.1 mg, give 1 tablet by mouth every 6 hours as needed for hypertension, if SBP >160, order date 2/24/2024, start date 2/24/2025. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 2/26/2025 at 12:30 p.m. with LVN 4, LVN 4 prepared 1 capsule of pregabalin 25 mg to be administered to Resident 368. LVN 4 stated Resident 368's order list also indicated hydralazine, but LVN 4 stated she wanted to check Resident 368's BP before preparing hydralazine. LVN 4 then proceeded to check BP using a BP monitor. LVN 4 placed the BP cuff onto Resident 368's right forearm close to the right wrist. LVN 4 stated resident had a line on the left side, so she checked BP on the right side. LVN 4 stated Resident 368's BP was 116 but could not state the full BP reading. After leaving Resident 368's room, LVN 4 requested the Director of Staff Development (DSD) to help her find the BP reading on the monitor and failed to find the BP reading. LVN 4 decided to recheck Resident 368's BP in the presence of DSD. During an observation on 2/26/2025 at 12:53 p.m. in Resident 368's room DSD educated and corrected LVN 4 when LVN 4 was confused about where to place BP cuff. DSD assisted LVN 4 in checking Resident 368's BP by placing the cuff on the right upper arm. LVN 4 stated and showed Resident 368's BP reading for right upper arm to be 147/78. LVN 4 stated she would now prepare hydralazine to be administered to Resident 368. During an observation on 2/26/2025 at 1:06 p.m. LVN 4 entered Resident 368's room to recheck BP before administering hydralazine. LVN 4 was interrupted by the DSD. DSD informed LVN 4 that since Resident 368 had a dialysis port on the right side, BP should have been conducted on the opposite arm than the shunt. LVN 4 and DSD proceeded to check Resident 368's BP on left arm and stated it was 113/65. Resident 368 refused to take hydralazine stating that her doctor wanted her to take hydralazine only if BP was over 160. LVN 4 explained to Resident 368 that physician order indicated to hold hydralazine 50 mg only if SBP was less than 100 and Resident 368's SBP was greater than 100. Resident 368 continued to refuse hydralazine 50 mg. LVN 4 stated the resident had the right to refuse medication and would inform physician and document in medical record that Resident 368 refused to take hydralazine. During an interview on 2/26/2025 at 1:15 p.m. with LVN 4, LVN 4 stated her competencies and trainings were provided by registry and not the facility. LVN 4 stated she had not worked at the facility in a long time. LVN 4 stated she was trained for administering medications and checking blood pressure. LVN 4 stated she placed the BP cuff on Resident 368's right forearm near the wrist area and not at right upper arm, because of what she has on the chest, has surgery. LVN 4 stated Resident 368's left arm had dialysis port, so LVN 4 decided to use the right arm. LVN 4 stated she did not want to go further up on the right arm because she had surgery on right side towards chest area. LVN 4 stated if Resident 368 did not take hydralazine as prescribed by physician, it increased risk for high blood pressure, seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), stroke (loss of blood flow to a part of the brain) and hospitalization . During an interview on 2/27/2025 at 10:05 a.m. with DSD, DSD stated Resident 368 had a catheter on her upper right side, so the BP should have been taken on her left arm (opposite side) of the port. DSD stated Resident 368 had an intravenous (IV) line on the left side and the IV should not be running when BP was being taken. DSD stated she should have caught the mistake about the correct site in the first instance. DSD stated as soon as she realized she decided to come back to instruct LVN 4 that the correct side to take BP was on Resident 368's left arm because IV was not running. (continued on next page)

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F 0726 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 10:05 a.m. with DSD, the photograph showing the placement of BP cuff, and resident's right hand and arm was reviewed. DSD stated the photograph indicated there was some edema (swelling due to fluid in tissues) on Resident 368's right hand and arm. DSD stated LVN 4 did not place the BP cuff appropriately while taking BP, because the location of the BP cuff should not have been the forearm, and it was taken on the wrong arm. DSD stated by taking the BP on the wrong arm which had the port, it increased the risk to the port. DSD stated by taking BP on the arm with edema and port, it increased risk for inaccurate BP reading, blocked circulation, additional pain, bruising, swelling, medication errors and hospitalization for Resident 368. DSD stated resident's physician should have been notified, there should have been an order for elevating the resident's arm by placing on a pillow to see if that would help with swelling. DSD stated the BP parameters should have been checked again and physician should have been notified immediately when Resident 368 refused to take hydralazine. DSD stated LVN 4 was from registry and training would be provided from them. DSD stated she conducted skills and competency assessment for Certified Nurse Assistant (CNA) only and would provide retraining for LVN staff if needed. DSD stated the Director of Nursing (DON) conducted skills and competency assessment for licensed nurses. During an interview on 2/27/2025 at 4:29 p.m. with the DON, the DON stated she had not conducted educational in-service about BP monitoring. DON stated, these things are discussed in the school, and facility reinforces this during the in-services. The DON stated, ideally it is important to use arm as your site of blood pressure. The DON stated in the scenario for Resident 368, the resident had one part of shunt because of dialysis, there should be BP check on the side opposite of the shunt. The DON stated, the side where IV line was placed could be used as long as it did not block the infusion flow. The DON stated the facility staff should not have been taking BP at the forearm. The DON stated if the BP was taken where edema was present, it could cause blood clot or present an inaccurate blood pressure and would not be able to manage the BP regimen. During a review of the facility's policy and procedure (P&P) titled, Blood Pressure, Measuring, dated 09/2010, the P&P indicated, Preparation: Review the resident's care plan to assess for any special needs of the resident General Guidelines: A blood pressure reading is represented as a ratio or fraction. The top number (the systolic pressure) measures the blood pressure during the contractions of the heart (systole) . The bottom number (the diastolic pressure) measures .at rest (diastole). The P&P indicated, Steps in the procedure: expose the resident's arm by rolling the sleeve up about 5 inches above the elbow. Wrap the blood pressure cuff evenly around the upper arm, approximately one (1) inch from the elbow. Note: The cuff should fit snugly, but not so tightly that the resident is uncomfortable. If the cuff is placed too loosely, you will get a false high blood pressure reading.) The P&P indicated, Reporting: Notify the supervisor if the resident refuses the treatment. During a review of the facility's P&P titled, Hypertension - Clinical Protocol, dated 11/2018, the P&P indicated, Assessment and Recognition - Blood pressure should be measured correctly, including use of a properly sized cuff, in both arms, and where possible, in the upright position. The P&P indicated, In addition, the nurse shall assess and document/report the following: all current medications, especially antihypertensive therapy.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 44898 Based on observation, interview and record review, the facility failed to ensure staffing information posted was accurate. This failure resulted in the inability of residents and visitors to have knowledge of the facility's staffing information to ensure safe staffing ratios are implemented. Findings: During an observation on 2/25/2025 at 11:15 a.m., near Nurses Station One, the staffing information was posted and dated 2/25/2025. During a concurrent interview and record review on 2/28/2025 at 2:42 p.m., with Director of Staff Development (DSD), the facility's CMS Daily Nurse Staffing Form and the Nursing Staffing Assignment and Sign-In-Sheet, dated 2/5/2025, 2/8/2025, 2/19/2025, 2/20/2025, and 2/22/2025 were reviewed. The Nursing Staffing Assignment and Sign-In-Sheet indicated one staff call off on 2/5/2025, 2/8/2025, 2/19/2025, 2/20/2025 and 2/22/2025. The DSD stated staffing was posted daily in the front of Nurses Station One. The DSD stated she does not update or change the posted staffing. The DSD agreed that the sign in signatures on the Nursing Staffing Assignment and Sign in Sheet does not match the posted staffing and should be updated due to discrepancies. The DSD stated quality of care suffers without accurate posted staffing.

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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** 49130 Based on observation, interview, and record review, the facility failed to administer medications in accordance with physician order and manufacturer specifications for two of ten reviewed residents (Residents 37 and 367) by failing to: a. Ensure Resident 37's Aspirin (a medication used to prevent heart attack [flow of blood and oxygen is blocked] and stroke [loss of blood flow to a part of the brain]) chewable tablet was administered as chewable during medication administration. b. Clarify order with physician and administer Resident 367's Vitamin D3 (also referred as cholecalciferol - a vitamin used to treat low level of vitamin D) within 60 minutes of its prescribed time as per facility's policy and procedure (P&P) titled, Medication Administration - General Guidelines, dated 11/2021. These failures of not administering medications to Residents 37 and 367 in accordance with physician orders or professional standards of practice had the potential to result in vitamin deficiency, stroke (damage to the brain from interruption of its blood supply), and hospitalization . Findings: During a review of Resident 37's Admission Record, the Admission Record indicated, Resident 37 was admitted to the facility on [DATE] with diagnoses including hypertension (high blood pressure) hyperlipidemia (high levels of fat particles in the blood) and long term (current) use of aspirin. During a review of Resident 37's Minimum Data Set (MDS-resident assessment tool), dated 12/23/2024, the MDS indicated Resident 37's cognition (ability to think, understand, learn, and remember) was moderately impaired. The MDS indicated, Resident 37 needed supervision level assistance from facility staff for ADLs such as eating and oral hygiene, moderate assistance for upper body dressing and personal hygiene, and dependent on facility staff for toileting, showering, lower body dressing and putting on/taking off footwear. During an observation on 2/26/2025 between 8:44 a.m. and 9:02 a.m., Licensed Vocational Nurse (LVN) 3 prepared and administered five medications for Resident 37 that included one tablet of aspirin 81 mg chewable from a manufacturer's bottle. LVN 3 failed to instruct Resident 37 to chew the aspirin tablet. Resident 37 was observed swallowing all medications including aspirin 81 mg chewable tablet. During a review of Resident 37's Physician Order Summary Report, dated 2/26/2025, the Physician Order Summary Report indicated but not limited to following physician order: Aspirin oral tablet chewable 81 mg, give 1 tablet by mouth one time a day for cerebrovascular accident ([CVA] - stroke, loss of blood flow to a part of the brain) prophylaxis (prevention), take with food, order date 9/16/2024, start date 9/17/2024 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/26/2025 at 9:49 a.m. with LVN 3, LVN 3 stated Resident 37 should have chewed the aspirin. LVN 3 stated he should have separated aspirin 81 mg chewable tablet from other medications and instructed resident to chew aspirin. LVN 3 stated the absorption of chewable aspirin would be affected and might not provide benefit to prevent stroke for Resident 37 if it was not taken as specified by manufacturer. b. During a review of Resident 367's Admission Record, the Admission Record indicated, Resident 367 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including other specified disorders of bone density (measure of bone strength) and structure and difficulty in walking. During a review of Resident 367's MDS, dated [DATE], the MDS indicated Resident 367's cognition was severely impaired. The MDS indicated, Resident 367 needed supervision level assistance from the facility staff for ADLs such as eating and oral hygiene, moderate assistance for upper body dressing and personal hygiene, and dependent on facility staff for toileting, lower body dressing and putting on/taking off footwear. During an observation on 2/26/2025 between 9:15 a.m. and 9:32 a.m., LVN 3 prepared six medications for Resident 367 to be administered. LVN 3 stated physician orders indicated one capsule of Vitamin D3 125 mcg, but LVN 3 did not have capsule formulation in stock. LVN 3 stated he would need to clarify with physician if tablet formulation would be okay to administer. During a review of Resident 367's Physician Order Summary Report, dated 2/26/2025, the Physician Order Summary report indicated but not limited to the following physician order: Cholecalciferol oral capsule 125 mcg (5000 UT), give 1 capsule by mouth one time a day for supplement, order date 2/11/2025, start date 2/12/2025. During a concurrent interview and record review on 2/26/2025 at 1:43 p.m. with LVN 3, the administration details for cholecalciferol (Vitamin D3) 125 mcg, dated 2/26/2025 was reviewed. The document indicated cholecalciferol (Vitamin D3) 125 mcg was administered and documented as administered at 1:36 p.m. LVN 3 stated he was able to clarify cholecalciferol order with physician and administered it to Resident 367 at 11:00 a.m. which was two hours later than the scheduled time of 9:00 a.m. LVN 3 stated medication should be administered and documented as administered in timely manner for its intended effect. During an interview on 2/27/2025 at 4:08 p.m. with the Director of Nursing (DON), the DON stated facility staff should have separated chewable aspirin from other medications to be swallowed and resident should have been instructed to chew the chewable formulation of aspirin for it to be effective and to prevent stroke and blood clots. The DON stated facility staff should have clarified Vitamin D3 order with physician before medication administration to prevent delays in medication administration to ensure a certain level of medication. (continued on next page)

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	055070	A. Building B. Wing	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seacrest Post-Acute Care Center	1416 West 6th Street San Pedro, CA 90732

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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, Medication Administration - General Guidelines, dated 11/2021, the P&P indicated, Medications are administered as prescribed in accordance with good nursing principles and practices and only by to do so. Medications are administered in accordance with written orders of the attending physician. Medications are administered without unnecessary interruptions. The P&P indicated, Medications are administered within 60 minutes of scheduled time, except . mealtimes).

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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** 49130 Based on interview and record review, the facility and consultant pharmacist (a professional responsible for reviewing each resident's medication profile monthly to identify and report changes) failed to identify irregularities during medication regimen review (MRR a comprehensive evaluation of a patient's current medication list to identify potential drug interactions, adverse effects, and other medication-related issues) related to administration of Seroquel (generic name - quetiapine, a medication used to treat schizophrenia [a mental illness that is characterized by disturbances in thought] without a medical diagnosis or indication, affecting one of five reviewed residents for unnecessary medications (Resident 22). This failure of failing to identify and report irregularities resulted in Resident 22 receiving quetiapine unnecessarily without an indication possibly resulting in medication side effects (a secondary, typically undesirable effect of a drug or medical treatment) and leading to a decrease in resident's physical, mental, or psychosocial well-being. Findings: During a review of Resident 22's Admission Record, the Admission Record indicated Resident 22 was admitted to the facility on [DATE] with diagnoses including sepsis (a life-threatening blood infection) due to Escherichia Coli (E.coli - a micro bacterium), acute cystitis (inflammation of the bladder) without hematuria (blood in the urine), encephalopathy (altered brain function), unspecified schizophrenia, hypo-osmolality (low levels of electrolytes, protein and nutrients in blood) and hyponatremia (low sodium level in blood) and vascular dementia (a progressive state of decline in mental abilities), mild, with agitation. During a review of Resident 22's Minimum Data Set (MDS-resident assessment tool), dated 1/30/2025, the MDS indicated Resident 41's cognition (ability to think, understand, learn, and remember) was moderately impaired. The MDS indicated, Resident 22 needed setup assistance from facility staff for Activities of Daily Living (ADLs) such as eating, supervision level assistance for oral and personal hygiene, moderate assistance for upper body dressing, maximal assistance for toileting, showering and lower body dressing, and was dependent on facility staff for putting on/taking off footwear. The MDS did not indicate Resident 22 with diagnoses of any psychiatric (mental) /mood disorders such as schizophrenia, anxiety (emotion characterized by feelings of tension, worried thoughts), depression or bipolar disorder (sometimes called manic-depressive disorder, mood swings that range from the lows of depression to elevated periods of emotional highs). During a review of Resident 22's Physician Order Summary Report, dated 2/1/2025, the order summary report indicated but not limited to the following physician order: 1.Seroquel oral tablet 25 mg (quetiapine fumarate), give 1 tablet by mouth at bedtime for delirium (a serious disturbance in a person's mental abilities that results in a decreased awareness of one's environment and confused thinking), order date 1/24/2025, start date 1/24/2025. (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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 22's Physician Order Summary Report, dated 2/27/2025, the Physician Order Summary report indicated but not limited to the following physician order: 1.Seroquel oral tablet 25 milligram ([mg] a unit of measurement for mass) (quetiapine fumarate), give 1 tablet by mouth at bedtime for schizophrenia manifested by (m/b) hallucination (sights, sounds, smells, tastes, or touches that a person believes to be real but are not real) informed consent obtained by medical doctor (MD) from responsible party. Risk and benefits explained, order date 2/1/2025, start date 2/1/2025. During a review of MRR dated 2/11/2025, the review indicated the consultant pharmacist failed to identify Resident 22 was receiving quetiapine without a corresponding medical diagnosis of a psychiatric disorder. The consultant pharmacist instead indicated Resident 22 was taking an atypical antipsychotic medication with a potential to cause type II adult-onset diabetes (a disorder characterized by difficulty in blood sugar control and poor wound healing) and hyperlipidemia (high levels of fat particles in the blood) and recommended to conduct periodic labs. During a review of Resident 22's Medication Administration Record (MAR), dated 1/24/2025 to 1/31/2025, the facility administered quetiapine 25 mg daily at 9:00 p.m. for a total of eight times. During a review of Resident 22's MAR, dated 2/1/2025 to 2/26/2025, the facility administered quetiapine 25 mg daily at 9:00 p.m. for a total of six times. During an interview on 2/28/2025 at 10:26 a.m. with Quality Assurance Licensed Vocational Nurse (QA LVN), QA LVN stated Resident 22 was receiving quetiapine for schizophrenia because of hallucinations. QA LVN stated the MDS did not indicate diagnosis of schizophrenia or other psychiatric disorders. QA LVN stated the IDT notes indicated the meeting was held with Resident 22 and Resident 22's daughter. QA LVN stated Resident 22 should not be on quetiapine without a corresponding diagnosis. QA LVN stated quetiapine would be considered as an unnecessary drug for Resident 22 and placed her at risk for altered mental status, allergy, shortness of breath, respiratory distress, dizziness, vomiting, hypotension (low blood pressure) and fever. QA LVN stated Resident 22 also had dementia and stated the administration of quetiapine without medical diagnosis could affect Resident 22's function negatively. During a review of the facility's policy and procedures (P&P) titled, Medication Regimen Reviews, dated 05/2019, the P&P indicated, The goal of the MRR is to promote positive outcomes while minimizing adverse consequences and potential risks associated with medication. The P&P indicated, The MRR involves a thorough review of the resident's medical record to prevent, identify, report and resolve medication related problems, medication errors and other irregularities, for example: a. medications ordered in excessive doses or without clinical indication .other medication errors, including those related to documentation. The P&P indicated, An 'irregularity' refers to the use of medication that is inconsistent with accepted pharmaceutical services standards of practice . not supported by medical evidence .It may also include the use of medication without indication, without adequate consequences.

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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** 49130 Based on interview and record review, the facility failed to ensure one of five reviewed residents (Resident 22), for unnecessary medication care area, was free from the use of unnecessary psychotropic drug (any medication capable of affecting the mind, emotions, and behavior) by failing to ensure there was a medical diagnosis and/or indication to support the administration of Seroquel (generic name - quetiapine, a medication used to treat schizophrenia [a mental illness that is characterized by disturbances in thought]. This failure had the potential to place Resident 22 at risk for significant adverse consequences (unwanted, uncomfortable, or dangerous effects that a drug may have) from the use of unnecessary psychotropic drug, which could result to impairment or decline in the resident's mental, physical condition, functional, and psychosocial status. Findings: During a review of Resident 22's Admission Record, the Admission Record indicated Resident 22 was admitted to the facility on [DATE] with diagnoses including sepsis (a life-threatening blood infection) due to Escherichia Coli (E.coli - a micro bacterium), acute cystitis (inflammation of the bladder) without hematuria (blood in the urine), encephalopathy (altered brain function), unspecified schizophrenia, hypo-osmolality (low levels of electrolytes, protein and nutrients in blood) and hyponatremia (low sodium level in blood) and vascular dementia (a progressive state of decline in mental abilities), mild, with agitation. During a review of Resident 22's Minimum Data Set (MDS-resident assessment tool), dated 1/30/2025, the MDS indicated Resident 41's cognition (ability to think, understand, learn, and remember) was moderately impaired. The MDS indicated, Resident 22 needed setup assistance from facility staff for Activities of Daily Living (ADLs) such as eating, supervision level assistance for oral and personal hygiene, moderate assistance for upper body dressing, maximal assistance for toileting, showering and lower body dressing, and was dependent on facility staff for putting on/taking off footwear. The MDS did not indicate Resident 22 with diagnoses of any psychiatric (mental) /mood disorders such as schizophrenia, anxiety (emotion characterized by feelings of tension, worried thoughts), depression or bipolar disorder (sometimes called manic-depressive disorder, mood swings that range from the lows of depression to elevated periods of emotional highs). During a review of Resident 22's Physician Order Summary Report, dated 2/1/2025, the order summary report indicated but not limited to the following physician order: 1.Seroquel oral tablet 25 mg (quetiapine fumarate), give 1 tablet by mouth at bedtime for delirium (a serious disturbance in a person's mental abilities that results in a decreased awareness of one's environment and confused thinking), order date 1/24/2025, start date 1/24/2025. During a review of Resident 22's Physician Order Summary Report, dated 2/27/2025, the Physician Order Summary report indicated but not limited to the following physician order: (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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1.Seroquel oral tablet 25 milligram ([mg] a unit of measurement for mass) (quetiapine fumarate), give 1 tablet by mouth at bedtime for schizophrenia manifested by (m/b) hallucination (sights, sounds, smells, tastes, or touches that a person believes to be real but are not real) informed consent obtained by medical doctor (MD) from responsible party. Risk and benefits explained, order date 2/1/2025, start date 2/1/2025. During a review of Medication Regimen Review report (MRR - a monthly evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences associated with medication), dated 2/11/2025, the MRR report indicated the consultant pharmacist failed to identify Resident 22 was receiving quetiapine without a corresponding medical diagnosis of a psychiatric disorder. The consultant pharmacist instead indicated Resident 22 was taking an atypical antipsychotic medication with a potential to cause type II adult-onset diabetes (a disorder characterized by difficulty in blood sugar control and poor wound healing) and hyperlipidemia (high levels of fat particles in the blood). During a review of Resident 22's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 1/24/2025 to 1/31/2025, the facility administered quetiapine 25 mg daily at 9:00 p.m. for a total of eight times. During a review of Resident 22's MAR, dated 2/1/2025 to 2/26/2025, the facility administered quetiapine 25 mg daily at 9:00 p.m. for a total of six times. During a concurrent interview and record review on 2/28/25 at 10:26 a.m. with Quality Assurance Licensed Vocational Nurse (QA LVN), the MDS dated [DATE], progress notes dated 2/1/2025, interdisciplinary team (IDT-team members from different departments working together with a common purpose to set goals and make decisions that ensure residents receive the best care) meeting notes dated 1/28/2025, and hospital admission records sent on 1/23/2025 were reviewed. The MDS did not indicate diagnosis of schizophrenia. The progress notes indicated, Resident 22 was seen and examined by psychiatrist on 2/1/2025, ordered to clarify indication of Seroquel 25 mg. Doctor on call made aware and agreed. Resident's daughter made aware. Risk and benefits were discussed and verbalized understanding. The IDT notes indicated, IDT held care plan meeting with resident and resident's daughter. Psych regimen reviewed as resident's daughter provided verbal consent for resident to continue Seroquel medication. THE IDT notes indicated Resident 22 daughter verbalized she is new to it, she started having delirium (a serious disturbance in person's mental abilities that results in a decreased awareness of one's environment and confused thinking) once she started the dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidneys have failed) it's only been like three weeks, but I think it's affecting her brain they told me it's called schizophrenia' .time. The hospital admission records' section of psychiatric review of systems indicated, No anxiety, depression, or insomnia. QA LVN stated, Resident 22 was receiving quetiapine for schizophrenia because of hallucinations. QA LVN stated the MDS did not indicate diagnosis of schizophrenia or other psychiatric disorders. QA LVN stated the IDT meeting notes indicated the meeting was held with Resident 22 and Resident 22's daughter. QA LVN stated Resident 22 should not be on quetiapine without a corresponding diagnosis. QA LVN stated quetiapine would be considered as an unnecessary drug for Resident 22 and placed her at risk for altered mental status, allergy, shortness of breath, respiratory distress, dizziness, vomiting, hypotension (low blood pressure) and fever. QA LVN stated Resident 22 also had dementia and stated the administration of quetiapine without medical diagnosis could affect Resident 22's function negatively. (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 review of the facility's policy and procedure (P&P) titled, Psychotropic Medication Use, dated 7/2022, the P&P indicated, Residents will not receive medications that are not clinically indicated to treat a specific condition. The P&P indicated, Psychotropic medication management includes a. indications of use. Residents who have not used psychotropic medication are not prescribed or given these medications unless the medication is determined to be necessary to treat a specific condition that is diagnosed and documented in the medical record. Cross reference F756

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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** 49130 Based on observation, interview, and record review, the facility failed to maintain a medication error rate of less than 5 percent (%) during medication pass for three of ten reviewed residents (Residents 54, 37 and 367) by failing to: a. Ensure Resident 54's Humalog [NAME] KwikPen ([generic name - insulin lispro] a medication used to treat high blood sugar) in medication cart was labeled with an 'open date' to ensure medication was not expired prior to medication administration. b. Ensure Resident 37's Aspirin (a medication used to prevent heart attack [flow of blood and oxygen is blocked] and stroke [loss of blood flow to a part of the brain]) chewable tablet was administered as a chewable during medication administration. c. Clarify order with physician and administer Resident 367's Vitamin D3 (also referred as cholecalciferol - a vitamin used to treat low level of vitamin D) within 60 minutes of its prescribed time as per facility's policy and procedure (P&P) titled, Medication Administration - General Guidelines, dated ,d+[DATE]. These failures of medication administration error rate of 11.54 percent (%) exceeded the five (5) percent (%) threshold. Findings: a. During a review of Resident 54's Admission Record, the Admission Record indicated, Resident 54 was admitted to the facility on [DATE] with diagnoses including type 2 Diabetes Mellitus ([DM] - a disorder characterized by difficulty in blood sugar control and poor wound healing) with hyperglycemia (high blood sugar), type 2 DM with foot ulcer (open wound that does not heal), type 2 DM with diabetic polyneuropathy (damage affecting peripheral nerves) and long term (current) use of insulin. During a review of Resident 54's Minimum Data Set (MDS -resident assessment tool), dated [DATE], the MDS indicated, Resident 54's cognition (ability to think, understand, learn, and remember) was intact. The MDS indicated, Resident 54 needed clean-up assistance from facility staff for Activities of Daily Living (ADLs) such as eating, oral hygiene, upper body dressing and personal hygiene, supervision level assistance for toileting, showering and lower body dressing, and moderate assistance from facility staff for putting on/taking off footwear. (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 observation and interview on [DATE] at 12:01 p.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 conducted a fingerstick blood glucose (BG-a simple procedure that measures the amount of glucose (sugar) in a small drop of blood from the fingertip) test for Resident 54 to measure blood glucose level. LVN 2 stated Resident 54's BG was at 230 milligrams (mg - a unit of measurement for mass) / deciliters (dL - a unit of measurement for volume). LVN 2 stated Resident 54 was supposed to receive seven units of insulin for BG level of 230 mg/dL. LVN 2 took out Humalog [NAME] 100 units per milliliters ([mL] a unit of measurement for volume) prefilled pen from medication cart and adjusted dose to seven units. Surveyor asked LVN 2 to show opened date on the Humalog pen. LVN 2 stated she did not see an opened date on the pen and would not know its expiration date. LVN 2 stated she needed to look for a new pen in medication refrigerator and return to Resident 54's room to administer dose. According to the manufacturer's product labeling, once opened / in-use or once stored at room temperature (below 86 Fahrenheit [(F) is a unit of temperature] or 30 Celsius [(C) is a unit of temperature]), Humalog [NAME] KwikPen must be used within 28 days or be discarded. During a concurrent observation and interview on [DATE] at 12:36 p.m. with LVN 2, LVN 2 prepared the following two medications to be administered to Resident 54. LVN 2 stated she found a new Humalog [NAME] pen in medication refrigerator to administer to Resident 54. 1. One capsule of gabapentin (a medication used to treat nerve pain and seizures [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness]) 300 mg 2. Seven units of Humalog [NAME] 100 units/mL prefilled pen During a review of Resident 54's Physician Order Summary Report, dated [DATE], the Physician Order Summary Report indicated but not limited to the following physician orders: 1. Gabapentin oral capsule 300 mg, give 1 capsule by mouth three times a day for neuropathy, order date [DATE], start date [DATE] 2.Insulin Lispro [NAME] KwikPen Subcutaneous Solution Pen-Injector 100 units/mL, inject 7 unit subcutaneously three times a day for DM 2 give before meals .order date [DATE], start date [DATE] During an interview on [DATE] at 1:05 p.m. with LVN 2, LVN 2 stated insulin should be labeled with an open date to be able to determine its expiration date. LVN 2 stated if the insulin was administered without knowing its expiration date, there was an increased risk of hyperglycemia for Resident 54. b. During a review of Resident 37's Admission Record, the Admission Record indicated, Resident 37 was admitted to the facility on [DATE] with diagnoses including hypertension (high blood pressure) hyperlipidemia (high levels of fat particles in the blood) and long term (current) use of aspirin. (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 review of Resident 37's MDS, dated [DATE], the MDS indicated Resident 37's cognition was moderately impaired. The MDS indicated, Resident 37 needed supervision level assistance from facility staff for ADLs such as eating and oral hygiene, moderate assistance for upper body dressing and personal hygiene, and dependent on facility staff for toileting, showering, lower body dressing and putting on/taking off footwear. During an observation on [DATE] between 8:44 a.m. and 9:02 a.m., LVN 3 prepared and administered the following five medications for Resident 37 that included one tablet of aspirin 81 milligram ([mg] a unit of measurement for mass) chewable from a manufacturer's bottle. LVN 3 failed to instruct Resident 37 to chew the aspirin tablet. Resident 37 was observed swallowing all medications including aspirin 81 mg chewable tablet. 1. One tablet of multivitamin with minerals 2. One tablet of aspirin 81 mg chewable 3. One tablet of vitamin B12 (vitamin used to treat low level of vitamin B12) 100 micrograms ([mcg] a unit of measurement for mass) 4. One tablet of ferrous sulfate (a medication used to treat low level of iron) 65 mg (325 mg) 5. One capful (17 gram [g] a unit of measurement for mass) of Clearlax (generic name - polyethylene glycol - a medication used to treat constipation) dissolved in 5 ounces ([oz] a unit of measurement for volume) During a review of Resident 37's Physician Order Summary report, dated [DATE], the Physician Order Summary report indicated but not limited to following physician order: Aspirin oral tablet chewable 81 mg (aspirin), give 1 tablet by mouth one time a day for cerebrovascular accident ([CVA] - stroke, loss of blood flow to a part of the brain) prophylaxis (prevention), take with food, order date [DATE], start date [DATE] During an interview on [DATE] at 9:49 a.m. with LVN 3, LVN 3 stated Resident 37 should have chewed the aspirin. LVN 3 stated he should have separated aspirin 81 mg chewable tablet from other medications and instructed resident to chew aspirin. LVN 3 stated the absorption of chewable aspirin would be affected and might not provide benefit to prevent stroke for Resident 37 if it was not taken as specified by manufacturer. c. During a review of Resident 367's Admission Record, the Admission Record indicated, Resident 367 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including other specified disorders of bone density (measure of bone strength) and structure and difficulty in walking. (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 review of Resident 367's MDS, dated [DATE], the MDS indicated Resident 367's cognition was severely impaired. The MDS indicated, Resident 367 needed supervision level assistance from the facility staff for ADLs such as eating and oral hygiene, moderate assistance for upper body dressing and personal hygiene, and dependent on facility staff for toileting, lower body dressing and putting on/taking off footwear. During an observation on [DATE] between 9:15 a.m. and 9:32 a.m., LVN 3 prepared the following six medications for Resident 367 to be administered. LVN 3 stated physician orders indicated one capsule of Vitamin D3 125 mcg, but LVN 3 did not have capsule formulation in stock. LVN 3 stated he would need to clarify with physician if tablet formulation would be okay to administer. 1. One capsule of celecoxib (a medication used to treat joint pain) 100 mg 2. One tablet of labetalol (a medication used to treat high blood pressure) 200 mg 3. One tablet of docusate sodium (a medication used to treat constipation) 100 mg 4. One tablet of ferrous sulfate 65 mg (325 mg) 5. One milliliter (ml- a unit of measurement for volume) of heparin (blood thinner) 5000 units 6. One gram of diclofenac topical gel (a topical medication used to treat pain) 1 percent ([%] a unit of measurement for strength) to be applied to each knee During a review of Resident 367's Physician Order Summary Report, dated [DATE], the Physician Order Summary report indicated but not limited to the following physician order: Cholecalciferol oral capsule 125 mcg (5000 UT), give 1 capsule by mouth one time a day for supplement, order date [DATE], start date [DATE] During a concurrent interview and record review on [DATE] at 1:43 p.m. with LVN 3, the administration details for cholecalciferol (Vitamin D3) 125 mcg, dated [DATE] was reviewed. The document indicated cholecalciferol (Vitamin D3) 125 mcg was administered and documented as administered at 1:36 p.m. LVN 3 stated he was able to clarify cholecalciferol order with physician and administered it to Resident 367 at 11:00 a.m. which was two hours later than the scheduled time of 9:00 a.m. LVN 3 stated medication should be administered and documented as administered in timely manner for its intended effect. (continued on next page)

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	055070	A. Building B. Wing	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seacrest Post-Acute Care Center	1416 West 6th Street San Pedro, CA 90732

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 3:57 p.m. with the Director of Nursing (DON), the DON stated when insulin was removed from the refrigerator and opened, facility should label it with an open date because they could only be stored up to 28 days. The DON stated with the opened date, facility staff could determine whether the insulin was expired or safe to be administered to resident. The DON stated if the insulin was not dated with open date, there was a risk that it could be expired and increased the risk of glycemic reactions (the effect of food or meal has on blood sugar) such as hypoglycemia (low blood sugar) or hyperglycemia (high blood sugar) if administered to resident. The DON stated facility staff should have separated chewable aspirin from other medications to be swallowed and resident should have been instructed to chew the chewable formulation of aspirin for it to be effective and to prevent stroke and blood clots. The DON stated facility staff should have clarified Vitamin D3 order with physician before medication administration to prevent delays in medication administration to ensure a certain level of medication. During a review of the facility's P&P titled, Medication Administration - General Guidelines, dated ,d+[DATE], the P&P indicated, Medications are administered as prescribed in accordance with good nursing principles and practices and only by .to do so. Medications are administered in accordance with written orders of the attending physician. Medications are administered without unnecessary interruptions. The P&P indicated, Medications are administered within 60 minutes of scheduled time, except . mealtimes). During a review of the facility's P&P titled, Medication Storage in the Facility, dated ,d+[DATE], the P&P indicated, medications and biologicals are stored safely, securely .following manufacturer's recommendations or those of the supplier. During a review of the facility's P&P titled, Medication Labeling and Storage, dated ,d+[DATE], the P&P indicated, The facility stores all medications .under proper temperature, humidity and light controls. The P&P indicated, Labeling of medications and biologicals .is consistent with applicable federal and state requirements and currently accepted pharmaceutical practices. The medication label includes, at a minimum: a. medication name . expiration date, when applicable .and precautions. Multi-dose vials that have been opened or accessed .are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49130 Based on observation, interview, and record review, the facility failed to: 1. Ensure Resident 54's Humalog [NAME] KwikPen ([generic name - insulin lispro] a medication used to treat high blood sugar) in medication cart was labeled with an 'open date' to ensure medication was not expired prior to medication administration, affecting one of ten reviewed residents. 2. Ensure medications requiring refrigeration were stored in accordance with manufacturer specifications and per facility's policy and procedure (P&P) titled, Storage of Medications, dated ,d+[DATE] at temperature range of 36 degrees Fahrenheit [(F) is a unit of temperature] to 46 F or 2 Celsius [(C) is a unit of temperature] to 8 C, affecting two of two facility's medication room refrigerators (Station 1 Medication Room Refrigerator and Station 2 Medication Room Refrigerator). These failures had the potential to result in Residents 54 and other residents receiving medications that had become expired, ineffective, or toxic due to improper storage and labeling possibly leading to adverse health consequences such as hyperglycemia (high blood glucose), bacterial or viral infections, eye complications and hospitalization . Findings: 1. During a review of Resident 54's Admission Record, the Admission Record indicated, Resident 54 was admitted to the facility on [DATE] with diagnoses including type 2 Diabetes Mellitus ([DM] - a disorder characterized by difficulty in blood sugar control and poor wound healing) with hyperglycemia (high blood sugar), type 2 DM with foot ulcer (open wound that does not heal), type 2 DM with diabetic polyneuropathy (damage affecting peripheral nerves) and long term (current) use of insulin. During a review of Resident 54's Minimum Data Set (MDS -resident assessment tool), dated [DATE], the MDS indicated, Resident 54's cognition (ability to think, understand, learn, and remember) was intact. The MDS indicated, Resident 54 needed clean-up assistance from facility staff for Activities of Daily Living (ADLs) such as eating, oral hygiene, upper body dressing and personal hygiene, supervision level assistance for toileting, showering and lower body dressing, and moderate assistance from facility staff for putting on/taking off footwear. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on [DATE] at 12:01 p.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 conducted a fingerstick blood glucose (BG-a simple procedure that measures the amount of glucose (sugar) in a small drop of blood from the fingertip) test for Resident 54 to measure blood glucose level. LVN 2 stated Resident 54's BG was at 230 milligrams (mg - a unit of measurement for mass) / deciliters (dL - a unit of measurement for volume). LVN 2 stated Resident 54 was supposed to receive seven units of insulin for BG level of 230 mg/dL. LVN 2 took out Humalog [NAME] 100 units per milliliters ([mL] a unit of measurement for volume) prefilled pen from medication cart and adjusted dose to seven units. Surveyor asked LVN 2 to show opened date on the Humalog pen. LVN 2 stated she did not see an opened date on the pen and would not know its expiration date. LVN 2 stated she needed to look for a new pen in medication refrigerator and return to Resident 54's room to administer dose. According to the manufacturer's product labeling, once opened / in-use or once stored at room temperature (below 86 Fahrenheit [(F) is a unit of temperature] or 30 Celsius [(C) is a unit of temperature]), Humalog [NAME] KwikPen must be used within 28 days or be discarded. During a review of Resident 54's Physician Order Summary Report dated [DATE], the Physician Order Summary Report indicated but not limited to the following physician orders: Insulin Lispro [NAME] KwikPen Subcutaneous Solution Pen-Injector 100 units/mL, inject 7 unit subcutaneously three times a day for DM 2 *give before meals*, hold if SBP <120, order date [DATE], start date [DATE] During an interview on [DATE] at 1:05 p.m. with LVN 2, LVN 2 stated insulin should be labeled with an open date to be able to determine its expiration date. LVN 2 stated if the insulin was administered without knowing its expiration date, there was an increased risk of hyperglycemia for Resident 54. 2a. During a concurrent observation and interview on [DATE] at 11:03 a.m. with LVN 6 of the medication refrigerator in Station 1 Medication Room, the following medications were found stored at temperature of 50 F, which were in a manner contrary to its manufacturer's requirements: 1. One unopened Emergency Kit (E-Kit small supply of medications kept in the facility) containing two vials of lorazepam (a medication used to treat anxiety (emotion characterized by feelings of tension, worried thoughts) and seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness) 2 milligram (mg-unit of measurement) /milliliter (ml-unit of measurement), one vial of Humulin N (a type of insulin used to treat high blood sugar) 100 units/ml, one vial of Humulin R 100 units/ml (a type of insulin used to treat high blood sugar), one vial of Humalog 100 units/ml and two promethazine (a medication used to treat nausea and vomiting) 25 mg suppositories. 2. One intravenous (IV administered into a vein) bag of Ceftriaxone (an antibiotic used to treat serious bacterial infections) 2 gram ([gm] a unit of measurement for mass) in 100 ml 0.9% normal saline (NS- type of intravenous fluid). 3. One IV bag of Vancomycin (an antibiotic used to treat serious bacterial infections) 1.6 gm in 500 mL NS. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. One unopened prefilled syringe of FluAD (an active immunization for [AGE] years of age and older against influenza disease). 5. Four vials of house supply of Aplisol ([generic name - tuberculin] a solution to test for infection) 5 TU/0.1 ml 6. Two unopened vials and one vial with broken seal of Procrit (a medication used to treat anemia [a condition where the body does not have enough healthy red blood cells]) 10,000 units/ml. 7. Three prefilled pens of Insulin Aspart 100 units/ml 8. 17 prefilled pens of Insulin Lispro 100 units/ml 9. Five prefilled pens of Lantus Solostar (a type of insulin used to treat high blood sugar) 100 units/ml 10. One vial of Humulin R 100 units/ml 11. One prefilled pen of Rezvoglar ([generic name - insulin glargine aglr] a type of insulin used to treat high blood sugar) According to the manufacturer's product labeling, medications requiring refrigeration should be stored in refrigerator temperature at 36 F to 46 F. LVN 6 stated it was important to check refrigerator temperature more frequently to ensure the temperature was within the recommended temperature range of 36 F to 46 F. LVN 6 stated all the medications found in refrigerator outside of manufacturer required temperature would not be safe or effective to administer to facility residents and placed residents at risk for adverse events such as hyperglycemia, loss of consciousness, influenza (highly contagious respiratory illness) and hospitalization . 2b. During a concurrent observation and interview on [DATE] at 12:27 p.m. with LVN 1 of the medication refrigerator in Station 2 Medication Room, the following medications were found stored at temperature of 50 F, which were in a manner contrary to its manufacturer's requirements: 1. One refrigerator E-Kit 2. 10 prefilled pens of Humalog (generic name - Insulin Lispro) 100 units/ml 3. Three prefilled pens of Insulin Lispro [NAME] KwikPen 100 units/ml 4. Twelve prefilled pens of Lantus (Solostar) 100 units/ml 5. Two bottles of Lorazepam oral concentrate 2 mg/ml 6. One pen of Ozempic ([generic name - semaglutide] a medication used to improve blood glucose) 2 mg/dose (8 mg/3ml) (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. Three bottles of Latanoprost (a medication in form of eye drops used to treat high eye pressure) ophthalmic solution 8. Two prefilled pens of Basaglar (generic name - insulin glargine) KwikPen 100 units/ml 9. Three prefilled pens of Insulin Glargine-yfgn 100 units/ml 10. One pen of Insulin Glargine-yfgn (a type of insulin used to treat high blood sugar) 11. One pen of Humulin R 100 units/ml 12. 11 Bisacodyl (a medication used to treat constipation) 10 mg suppositories 13. Eight Acetaminophen (a medication used to treat pain and fever) 650 mg suppositories According to the manufacturer's product labeling, medications requiring refrigeration should be stored in refrigerator at 36 F to 46 F. LVN 1 stated medication refrigerator temperature was at 50 F, which was not the recommended temperature range of 36 F to 46 F. LVN 1 stated the medications would not be safe or effective to administer to facility residents. During an interview on [DATE] at 3:13 p.m. with the Director of Nursing (DON), the DON stated it was important to keep the medications in refrigerator at the temperature range of 36 F to 46 F to keep the medications safe and effective. The DON stated she had ordered two new refrigerators to replace the old refrigerators. The DON stated if the medications that were not stored at manufacturer recommended temperatures were administered to facility residents, it would increase risk for residents' harm, and adverse events such as hypoglycemia, hyperglycemia, infection, and hospitalization . During a review of the facility's P&P titled, Medication Storage in the Facility - Storage of Medications, dated , d+[DATE], the P&P indicated, medications and biologicals are stored safely, securely .following manufacturer's recommendations or those of the supplier. The P&P indicated, Medications requiring refrigeration or temperatures between 2 C (36 F) and 8 C (46 F) are kept in a refrigerator with a thermometer to allow temperature monitoring. During a review of the facility's P&P titled, Medication Labeling and Storage, dated ,d+[DATE], the P&P indicated, The facility stores all medications .under proper temperature, humidity and light controls. The P&P indicated, Labeling of medications and biologicals is consistent with applicable federal and state requirements and currently accepted pharmaceutical practices. The medication label includes, at a minimum: a. medication name . expiration date, when applicable and precautions. Multi-dose vials that have been opened or accessed .are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 38740 Based on observation, interview and record review, the facility failed to ensure kitchen staff were routinely trained and evaluated for competency related to their duties when: 1.Dietary Aide (DA 1) did not know the proper sanitizer test strip to use for the dish machine sanitizer and the concentration strength of the chlorine sanitizer used in the dish machine (chlorine sanitizer a product that is used to reduce or eliminate pathogenic agents on surfaces). This failure had the potential to result in unsafe and unsanitary food production that could place 60 out of 62 residents in the facility who received food at risk for food borne illness (illness cause by food contaminated with bacteria, viruses, parasites, or toxins) Findings: During an observation on 2/25/2025 at 10:15 a.m., in the dishwashing area, DA1 was requested to check the dish machine sanitizer concentration (chlorine sanitizer). DA1 attempted to pick up the QUAT sanitizer test strips (QUAT another type of sanitizer) to test the sanitizer concentration in the dish machine. [NAME] 2 stopped DA1 and asked to look for the other test strip that is purple in color. [NAME] 2 stated DA1 is new and forget which test strip to use. DA1 stated she cannot find any other test strips. During an interview on 2/25/2025 at 10:20 a.m., with DA1, DA1 stated she cannot find the test strip to check the sanitizer. DA 1 stated she does not know where the test strip container was. During a concurrent interview and review with DA 1, reviewed the dish machine sanitizer log. DA1 stated it was her signature on the dish machine sanitizer log for morning shift. DA1 then stated she used the last test strip. During an interview on 2/25/2025 at 10:25 a.m., with DA 1 and DS, DS stated DA 1 should report to him when the test strip container was finished. During an observation on 2/25/2025 at 10:35 a.m., in the kitchen, observed DA 3 provided new test strips borrowed from a nearby sister facility to check the dish machine sanitizer. During an observation on 2/25/2025 at 10:40 a.m., in the dish machine area, DA 1 did not know how to check the dish machine sanitizer concentration. DA 1 did not know the normal range for the dish machine sanitizer concentration. During a review of facility's policy and procedure (P&P) titled Dishwashing (dated 2023) indicated, A chlorine log for low temperature machines will be kept and maintained by the dishwashers to assure that the dish machine is working correctly. This log will be completed each meal prior to any dishwashing .The chlorine should read 50-100 PPM on dish surface in final rinse. The proper chlorine level is crucial in sanitizing the dishes. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of facility dishwashers job description indicated, Job knowledge: Ability to operate dish machine, handle cleaning supplies and equipment, sort, stack and store clean dishes; knowledge of sanitary requirements, rules and regulations.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38740 Based on observation, interview and record review, the facility failed to ensure safe and sanitary food storage and preparation practices when: 1.There was no trash receptacle (trash can) next to the handwashing sink area in the kitchen. 2. One Dietary Aide (DA1) working in the dish machine area did not wash hands and change gloves when removing the clean and sanitized dishes from the dish machine. 3. Several food items were stored in the refrigerator with dates exceeding storage periods for the ready to eat food. There were 25 previously prepared vanilla flavored pudding and 25 previously prepare chocolate flavored pudding stored in small single serve plastic cups with date of [DATE] exceeding storage period for pudding were stored in the reach in refrigerator. There were 20 single serve cartons of Nutritional Supplements that were voluntarily recalled by manufacturer for potential contamination with listeria (Listeria infection is a foodborne bacterial illness that can be very serious for pregnant women, people older than 65 and people with weakened immune systems. Most commonly caused by eating improperly processed deli meats and unpasteurized milk products) were stored in the reach in refrigerator. There were 23 single serve containers of milk with manufactures expiration date of [DATE] expired and one carton of thickened milk with no open date stored in the reach in refrigerator. Two unopened packages of sliced turkey deli meat thawed with date of [DATE] stored in the freezer to refreeze potentially affecting food quality. Unpasteurized shell eggs were stored in the facility reach in refrigerator. Residents received fried eggs with unpasteurized shell eggs. (Salmonella may be present in raw shell eggs that are not pasteurized). 4. Food Contact surfaces were not sanitized with adequate amount of sanitizer solution per manufactures guidelines. Sanitizers and disinfectant are used on food contact surfaces to prevent cross contamination and food borne illness. These failures had the potential to result in harmful bacteria growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to food borne illness (illness cause by food contaminated with bacteria, viruses, parasites, or toxins) in 60 out of 62 residents who received food from the facility and including 10 residents who were receiving nutritional supplements that were on voluntary recall list. Findings: 1.During an observation in the kitchen on [DATE] at 9:00 a.m.,there was no trash receptacle (trash can) next to the handwashing sink. During the same tour of the kitchen after washing hands there was no trash can to discard used paper towels. (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 concurrent observation and interview [DATE] at 9:05 a.m., with [NAME] (Cook 2), [NAME] 2 was assisting the dishwasher in the dishwashing area. [NAME] 2 stated she did not know where the trash can is. During an interview on [DATE] at 9:30 a.m., with Dietary Supervisor (DS), DS stated there should be a trash can to discard the paper towels. DS stated the trash can was left outside to be cleaned. During an observation in the kitchen on [DATE] at 12:00 p.m., the trash can lid was broken and had to use clean hands to remove the lid and discard the paper towel. During the same observation and interview with DS, DS stated the trash can foot peddle to open the lid was broken and will replace the trash can. DS stated the lid should open when you press on peddle to not contaminate washed hands. During a review of the 2022 U.S. Food and Drug Administration Food Code titled Disposable Towel, Waste receptacle Code# ,d+[DATE].20, indicated, A handwashing sink, or group of adjacent handwashing sinks that is provided with disposable towels shall be provided with a waste receptacle as specified under , d+[DATE].16 (C). During a review of the 2022 U.S. Food and Drug Administration Food Code Titled Storage Areas, Rooms, and Receptacles, Capacity and Availability Code ,d+[DATE].16 indicated, (C) If disposable towels are used at handwashing lavatories, a waste receptacle shall be located at each lavatory . During a review of the 2022 U.S. Food Code titled Disposable Towels, Waste Receptacle Code ,d+[DATE]. 20 indicated, Waste receptacles at handwashing sinks are required for the collection of disposable towels so that the paper waste will be contained, will not contact food directly or indirectly, and will not become an attractant for insects or rodents. 2.During an observation in the dishwashing area on [DATE] at 9:15 a.m., Dietary Aide (DA1) was observed rinsing soiled dishes and loading the dirty dishes in the dish machine. DA 1 had gloves on her hands, DA 1 rinsed her gloved hands in the handwashing sink shook excess water off and proceeded to remove the clean and sanitized dishes from the dish machine without washing hands and replacing gloves. DA 1 repeated the same process of loading dirty dishes, rinsing gloved hands then picking up clean dishes three times. During a concurrent interview on [DATE] at 9:25 a.m., with [NAME] 2 and DA 1, [NAME] 2 was also working in the dishwashing area. [NAME] 2 stated DA 1 was new to the facility and was still in training. [NAME] 2 stated she will explain to DA 1 the importance of removing gloves and washing hands during dishwashing. During the same interview DA 1 stated she should remove gloves and wash hands before touching the clean dishes. DA 1 stated not changing gloves and washing hands can contaminate clean dishes and can make residents sick. During a review of facility's policy and procedure (P&P) titled Hand washing procedure (dated 2023) indicated, When hands need to be washed: After handling soiled dishes and utensils. (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, Glove Use Policy (dated 2023) indicated, When gloves need to be changed .before beginning a different task. During a review of facility's P&P titled Sanitation (dated 2023) indicated, All food and nutrition services staff shall know the proper hand washing technique. The Food and nutrition services director is responsible for the proper training of this. The hand washing sink shall have running hot and cold water, soap, paper toweling, and appropriate receptacles for waste paper. During a review of facility's P&P titled Sanitation (dated 2023) indicated, A minimum of two employees will be used when dishes are machine washed. One will handle the soiled area, and one will handle the clean side. If an employee does need to go from soiled end to clean end, a strict hand washing routine much be followed. During a review of the 2022 U.S. Food and Drug Administration Food Code, Code ,d+[DATE].14 When to Wash. Indicated, Food employees shall clean their hands and exposed portions of their arms as specified under S ,d+[DATE].12 immediately E) After handling soiled equipment or utensils. 3.During an observation in the kitchen on [DATE] at 9:30 a.m., there were previously prepared vanilla and chocolate pudding stored in small individual serve plastic containers. There were about 25 vanilla flavor and 25 chocolate flavor pudding on the trays. The puddings had a date of [DATE]. During a concurrent interview with cook (Cook 1), she stated the pudding was prepared on [DATE]. During a concurrent interview and record review on [DATE] at 9:30 a.m., with Dietary Supervisor (DS), reviewed facility food storage guidelines. DS stated previously prepared pudding should be stored for 3 days then discarded. DS removed the pudding from reach in refrigerator to discard. During the same observation there was one container of sour cream with open date of [DATE] stored in the reach in refrigerator. During a concurrent interview and record on [DATE] at 9:35 a.m., with DS, reviewed food storage guidelines. DS stated the maximum refrigeration time for sour cream was 7 days after opening. DS discarded the sour cream from the reach in refrigerator. During a concurrent observation and interview on [DATE] at 9:45a.m., with DS, observed a tray with 20 single serve cartons of sugar free Nutritional Supplements stored in the reach in refrigerator with a sign of do not use on it. DS stated the vendor called the facility regarding the recall on frozen nutritional supplements by manufacturer for potential contamination with listeria. DS stated food delivery vendor told them the sugar free nutritional supplements were not on recall list. DS stated he kept them in refrigerator but told staff not to use. DS stated he should not leave something that was on recall in the refrigerator because staff can accidently use it and cause food borne illness in residents. During a review of letter published by US Food and Drug administration sugar free nutritional supplements were also voluntarily recalled by manufacturer. (continued on next page)

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	055070	A. Building B. Wing	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During the same observation on [DATE] at 9:45 a.m., there were 23 single serve cartons of milk with manufacturer expiration date of [DATE] stored in the reach in refrigerator and there was one open carton of thickened milk dated with received date of [DATE] but no open date. During a review of the manufacturer storage instructions for the thickened milk product indicated to refrigerate after opening and use within 7 days. During a concurrent observation and interview on [DATE] at 9:45 a.m., with DS, DS stated the milk should be discarded and every open product had to be dated with open date. DS discarded the single serve cartons of milk and the thickened milk. DS stated there should be open date on all products to know when to discard before it goes bad. During an observation on [DATE] at 9:50 a.m., in the facility reach in freezer, there were two unopened packages of sliced turkey deli meat (cold cut) that were thawed and soft to touch. The packages of the turkey cold cut had the date of [DATE]. During the same observation and interview with DS, DS stated he does not know why the turkey was thawed in the freezer. During the same interview on [DATE] at 9:50 a.m. with [NAME] (Cook 1), Cook1 stated there was a lot of turkey cold cut in the refrigerator, [NAME] 1 retuned two packages to the freezer. [NAME] 1 sated they were already thawed, and she put them in the freezer an hour ago. [NAME] 1 stated she thinks they were in the refrigerator to thaw since [DATE] the date on the package. [NAME] 1 stated she made a mistake and should not refreeze an already thawed food. DS stated refreezing thawed food can affect the quality of the product and removed them from the freezer to discard. During the same observation on [DATE] at 9:55 a.m., in the kitchen there were unpasteurized shell eggs stored in the reach in refrigerator. During a concurrent observation and interview with DS, DS stated the vendor did not have pasteurized eggs because of the egg shortage. DS stated this morning breakfast was made with unpasteurized shell eggs. During an interview on [DATE] at 3:32 p.m., with [NAME] (Cook 2), [NAME] 2 stated this morning she prepared fried eggs for breakfast. [NAME] 2 stated facility used pasteurized shell eggs. [NAME] 2 stated she fried the eggs in a skillet, 6 eggs at a time. [NAME] 2 stated there are two residents who want scrambled eggs but the rest like the fried eggs. [NAME] 2 did not know the shell eggs in the refrigerator were not pasteurized. During a review of the 2022 U.S. Food and Drug Administration Food Code titled Eggs and Milk Products, Pasteurized. Code ,d+[DATE].14 indicated, (A) Egg products [NAME] be obtained pasteurized. During a review of facility's P&P titled Procedure for Refrigerated Storage (dated 2023) indicated, Frozen food should be left in a refrigerator to thaw. Once thawed .Cured meats, which are to be used within 5 days . Raw eggs shall be obtained pasteurized. (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 Labeling and Dating of Foods (dated 2023) indicated, Newly opened food items will need to be closed and labeled with an open date and used by the date that follows the various storage guidelines. During a review of facility refrigerated storage guide (dated 2023) indicated, For sour cream follow expiration date or 7 days after opening, whichever comes first .Desserts, prepared, including puddings and cream pies store for 3 days. During a review of the 2022 U.S. Food and Drug Administration Food Code titled Ready to Eat, Time/Temperature control for safety food, Date Marking Code#,d+[DATE].17, indicated, Ready to eat, time temperature control for safety food prepared and packaged by food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24hours, to indicate the date or day by which the food shall be consumed, sold, or discarded. During a review of the 2022 U.S. Food and Drug Administration Food Code titled Frozen Food Code , d+[DATE].11 indicated, Freezing prevents microbial growth in foods, but usually does not destroy all microorganisms. Improper thawing provides an opportunity for surviving bacteria to grow to harmful numbers and/or produce toxins. If the food is then refrozen, significant numbers of bacteria and/or all preformed toxins are preserved. 4.During an observation on [DATE] at 10:45 a.m., in the kitchen food preparation area, observed [NAME] (Cook1) was preparing lunch and cleaned the counter using kitchen cloth stored in a solution inside a red bucket. During a concurrent observation and interview with [NAME] 1, [NAME] 1 stated the kitchen cloth was stored in the sanitizer red bucket. [NAME] 1 stated after wiping and washing counter with soap and water, [NAME] 1 used the cloth in the sanitizer to sanitize food contact surfaces. [NAME] 1 was asked to test the sanitizer effectiveness inside the red bucket. [NAME] 1 immersed a test strip in the bucket and compared the color change to the test strip container. The test strip resulted in sanitizer not effective. [NAME] 1 replaced the sanitizer solution and retested . The sanitizer test strip resulted in sanitizer not effective again. [NAME] 1 stated when sanitizer was prepared in the morning it was always tested . [NAME] 1 stated she did not prepare the sanitizer solution in the container. [NAME] 1 stated when the test strip results in sanitizer not effective it means there was no sanitizer, and the counters were not sanitized. During an interview on [DATE] at 11:00 a.m., with [NAME] 2, [NAME] 2 stated she filled the buckets with the sanitizer solution using the faucet that directly dispenses the QUAT sanitizer solution (Quat sanitizer-Quaternary Ammonium a type of sanitizer used in the kitchen). [NAME] 2 stated that she filled the buckets for the staff at 5:15 a.m. [NAME] 2 stated that she changes the solution three times a day and as needed when the solution was visibly soiled or cloudy. [NAME] 2 stated she should test the sanitizer solution effectiveness using the test strip before distributing to the stations. [NAME] 2 stated she did not check it this morning. [NAME] 2 stated when there was no sanitizer then the counters were not being sanitized and it can cross contaminate the food, making residents sick. (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 Quaternary Ammonium Log Policy (no date) indicated, The concentration of the ammonium in the quaternary sanitizer will be tested to ensure the effectiveness of the solution. The quaternary solution, used for sanitizing clean work surfaces in the kitchen, will be made according to the instruction on the product or dispensing device.Food and nutrition worker will place the solution in the appropriate bucket .and will test the concentration of the sanitation solution. The concentration will be tested at least every shift or when the solution is cloudy. The solution will be replaced when the reading is below 200 parts per million (PPM- a unit used to express the concentration of a substance in a solution). The replacement solution will be tested prior to usage

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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** 49889 Based on observation, interview and record review, the facility failed to observe infection control measures by not ensuring staff perform hand hygiene for one of one reviewed resident (Resident 33). This failure had the potential to result in cross contamination (the physical movement or transfer of harmful bacteria from one person, object, or place to another) and place the residents at risk for the spread of infection. Findings: During a review of Resident 33's Admission Record dated 2/28/25 the Admission Record indicated, Resident 33 was admitted on [DATE] with the diagnoses including osteomyelitis (bone infection) left ankle and foot, type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), partial traumatic amputation (surgically cutting off limb) of left foot. During a review of Resident 33's Minimum Data Set (MDS - a resident assessment tool) dated 2/11/25, the MDS indicated Resident 33's cognition (ability to think, understand, learn, and remember) was intact. The MDS also indicated that Resident 33 needs partial/moderate assistance (helper does less than half the effort) with Activities of Daily Living (ADLs- activities such as toileting, bathing and dressing a person performs daily). During a review of Resident 33's Physician Order Summary Report dated 2/28/25, the Physician Order Summary Report indicated Resident 33 had order to clean left transmetatarsal amputation (TMA-surgical procedure that removes part of the foot) with hibiciens(wound cleaner) pat dry apply Bactroban (topical antibiotic used to treat bacterial infections) and medihoney(medical grade honey used to treat wounds and burns) then cover with calcium alginate (wound treatment used for moderate to heavy draining wounds) and a dry dressing then wrap with kerlix (gauze dressing). During an observation on 2/26/25 at 10:32 a.m. in Resident 33's room Resident 33's wound care was observed. The treatment nurse was observed not performing hand hygiene in between glove changes four times while providing wound care for Resident 33. During an interview on 2/26/25 at 3:44 p.m. with the treatment nurse (TXN), the TXN stated she was thinking she did not touch her gloves that is why she did not wash her hands. TXN stated she should have performed hand hygiene in between glove changes to remove the germs. TXN stated there was a possibility to spread infection when not washing her hands in between glove changes. During an interview on 2/27/25 at 5:07 p.m., with the Director of Nursing (DON), the DON stated when providing wound care, hand hygiene must be done every time you change your gloves. The DON stated there was a possibility of cross contamination when not doing proper hand hygiene in between glove changes. (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 procedure (P&P) titled Handwashing/Hand Hygiene dated 10/2023, the P&P indicated The facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. The use of gloves does not replace hand washing/hand hygiene Indications for hand hygiene. A. Immediately before touching a resident B. Before performing an aseptic task (for example, placing an indwelling device or handling an invasive medical device). C. After contact with blood, body fluids, or contaminated surfaces D. After touching a resident E. After touching the resident's environment F. Before moving from work on a soiled body site to a clean body site on the same resident G. Immediately after glove removal

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44898 Based on interview and record review the facility failed to ensure a Surveillance Data Collection form was completed for one of 16 reviewed residents (Resident 39) who received Keflex (antibiotic used to treat infections caused by bacteria) 500 milligrams (mg-unit of measurement) by mouth twice a day from 1/23/2025 to 1/30/2025 to treat a urinary tract infection (UTI- an infection in the bladder/urinary tract). This failure had the potential to put Resident 39 at risk for antibiotic resistance (when bacteria change to resist antibiotics used to effectively treat them) and inappropriate use of antibiotic. Findings: During a review of Resident 39's Admission Record, the Admission Record indicated Resident 39 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including urinary tract infections, diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), bronchitis (inflammation of the bronchial tubes, the airways that carry air to and from the lungs), and dementia (a progressive state of decline in mental abilities). During a review of Resident 39's Initial History and Physical (H&P) Examination, dated 11/27/2024, the Initial H&P Examination indicated Resident 39 had recurrent urinary tract infections associated with poor hygiene and was given Rocephin (medication to treat infection), then changed to Keflex. The Initial H&P Examination indicated Resident 39 will need to follow-up on urine culture (a laboratory test that detects the presence and type of bacteria or other microorganisms in a urine sample) results. During a review of Resident 39's Minimum Data Set (MDS-a resident assessment tool), dated 12/4/2024, the MDS indicated Resident 39 had the ability to express ideas and wants. The MDS Indicated Resident 39 was able to make self understood. The MDS indicated Resident 39 had the ability to understand others with clear comprehension. The MDS indicated Resident 39 needed substantial to maximal assistance from nursing staff with toileting and showering. The MDS indicated Resident 39 needed partial to moderate assistance from nursing staff with oral hygiene, dressing, putting on and taking off footwear. The MDS indicated Resident 39 needed partial to moderate assistance from nursing staff with lying flat on the bed, sitting, standing, walking, and transferring. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/27/2025 at 3:17 p.m., with the Infection Preventionist Nurse (IP), the IP stated he monitors antibiotic use for the residents and monitors if the resident needs the antibiotic. The IP stated he continues to monitor the resident for any signs and symptoms of infection while receiving antibiotic. The IP stated he will check the resident's Nursing Progress Notes for documentation of any signs and symptoms of infection and then notifies the doctor. The IP stated he uses the Surveillance Data Collection form to document signs and symptoms of infection and to document antibiotics prescribed. The IP stated he failed to document Resident 39 was on antibiotics in the Antibiotic Stewardship (refers to a set of commitments and actions designed to optimize the treatment of infections while reducing the adverse events associated with antibiotic use) binder. The IP stated he did not see any documentation in the Nursing Progress Notes that Resident 39 had signs and symptoms of a urinary tract infection. The IP stated he did not check Resident 39's antibiotic order for Keflex 500 mg by mouth twice a day. The IP stated he did not check Resident 39's urine culture and sensitivity. The IP stated he checks daily to see what residents are receiving antibiotics and missed Resident 39's order for antibiotics. The IP stated if he had completed the Surveillance Data Collection form, he would have found that Resident 39 did not meet the criteria to start antibiotic for a urinary tract infection. IP stated Resident 39 could develop resistance to antibiotics. During a review of the facility's policy and procedure (P&P) titled, Antibiotic Stewardship, revised 12/2016, the P&P indicated, The purpose of our antibiotic stewardship program is to monitor the use of antibiotics in our residents .When a nurse calls a physician/prescriber to communicate a suspected infection, he or she will have the following information available signs and symptoms, when symptoms were first observed, resident's hydration status, current medication list, allergy information, infection type, any orders for warfarin and results of last INR, last creatinine clearance or serum creatinine, if available, and time of the last antibiotic dose. During a review of the facility's P&P titled, Surveillance for Infections, date revised 9/2017, the P&P indicated, Infections that will be included in routine surveillance include those with clinically significant morbidity or mortality associated with infection (e.g., pneumonia, UTIs, C.difficile) . Nursing staff will monitor residents for signs and symptoms that may suggest infection, according to current criteria and definitions of infections, and will document and report suspected infections to the charge nurse as soon as possible. The infection preventionist or designated infection control personnel is responsible for gathering and interpreting surveillance data. The infection control committee and/or QAPI committee may be involved in interpretation of the data. The surveillance should include a review of any or all of the following information to help identify possible indicators of infections laboratory records skin care sheets infection control rounds or interviews verbal reports from staph infection documentation records temperature logs, pharmacy records antibiotic review and transfer log/summaries. If laboratory reports are used to identify relevant information, the following findings merit further evaluation, positive blood cultures positive wound cultures that do not just represent surface colonization, positive urine cultures (bacteriuria) with corresponding signs and symptoms that suggest infection .

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F 0911 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44088 Based on observation, interview, and record review. The facility failed to ensure bedrooms room [ROOM NUMBER] and 34 accomodate no morethan four residents. Findings: During the initial the initial tour on 2/26/2025 at 10:00 a.m., to the facility, room [ROOM NUMBER] and 34 housed five residents per room. During a record review of Client Accommodations Analysis form, provide by the facility Maintenance Supervisor (MS) rooms [ROOM NUMBERS] occupied by five residents. During a review of Room Waiver letter dated 2/28/2025 provided by the Administrator (Admin) indicated, all residents and caregivers have ample space in mobility with walkers and wheelchairs. Residents can get in and out of their rooms with ease and facility staff are able to give care of administering treatment or medications to the residents inside the room. The floor size of room [ROOM NUMBER] was 500.73 sq. ft (100.14 sq. ft per bed), and room [ROOM NUMBER] was 534.42 sq. ft (106.88 sq. ft per bed). This exceeds the required 80 sq. ft per bed requirement. During the survey observations from 2/25/2025 to 2/28/2025, the other resident's room were observed with sufficient space to move around freely within the room, and the nursing staff had enough space to provide care. There was space for the beds, side tables, dressers, and resident care equipment. There were no adverse effects noted to the residents' privacy, health, and safety, which could have been compromised by the size of the rooms.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. 45981 Based on observation, interview, and record review. The facility failed to ensure 8 of 17 residents rooms met the 80 square feet (sq. ft.-unit of measurement) per residents in multiple resident rooms. Rooms 20, 21, 22, 23, 25, 26,27 and 32. This failure had the potential to result in an inadequate provision of safe nursing care, and privacy for the residents. Findings: During the initial the initial tour on 2/26/2025 at 10:00 a.m., to the facility, Rooms 20, 21,22, 23, 25, 26, 27, and 32 rooms did not meet the requirement of 80 sq. ft. per residents. During a record review of Client Accommodations Analysis form, provide by the facility Maintenance Supervisor (MS) Rooms 20, 21, 22, 23, 25, 26, 27 and 32 rooms did not meet the requirement of 80 sq.ft per residents. During a review of Room Waiver letter dated 2/28/2025 provided by the Administrator (Admin) indicated, all residents and caregivers have ample space in mobility with walkers and wheelchairs. Residents can get in and out of their rooms with ease and facility staff are able to give care of administering treatment or medications to the residents inside the room. During the survey observations from 2/25/2025 to 2/28/2025, the other resident's room were observed with sufficient space to move around freely within the room, and the nursing staff had enough space to provide care. There was space for the beds, side tables, dressers, and resident care equipment. There were no adverse effects noted to the residents' privacy, health, and safety, which could have been compromised by the size of the rooms.

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program for all new and existing staff members. 45981 Based interview and record review, the facility failed to ensure that staff were being in serviced (staff education) for dementia (a progressive state of decline in mental abilities) care. This failure had the potential to jeopardize the safety of residents when staff are not adequately trained. Findings: During an interview on 2/27/2025 at 12:21 p.m., with Certified Nurse Assistant (CNA) 1, CNA 1 stated that she had not received dementia training. CNA 1 stated that she does provide care for residents with dementia in the facility. CNA 1 stated staff should receive dementia training because residents with dementia require special care. CNA 1 stated residents with dementia need to be approached and communicated differently. CNA 1 stated residents with dementia could become agitated easily if they are not approach appropriately. CNA 1 stated that residents with dementia could become combative and injure the other residents and staff if not approached appropriately. During an interview on 2/27/2025 at 12:33 p.m., with CNA 2 stated that she provides care for residents with dementia. CNA 2 stated that she had not received dementia care training. CNA 2 stated that dementia care training is important in order to provide the best care and services to the residents. CNA 2 stated that without dementia care training it could affect the safety and care of the residents. During a concurrent interview and record on 2/27/2025 at 2:04 p.m., with the Director of Staff Development (DSD), the facility's In-Service Calendar, dated 2025 was reviewed, the In-Service Calendar indicated, January Dementia/Alzheimer's Disease Training. DSD stated that she was responsible for providing dementia care trainings to the staff. DSD stated CNAs should receive dementia training upon hire, every three months, and as needed. DSD stated it was important that the CNAs have the proper dementia care training to ensure that the residents are receiving the proper care that they deserve. DSD stated without the CNAs receiving the proper training that was required could potentially lead to physical and mental harm to the residents. DSD stated the staff need to have the proper training to know how to approach the residents with dementia. DSD validated that she had not provided the dementia care training for January as indicated on the In-Service calendar. DSD validated that the new staff that had been hired had not received dementia care training. During an interview on 2/27/2025 at 3:30 p.m., with Registered Nurse (RN) 1, RN 1 stated dementia care training is imperative for staff to ensure that the residents receive the care and services that they require and deserve. RN 1 stated dementia care training allows the staff to understand their needs, maintain a connection with them and supports their dignity. During a review of the Facility's Assessment titled, Required in-service training for nurse aides- In-service training dated February 2025, the Facility Assessment indicated Must include dementia management training and resident abuse training. (continued on next page)

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Seacrest Post-Acute Care Center	1416 West 6th Street San Pedro, CA 90732

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 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a of the facility's policy and procedure (P&P) titled, Dementia-Clinical Protocol, dated 2018, the P&P indicated, Nursing assistants will receive initial training in the care of residents with dementia and related behaviors. In-services will be conducted at least annually thereafter. Additionally, performance reviews will be conducted annually, and in-service education will be based on the results.