STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055104	A. Building B. Wing	04/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Manor Conv Hosp	2720 Nevada Avenue El Monte, CA 91733

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48905 Based on observation, interview, and record review, the facility failed to provide reasonable accommodation of needs for two of two sampled residents (Resident 2 and Resident 270) by failing to: a. Ensure a call light to accommodate a resident's mobility limitations was provided when Resident 270 was unable to move Resident 270's bilateral upper arms and hands. b. Ensure call light was within reach for Resident 2 who was assessed as high risk for fall as indicated in the facility's policy and procedure (P&P) titled, Call Lights: Accessibility and Timely Response and the resident's care plan. These failures had the potential to result in Resident 270 and Resident 2 being unable to notify staff for needs and possibly, an emergency. Findings: a. During a review of Resident 270's Admission Record (AR), the AR indicated Resident 270 was admitted to the facility on [DATE] with diagnoses that included but are not limited to myotonic muscular dystrophy (genetic condition that causes progressive muscle weakness and wasting), contracture (permanent tightening of muscles and nearby tissues that causes joints to become very stiff, preventing normal movement of a joint or other body part) of the right and left shoulder, dependence on a ventilator (machine that helps a person breathe or breathes for the person), and tracheostomy tube (trach tube, surgical procedure in which a tube is inserted from an opening in the neck into the trachea [windpipe]). During a review of Resident 270's Baseline Care Plan and Summary (BCPS) dated 4/3/2024 at 5:32 AM, the BCPS indicated Resident 270's cognitive abilities (ability to think, learn, and process information) were intact. During a review of Resident 270's untitled care plan (CP) dated 4/10/2024, the CP indicated staff to assist Resident 270 with use of adaptive equipment or devices to promote successful participation in activities or care. The CP indicated on 4/3/2024, staff to use alternative communication tools as needed due to Resident 270's communication problem. The CP indicated on 4/3/2024, staff to place the Resident 270's call light within reach and to encourage the resident to use it for assistance as needed. (continued on next page)

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

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 4/9/2024 at 9:56 AM, Resident 270 was in bed with the trach tube connected to the ventilator machine. The soft touch call light (flattened pad that is activated by slight pressure from the hand, arm, or body) was out of reach and pinned to the pillow behind Resident 270's head. Resident 270 stated he needed to be suctioned through his trach tube and was unable to use the call light. Resident 270 stated he was unable to move bilateral arms and hands, and stated he could only move his head. During an interview on 4/10/2024 at 8:43 AM with Registered Nurse Supervisor (RN Sup) 1, RN Sup 1 stated the facility has two types of call lights: a button and a soft touch call light. RN Sup 1 stated Resident 270 had a specific need due to the resident was unable to move the resident's arms but was alert. RN Sup 1 stated staff could request a special call light through Social Services, Administrator (ADM), or Central Supply (department responsible for receiving, storing, and distributing medical and surgical supplies and equipment). During an interview on 4/10/2024 at 11:15 AM with Licensed Vocational Nurse (LVN) 5, LVN 5 stated Resident 270 was unable to use his arms and hands and has the round flat call light at the bedside. LVN 5 stated staff can ask supervisors for the devices to accommodate a resident's physical or mobility limitation. LVN 5 stated Resident 270's call light should've been changed earlier to accommodate the resident's mobility limitations. LVN 5 stated not changing Resident 270's call light to accommodate the resident's mobility limitations put the resident at risk of not being able to notify staff and would not promote the resident's independence since the resident was able to make his needs known. During an interview on 4/11/2024 at 11:40 AM with Resident 270, Resident 270 stated he was not offered to change the call light since he has been admitted on [DATE]. Resident 270 stated he hasn't been able to use the soft touch call light and would have to wait for staff to come by to check on him. Resident 270 stated, it made me feel awful not being able to call anyone if I needed help with something, especially with suctioning. During an interview on 4/12/2024 at 9:50 AM with the Assistant Director of Nursing (ADON), the ADON stated during admission, the nurse was to communicate to the Director of Nursing (DON), Social Worker, or ADM when the resident needed an accommodation with a device. The ADON stated there were three types of call lights that can be provided to the resident: a button, a soft touch, and an EZ light (a sensitive call light that can be placed near the face of the resident). ADON stated the risk of not having a proper call light to accommodate the resident's physical and mobility needs put the resident at risk of not meeting his needs. The ADON stated it can impact Resident 270's independence as Resident 270 was alert and able to make his needs known. The ADON stated it was not acceptable to not have accommodated Resident 270's need for a EZ call light since his admission to the facility. During a review of the facility's policy and procedure (P&P) titled, Call Lights: Accessibility and Timely Response dated 10/2022, the P&P indicated each resident shall, as much as possible, be evaluated for unique needs and preferences to determine any special accommodations that may be needed for the resident to utilize the call system. During a review of the facility's P&P titled, Accommodation of Needs dated 10/2022, the P&P indicated the facility will make reasonable accommodations to individualize the resident's physical environment including personal bathroom, bedroom, and common living areas within the facility. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	40438 b. During a review of Resident 2's Admission Record (AR), the AR indicated, the facility initially admitted Resident 2 to the facility on [DATE], and readmitted the resident on 2/20/2024, with diagnoses that included abnormalities of gait (a person's manner of walking) and mobility (the ability to move) and history of falling. During a review of Resident 2's Fall Risk Assessment (FRA, method of assessing a patient's likelihood of falling)), dated 2/21/2024, Resident 2 was assessed at risk for falls due to intermittent confusion (lack of understanding), using assistive devices (a device used for assistance during walking and standing), balance problem while standing and walking, and decreased muscular coordination (orchestrated movement of multiple body parts to accomplish intended actions). During a review of Resident 2's untitled Care Plan (CP), dated 2/22/2024, the CP indicated, Resident 2 had an unwitnessed fall. The CP goal indicated, fall risk for Resident 2 will be minimized by next review date. The CP intervention indicated to place the call light within arm's reach. During a review of Resident 2's untitled CP, dated 2/22/2024, the CP indicated Resident 2 had a communication problem related to hard of hearing, mumbled/tried to communicate verbally but unable, at risk for unmet needs, social isolation sensory deprivation, and further decline with cognition, mood, and behavior. The CP goal indicated Resident 2 to improve communication function through the review date. The CP intervention included to provide a safe environment and call light within reach. During a review of Resident 2's Minimum Data Set (MDS, a resident assessment and care-screening tool), dated 3/11/2024, the MDS indicated, Resident 2 had severely impaired cognitive skills (ability to understand) for daily decision making, and dependent (helper did all of the effort, resident did none of the effort to complete activity) on the staff for eating, oral hygiene, toileting, shower, upper and lower body dressing, and personal hygiene. During a concurrent observation and interview on 4/10/2024 at 9:30 am with the Licensed Vocational Nurse (LVN) 2 inside Resident 2's room, Resident 2 was in bed, moving and in an oblique position. Resident 2's head was on the left side of the bed and his legs on the right side of the bed. Resident 2 had his left fingers pointing on the wall. LVN 2 could not understand what Resident 2 was trying to communicate. Resident 2 wanted his TV and wall fan on. Resident 2 did an ok and thumbs up hand signs after LVN 2 understood him. LVN 2 stated Resident 2's call light was hanging on the siderails on the right upper side of the bed and covered with a pillow. LVN 2 stated call light needed to be close by and within the resident's reach for the resident to use to call for help or assistance. During an interview on 4/12/2024 at 8:53 am with the Registered Nurse Supervisor (RN Sup) 1, RN Sup 1 stated call light needed to be placed within the resident's reach for the safety of the resident. During a review of the facility's P&P titled, Call Lights: Accessibility and Timely Response, with revised on 12/19/2022, the P&P indicated, staff ensured the call light was within reach of residents and secured, as needed. The call system was accessible to residents while in their bed or other sleeping accommodations within the resident's room.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42781 Based on interview and record review the facility failed to provide information of Advance Directive (AD, written preferences regarding treatment options, a process of communication between individuals and their healthcare agents to understand and plan for future healthcare decisions for a time when individuals are not able to make their own healthcare decisions) for two of two sampled residents (Residents 45 and 47) in accordance with facility's policy titled Residents' Rights Regarding Treatment and Advance Directives. These failures had the potential for Residents 45 and 47 to receive treatment and services against the residents' will. Findings: a. During a review of Resident 45's Admission Record (AR), the AR indicated Resident 45 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus (a disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in elevated levels of glucose/sugar in the blood and urine) with hyperglycemia (high blood sugar). During a review of Resident 45's History and Physical (H&P), dated 3/20/2024, the H&P indicated Resident 45 had fluctuating capacity to understand and make decisions. During a review of Resident 45's Minimum Data Set (MDS- a standardized assessment and care planning tool), dated 3/24/2024, the MDS indicated Resident 45 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated, Resident 45 required total dependence (totally dependent with staff for assistance of activities of daily living) with toileting hygiene, shower, lower body dressing and putting on or taking off footwear. During a review of Resident 45's Advance Directive Acknowledgement form dated 3/20/2024, the AD Acknowledgement Form was not completed. During an interview with the Assistant Social Service Director (ASSD) and concurrent record review of Resident 45's medical records on 4/10/2024 at 10:30 am, the ASSD stated Resident 45's AD Acknowledgement Form needed to be filled out completely. The DON stated it was the resident's right to formulate AD upon admission for the facility to provide care and treatment to meet the resident's wishes. During an interview on 4/12/2024 at 8:51 am with the facility's Assistant Director of Nursing (SDON), the SDON stated Social Services needed to follow up if the AD was formulated for Resident 45 upon admission. The ADON stated, AD Acknowledgement Form needed to be filled out completely by Resident 45. b. During a review of Resident 47's AR, the AR indicated Resident 47 was admitted to the facility on [DATE] with diagnoses that included hypertension (high blood pressure). (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 47's History and Physical (H&P), dated 3/31/2023, the H&P indicated Resident 47 did not have the capacity to understand and make decisions. During a review of Resident 47's MDS dated [DATE], the MDS indicated Resident 47 had moderately impaired cognition for daily decision making. The MDS indicated, Resident 47 required total dependence with toileting hygiene, shower, lower body dressing and putting on/taking off footwear. During an interview with the Assistant Social Service Director (ASSD), and concurrent record review Resident 47's medical record on 4/10/2024 at 10:37 am, the ASSD stated there was no AD assessment performed for Resident 47. During an interview on 3/4/2024 at 2:50 pm, ASSD stated, there was no documentation indicating Resident 47's AD information was offered to Resident 47 or Resident 47's Responsible Party. The ASSD stated, it was important to have the AD information documented in Resident 47's medical records upon admission, in order for the facility to provide care and treatment in accordance with the resident's wishes. During a review of the facility's Policy and Procedure titled, Residents' Rights Regarding Treatment and Advance Directives, revised 12/19/2022, the P&P indicated on admission, the facility will determine if the resident has executed an advance directive, and if not, determine whether the resident, if cognitively able to, would like to formulate advance directive. The P&P indicated, upon admission, should the resident have an advance directive, copies will be made and placed on the chart as well as communicated to the staff.

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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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42781 Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS- a resident assessment and care planning tool) dated 1/11/2024 assessment reflected an accurate assessment of the discharge destination for two of two sampled residents (Residents 68 and 67) by failing to ensure : a. Resident 68 who was discharged to a Skilled Nursing Facility (SNF - an inpatient rehabilitation and medical treatment center staffed with trained medical professionals) was coded in the MDS assessment as being discharged to home. b. Resident 67 who was discharged to home was coded in the MDS assessment as being discharged to a General Acute Care Hospital (GACH). These deficient practices resulted in an inaccurate reporting to the Centers of Medicare and Medicaid (CMS, a federal agency that administers the Medicare program and works with state governments to administer the Medicaid and health insurance portability standards) agency and had the potential for Residents 68 and 67 not to receive interventions to address specific care concerns upon discharge. Findings: a. During a review of Resident 68's Admission Record (AR), the AR indicated Resident 68 was admitted to the facility on [DATE] with diagnoses that included dysphagia (difficulty in swallowing) and hyperlipidemia (high level of fats in the blood). During a review of Resident 68's Physician's Order dated 1/11/2024, the physician's order indicated to transfer Resident 68 to a SNF. During a review of Resident 68's MDS dated [DATE], the MDS indicated Resident 68 was discharged to home. During an interview on 4/11/2024 at 12:38 pm with the facility's Minimum Data Set Nurse (MDSN), the MDSN stated Resident 68 was discharged to SNF on 1/11/2024. The MDSN stated, Resident 68's MDS assessment needed to be coded discharged to SNF and not to home. The MDSN stated Resident 68's MDS assessment needed to be coded accurately to give accurate information to CMS. 40438 b. During a review of Resident 67's Admission Record (AR), the AR indicated, the facility admitted Resident 67 to the facility on [DATE], with diagnoses that included osteomyelitis (inflammation and infection of bone) of the left ankle and left foot and end stage renal disease (ESRD, permanent kidney failure that requires a regular course of dialysis or a kidney transplant). During a review of Resident 67's Physician's Order (PO), dated 2/7/2024, the PO indicated, Resident 67 had a discharge order for home on 2/29/2024 with home health (a wide range of health care services that can be given in the home for an illness or injury). (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	During a review of Resident 67's MDS, dated [DATE], the MDS indicated, Resident 67 was discharged to the short-term general hospital (acute hospital). During a review of Resident 67's Post Discharge Plan of Care and Summary (DPOCS), dated 2/29/2024, the DPOCS indicated, Resident 67 was discharged home under the care of organized home health service organization. During a review of Resident 67's Progress Notes (PN), dated 2/29/2024, timed at 12:40 pm, the PN indicated, Resident 67 was discharged home and left the facility at 12:30 p.m. in stable condition. During an interview on 4/12/2024 at 9:14 am with the MDS coordinator (MDS C), MDS C stated Resident 67 was discharged home and was not transferred to the acute hospital. MDS C stated discharge destination of the resident needed to be accurately reflected in the MDS assessment for the continuation of care of the resident. During an interview on 4/12/24 at 12:11 pm with the Director of Nursing (DON), the DON stated assessment of the resident needed to be accurate because it was important to give accurate information to the Centers for Medicare & Medicaid (CMS, a federal agency that administered the Medicare program and worked with state governments to administer the Medicaid and health insurance portability standards) and to be able to provide the necessary care to the resident. During a review of the facility's policy and procedure (P&P) titled, Conducting an Accurate Resident Assessment, revised on 12/19/2022, the P&P indicated, the purpose of the policy was to assure that all residents received an accurate assessment, reflective of the resident's status at the time of the assessment, by staff qualified to assess relevant care areas using the resident assessment instrument (RAI) specified by CMS.

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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** 48905 Based on interview and record review, the facility failed to initiate and implement a care plan for one of one sampled resident (Resident 274) when Resident 274 has a left lateral (side) mid foot unstageable (bed sore that occurred when there was prolong pressure on a specific area to the skin resulting in an open wound. Tissue was lost and the depth of the wound was obscured by eschar [dry, dead tissue within the wound]) pressure injury (PI), left medial (toward middle or center) foot unstageable PI, left medial malleolus (ankle bone) stage two (shallow open ulcer with a red or pink wound bed) PI, left metatarsal (long bone in each foot) first toe unstageable PI, right heel deep tissue injury (DTI, pressure injury that are purple or maroon that appear on intact skin due to damage of underlying tissue), right lateral malleolus unstageable PI, right lateral mid foot stage two PI, left lateral lower leg unstageable PI, and right posterior lower leg PI. This failure had the potential to result in Resident 274's PIs to worsen. Findings: During a review of Resident 274's Admission Record (AR), the AR indicated Resident 274 was admitted to the facility on [DATE] with diagnoses that included but are not limited to PIs of the sacral region, right and left buttocks, right ankle, right heel stage one (skin is intact and appears reddened and does not blanch [lost color briefly when pressing finger on it and removing finger]) PI, open wound on right and left foot, dependence on a ventilator (machine that helps a person breathe or breathes for the person), gastrostomy tube (G-tube, feeding tube that is surgically placed through an opening into the stomach from the abdominal wall), and tracheostomy tube (trach tube, surgical procedure in which a tube was inserted from an opening in the neck into the trachea [windpipe]). During a review of Resident 274's History and Physical (H&P, formal document of a medical provider's examination of a patient) dated 4/5/2024, the H&P indicated Resident 274 had fluctuating capacity to understand and make decisions. During a review of Resident 274's Braden Scale (BS, assessment tool for early identification of residents at risk of pressure ulcers) dated 4/4/2024 at 5:04 AM, the BS indicated Resident 274 was a high risk for developing a pressure injury. During a review of Resident 274's Order Summary Report (OSR) dated 4/3/2024 to 4/11/2024, the OSR indicated Resident 274 had an active Medical Doctor (MD) order to cleanse with normal saline (pH mixture of water and salt), pat dry, apply betadine solution (antiseptic solution to prevent infections), and cover with abdominal pad or foam dressing for the following PI's: Left lateral mid foot unstageable PI; Left medial foot unstageable PI; Left medial malleolus stage two PI; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Left metatarsal first toe unstageable PI; Right heel DTI; Right lateral malleolus unstageable PI; Right lateral mid foot stage two PI; Left lateral lower leg unstageable PI; Right posterior lower leg unstageable PI; Lower back DTI; and Sacrcoccyx (sacrum [triangle bone at the base of the spine] and coccyx [tailbone]) extending to left and right buttocks unstageable PI. During a review of Resident 274's Skin Evaluation (SE) dated 4/4/2024 at 3:23 PM, the SE indicated Resident 274 was admitted with an unstageable PI on the right ankle, stage one PI on the right heel, DTI on the right foot, traumatic wound on the right foot, unstageable PI on the posterior right leg, stage two PI on the left posterior thigh, left and right shoulder tear, stage one PI on the lower back, and an unstageable PI on the coccyx. During a concurrent interview and record review on 4/11/2024 at 10:41 AM with Licensed Vocational Nurse (LVN) 4, Resident 274's untitled care plan (CP) dated 4/5/2024 was reviewed. The CP indicated a CP for the following PI's: Unstageable PI on Sacrococcyx extending to left and right buttocks; Right and left posterior shoulder skin tear; Left upper back skin tear; Stage two PI on the left ischium; and Stage one PI on lower back. LVN 4 stated CP's were completed on admission and as needed. LVN 4 stated the purpose of CP's were to list specific problems or issues, goals for the problem, and interventions for staff to follow to promote the resident's wellbeing. LVN 4 stated the CP was tailored to each resident's needs. LVN 4 stated there was no CP for the following PI's: Left lateral mid foot; Left medial foot; Left medial malleolus; Right heel; Right lateral malleolus; Right lateral mid foot; Left lateral lower leg; and Right posterior lower leg. LVN 4 stated Resident 274's CP should list each PI. LVN 4 stated the risk of not having a CP for each pressure injury could result in the PIs to worsen, or possibly, get infected and septic (life-threatening emergency that happens when your body's response to an infection damages vital organs, and often, death) when it was not treated. During an interview on 4/11/2024 at 11:16 AM with Registered Nurse Supervisor (RN Sup) 1, RN Sup 1 stated there was no CP for Resident 274's PIs on the bilateral lower legs and feet. RN Sup 1 stated not having a CP for each PI could put current PIs at risk because the nurse would not be aware of the plan of care for the resident. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/12/2024 at 9:16 AM with the Assistant Director of Nursing (ADON), The ADON stated the charge nurse was responsible for initiating the CP. The ADON stated the purpose of CP's were to inform staff of resident's preferences, plan of care, and interventions for staff to follow. The ADON stated CP's are necessary for PIs as it would list the plan of care for each specific PI. The ADON stated not listing each PI could put the PI at risk of getting worse because staff would not be aware of what interventions to follow. The ADON stated it was not acceptable for the CP to not list each PI and stated it should've been completed on admission. During a review of the facility's policy and procedure (P&P) titled, Comprehensive Care Plan, dated 12/19/2022, the P&P indicated The comprehensive care plan F include measurable objectives and timeframes to meet the resident's needs. The P&P indicated objectives will be utilized to monitor the resident's progress, and alternative interventions will be documented as needed. During a review of the facility's P&P titled, Pressure Injury Prevention and Management, revised 9/12/2023, the P&P indicated interventions on a resident's plan of care will be modified as needed. The P&P indicated considerations for needed modification include: A. Changes in a resident's degree of risk for developing a PI. B. New onset or recurrent PI development. C. Lack of progression towards healing. D. Resident non-compliance. E. Changes in the resident's goals and preferences, such as end of life.

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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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40438 Based on observation, interview, and record review, the facility failed to ensure one of two sampled residents (Resident 2) selected for language/communication care area was provided with Passy-Muir Valve (PMV, allow tracheostomy [a procedure to help air and oxygen reach the lungs by creating an opening into the trachea (windpipe) from outside the neck] patients to produce speech sounds) for effective communication. This failure had the potential for Resident 2 to not receive necessary care and services due to lack of effective communication aids. Findings: During a review of Resident 2's Admission Record (AR), the AR indicated, the facility initially admitted Resident 2 to the facility on [DATE], and readmitted the resident on 2/20/2024, with diagnoses that included tracheostomy and chronic respiratory failure (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body). During a review of Resident 2's Minimum Data Set (MDS, a resident assessment and care-screening tool), dated 3/11/2024, the MDS indicated, Resident 2 had unclear speech, sometimes made self-understood (ability was limited to making concrete requests) and sometimes had the ability to understand others (responded adequately to simple, direct communication only). The MDS indicated, Resident 2 was dependent (helper did all the effort, resident did none of the effort to complete activity) on staff for eating, oral hygiene, toileting, shower, upper and lower body dressing, and personal hygiene. During a review of Resident 2's untitled Care Plan (CP), dated 2/22/2024, the CP indicated, Resident 2 had a communication problem related to mumbled/tried to communicate verbally but unable to, use of clipboard and pen, at risk for unmet needs, social isolation, sensory deprivation, and further decline with cognition, mood, and behavior. The CP goal indicated, Resident 2 will improve communication function through the review date. The CP interventions indicated, monitor effectiveness of communication strategies and assistive devices, pen, and board. During a review of Resident 2's Physician Order (PO), dated 2/26/2024, the PO indicated, Resident 2 had an order for tracheostomy PMV as tolerated. During a concurrent observation and interview on 4/10/2024 at 9:30 am with Licensed Vocational Nurse (LVN) 2 inside Resident 2's room, Resident 2 had his left fingers pointing on the wall. LVN 2 could not understand what Resident 2 was trying to communicate. Resident 2 wanted his TV and wall fan on. Resident 2 did an ok and thumbs up hand signs after LVN 2 understood him. During an interview on 4/12/2024 at 9:52 am with LVN 4, LVN 4 stated she communicated with Resident 2 verbally. LVN 4 stated Resident 2 replied by sign language or pointing. LVN 4 stated she could understand Resident 2's needs sometimes. LVN 4 stated she did not know that Resident 2 had a PMV or speaking valve at the bedside that she could put on the resident for better communication. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 4/12/2024 at 9:54 am with the Respiratory Therapist (RT) 1 inside Resident 2's room, Resident 2 had a PMV in a small green box dated 3/24/2024 inside his drawer. RT 1 stated Resident 2 had a PMV that could be put on as needed and as tolerated for speaking to help resident communicate better with the staff. RT 1 stated licensed nurses were trained on how to put the PMV on the resident. During an interview on 4/12/2024 at 9:56 am with the Registered Nurse Supervisor (RN Sup) 1, RN Sup 1 stated any licensed staff can put the PMV on the resident whenever they need to communicate with the resident to be able to understand and address the resident's needs. RN Sup 1 stated all licensed nurses were trained and in-serviced on how to apply and use the PMV. During a review of the facility's policy and procedure (P&P) titled, Passy-Muir Speaking Valve (PMV), undated, the P&P indicated, the facility provided tracheostomy resident with a PMV at the request of the resident and/or family, and a physician's order, so the resident can verbalize. The P&P indicated, PMV will be provided to the resident only with a physician's order, and applied to the resident by an RT, RN, or LVN that had been trained in the use of the PMV and passed the tracheostomy care skills test.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48905 Based on observation, interview, and record review, the facility failed to follow own policy and procedure (P&P) for pressure injury (PI, injuries to the skin and tissue below that are due to pressure on skin for long periods of time) prevention for one of one sampled residents (Resident 274). Resident 274's bilateral heel protectors (cushioned heel protectors that assist in reducing pressure in heels which can decrease the risk of pressure damage) were not on per Medical Doctor's (MD) order. Resident 274 who had a left lateral (side) mid foot unstageable (bed sore that occurs when there is prolong pressure on a specific area to the skin resulting in an open wound. Tissue was lost and the depth of the wound were obscured by eschar [dry, dead tissue within the wound]) PI, left medial (toward middle or center) foot unstageable PI, left medial malleolus (ankle bone) stage two (shallow open ulcer with a red or pink wound bed) PI, right heel deep tissue injury (DTI, pressure ulcers that were purple or maroon that appear on intact skin due to damage of underlying tissue), right lateral malleolus unstageable PI, and a right lateral mid foot stage two PI. This failure had the potential to result in new PIs to develop or worsen for Resident 274. Findings: During a review of Resident 274's Admission Record (AR), the AR indicated Resident 274 was admitted to the facility on [DATE] with diagnoses that included but are not limited to PIs of the sacral region, right and left buttocks, right ankle, right heel stage one (intact skin with non-blanchable [skin temporality turning white when pressed] redness over a bony area) PI, open wound on right and left foot, dependence on a ventilator (machine that helps a person breathe or breathes for the person), gastrostomy tube (G-tube, feeding tube that is surgically placed through an opening into the stomach from the abdominal wall), and tracheostomy tube (trach tube, surgical procedure in which a tube is inserted from an opening in the neck into the trachea [windpipe]). During a review of Resident 274's History and Physical (H&P, formal document of a medical provider's examination of a patient) dated 4/5/2024, the H&P indicated Resident 274 had fluctuating capacity to understand and make decisions. During a review of Resident 274's Braden Scale (BS, assessment tool for early identification of residents at risk of pressure ulcers) dated 4/4/2024 at 5:04 AM, the BS indicated Resident 274 was a high risk for developing a pressure injury. During a review of Resident 274's Order Summary Report (OSR) dated 4/3/2024 to 4/11/2024, the OSR indicated Resident 274 had an active MD order dated 4/4/2024 for bilateral heel protectors for wound management. The OSR indicated Resident 274 had an active MD order to cleanse with normal saline (pH mixture of water and salt), pat dry, apply betadine solution (antiseptic solution to prevent infections), and cover with abdominal pad or foam dressing for the following PI's: Left lateral mid foot unstageable PI; Left medial foot unstageable PI; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Left medial malleolus stage two PI; Left metatarsal first toe unstageable PI; Right heel DTI; Right lateral malleolus unstageable PI; Right lateral mid foot stage two PI; Left lateral lower leg unstageable PI; Right posterior lower leg unstageable PI; Lower back DTI; and Sacrcoccyx (sacrum [triangle bone at the base of the spine] and coccyx [tailbone]) extending to left and right buttocks unstageable PI. During a concurrent observation and interview on 4/10/2024 at 3:46 PM with Licensed Vocational Nurse (LVN) 4 in Resident 274's room, bilateral heel protectors were observed to not be on Resident 274. LVN 4 stated Resident 274 had an MD order to have bilateral heel protectors on for wound management and stated the heel protectors are not on Resident 274. LVN 4 stated the risk of not having the bilateral heel protectors on as ordered could put current pressure injuries at risk to worsen. During an interview on 4/11/2024 at 11:17 AM with Registered Nurse Supervisor (RN Sup) 1, RN Sup 1 stated bilateral heel protectors were used to protect heels from a pressure injury. RN sup 1 stated current PIs would be at risk if the bilateral heel protectors were not on per MD's order. During an interview on 4/12/2024 at 9:22 AM with the Assistant Director of Nursing (ADON), the ADON stated heel protectors lift heels to reduce pressure and promote healing. The ADON stated it could only be placed when there was an MD's order. The ADON stated there was no excuse why bilateral heel protectors were not on if it was ordered. The ADON stated the risk of not placing bilateral heel protectors per MD's order could cause new PIs to develop or worsen. During a review of the facility's P&P titled, Skin Integrity Foot Care, revised 9/12/2023, the P&P indicated appropriate offloading (minimizing or removing weight on foot) or orthopedic devices, diabetic shoes, or pressure-relieving devices will be utilized. During a review of the facility's P&P titled, Pressure Injury Prevention and Management, revised 9/12/2023, the P&P indicated evidenced based interventions for prevention will be implemented for all residents assessed at risk or who a PI present. Basic or routine care interventions include redistributing pressure, such as, repositioning, protecting and or offloading heels, etc.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40438 Based on observation, interview, and record review, the facility failed to provide care and services for one of five sampled residents (Resident 48) with pressure ulcers (localized damage to the skin and/or underlying tissue usually over a bony prominence as a result of pressure) by failing to turn and reposition Resident 48 every two hours as indicated in the facility's policy and procedure (P&P) titled Turning and Repositioning and Resident 48's care plan. This failure had the potential to lead to further skin breakdown (damage to the skin's surface), infection, worsening, and/or delayed wound healing for Resident 48. Findings: During a review of Resident 48's Admission Records (AR), the AR indicated, the facility initially admitted Resident 48 to the facility on [DATE], and readmitted the resident on 10/13/2023, with diagnoses that included stage 4 (full thickness tissue loss with exposed bone, tendon, or muscle) pressure ulcers (injury to skin and underlying tissue resulting from prolonged pressure on the skin) on the right and left buttock, sacral region (at the bottom of the spine), and right hip, and contracture (permanent tightening of the muscles, tendons, skin and nearby tissues that causes the joints to shorten and become stiff) of right and left ankle. During a review of Resident 48's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 1/31/2024, the MDS indicated, Resident 48 had severely impaired cognitive skills (ability to understand) for daily decision making and was totally dependent on staff for eating, oral and toileting hygiene, shower, upper and lower body dressing, and personal hygiene. The MDS indicated, Resident 48 had urinary and bowel incontinence (inability to control) and pressure ulcers upon admission/entry or reentry to the facility. The MDS indicated, Resident 48 was on turning/repositioning program. During a review of Resident 48's untitled Care Plan (CP), dated 2/16/2024, the CP indicated Resident 48 had history of cerebral vascular accident (CVA, damage to the brain from interruption of its blood supply). The CP goal indicated, Resident 48 would be free from signs and symptoms of complications of CVA and contractures. The CP interventions included for staff to turn and reposition Resident 48 at least every 2 hours and as needed and to keep the resident's body in good alignment. During a review of Resident 48's untitled CP, dated 2/16/2024, the CP indicated Resident 48 was admitted with multiple pressure injury, vascular ulcer (a wound on the leg or ankle caused by abnormal or damaged veins) and potential for development of more skin problem. The CP interventions included to educate the resident/family/caregivers as to causes of skin breakdown, transfer/positioning requirements, good nutrition, frequent repositioning and following facility policies and protocols for the prevention/treatment of skin breakdown. During a review of Resident 48's Turn and Reposition Log (TRL), dated 4/9/2024, 4/10/2024, and 4/11/2024, the TRL indicated Resident 48 was turned and repositioned every 2 hours from 12:00 am to 10:00 pm. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 4/9/2024 at 11:45 am with the Licensed Vocational Nurse (LVN) 1 inside Resident 48's room, Resident 48 was not in her room. LVN 1 stated Resident 48 left the facility at 10:00 am for her scheduled dialysis. LVN 1 stated Resident 48 had her dialysis on Tuesdays, Thursdays, and Saturdays. During an observation on 4/10/2024 inside Resident 48's room, Resident 48 was in bed, positioned on her left side, facing the door for four hours from 10:27 am to 2:32 pm. During an observation on 4/11/2024 at 10:15 am in the hallway, Resident 48 was picked up by ambulance for her dialysis. Resident 48 left the facility at 10:22 am. During an interview on 4/11/2024 at 10:01 am with the Certified Nurse Assistant (CNA) 1, CNA 1 stated all her total care residents were turned and repositioned every 2 hours to prevent developing or worsening of skin sores. During an interview on 4/12/2024 at 8:24 am with the Registered Nurse Supervisor (RN Sup) 1, RN sup 1 stated turning and repositioning was done at least every 2 hours and as needed for all totally dependent residents to prevent sores and skin breakdown from developing and worsening. During a review of the facility's policy and procedures (P&P) titled, Turning and Repositioning, revised on 11/27/2023, the P&P indicated, facility implemented turning and repositioning as part of its systematic approach to pressure injury prevention and management. The P&P indicated, residents at risk of, or with existing pressure injuries, will be turned and repositioned, frequently, as tolerated, unless it was contraindicated due to a medical condition. The P&P indicated, the facility established routine turning and repositioning schedules consisting of every 2-4 hours, on the even hour. The P&P indicated, a maximum of thirty minutes before or after scheduled time would be allotted for compliant with the schedule.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40438 Based on observation, interview, and record review, the facility failed to ensure the resident's right-hand splint (a medical device that supported and protected joints and its surrounding structures and worked by positioning the hand and wrist correctly) was maintained and properly applied in accordance with the facility's policy and procedure titled, Restorative Nursing Programs and resident's care plan for one of three sampled residents (Resident 16) selected for position mobility care area. This deficient practice placed Resident 16 at risk for contractures and had the potential to cause decline in Resident 16's physical function. Findings: During a review of Resident 16's Admission Record (AR), the AR indicated, the facility admitted Resident 16 to the facility on [DATE], with diagnoses that included muscle wasting (loss of muscle mass and strength) and contracture (shortening and hardening of muscles, tendons, skin, and other tissues that causes the joints to shorten and become stiff) of right and left hand. During a review of the Resident 16's untitled Care Plan (CP), dated 8/26/2021, the CP indicated, Resident 16 was on Restorative Nursing Program [RNP, nursing program that use a restorative nursing aide (RNA) to help residents maintain their function and joint mobility] to address potential for decline in range of motion. The CP interventions included for staff to apply wrist and hand splints to the resident's right and left wrist/hand for four (4) hours daily five times a week or as tolerated. During a review of Resident 16's Minimum Data Set (MDS, a resident assessment and care-screening tool), dated 1/31/2024, the MDS indicated, Resident 16 had severely impaired cognitive skills (ability to understand) for daily decision making and was totally dependent (helper does all the effort, resident does none of the effort to complete the activity) on staff for oral and toileting hygiene, shower, upper and lower body dressing, and personal hygiene. During a concurrent observation and interview on 4/9/2024 at 11:38 am with the Licensed Vocational Nurse (LVN) 1 inside Resident 16's room, Resident 16 had a splint on her left wrist/hand. The splint on Resident 16's right wrist/hand was not connected and was observed on the resident's bed. LVN 1 stated Resident 16 was on RNA services for exercises and application of the wrist/hand splints. LVN 1 stated the splints needed to be kept in place for four hours as scheduled to prevent further contracture of the hands. During an interview on 4/12/2024 at 10:04 am with the Restorative Nurse Assistant (RNA), the RNA stated RNAs needed to ensure the resident kept the hand splint in place as tolerated to prevent contracture and to maintain good mobility of the affected extremity. During an interview on 4/12/2024 at 11:37 am with the Assistant Director of Nursing (ADON), the ADON stated RNAs needed to monitor and ensure the resident maintained the splint in place and the splint was properly applied to prevent contracture and declined mobility. (continued on next page)

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F 0688 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, Restorative Nursing Programs, revised on 12/19/2022, the P&P indicated, facility provided maintenance and restorative services designed to maintain or improve a resident's abilities to the highest practicable level. The P&P indicated, residents, as identified during a comprehensive assessment process, received services from restorative aides when they were assessed to have a need for restorative nursing services. These services may include splint or brace assistance. The P&P indicated, restorative aides implemented the plan for a designated length of time, performing the activities, and documenting on the electronic health record.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48905 Based on observation, interview, and record review, the facility failed to supervise and follow policy and procedure (P&P) for Hoyer Lift (mechanical device that is operated by two people and used to lift and transfer residents safely) for one of one sampled resident (Resident 274) by failling to ensure 2 staff memberd operated the Hoyer lift to lift Resident 274 from the resident's bed. Resident 274 was left suspended in the air, unsupervised when Certified Nurse Assistant 2 (CNA 2) walked away from the Hoyer Lift to close the currtain. This failure had the potential to result in Resident 274 to sustain a serious injury. Findings: During a review of Resident 274's Admission Record (AR), the AR indicated Resident 274 was admitted to the facility on [DATE] with diagnoses that included but were not limited to pressure injuries (PI, injuries to the skin and tissues that were due to prolonged pressure) of the sacral region, right and left buttocks, right ankle, right heel stage one (intact skin with non-blanchable [skin temporality turning white when pressed] redness over a bony area) PI, open wound on right and left foot, dependence on a ventilator (machine that helps a person breathe or breathes for the person), gastrostomy tube (G-tube, feeding tube that was surgically placed through an opening into the stomach from the abdominal wall), and tracheostomy tube (trach tube, surgical procedure in which a tube was inserted from an opening in the neck into the trachea [windpipe]). During a review of Resident 274's History and Physical (H&P, formal document of a medical provider's examination of a patient) dated 4/5/2024, the H&P indicated Resident 274 had fluctuating capacity to understand and make decisions. During a review of Resident 274's Order Summary Report (OSR) dated 4/3/2024 to 4/11/2024, the OSR indicated Resident 274 had an active Medical Doctor (MD) order dated 4/4/2024 for a low air loss (LAL, type of medical mattress designed to reduce pressure on the skin which helps prevent pressure injuries) mattress for wound management. During a review of Resident 274's Interdisciplinary Team (IDT, team that comprises of professionals from various disciplines who work in collaboration to address a residents multiple physical and psychological needs) note dated 4/4/2024 at 4:55 PM, the IDT note indicated Resident 274 required assistance with daily care. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 4/9/2024 at 11:24 AM in Resident 274's room, Resident 274 was in bed connected to the ventilator via trach tube and enteral feeding (tube feeding that supplies nutrients and fluids to the body if unable to safely chew or swallow) via g-tube. The Hoyer Lift sling was underneath Resident 274 with the curtain drawn closed. CNA 2 placed the Hoyer Lift's base under Resident 274's bed and connected sling straps on to the spreader bar (long bar that holds two slings apart). CNA 2 operated the Hoyer Lift alone and lifted Resident 274 into the air roughly with one foot above the resident's bed. Licensed Vocational Nurse (LVN) 3 was at the door calling other staff members for assistance for the LAL mattress. Resident 274 was suspended in the air with CNA 2 by the Hoyer Lift. At 11:28 AM, CNA 2 walked away from the Hoyer Lift while Resident 274 was suspended in the air. CNA 2 walked behind the closed curtain, and waited for other staff members to bring the LAL mattress. No staff members were at the bedside when Resident 274 was suspended in the air. During a review of Resident 274's Baseline Care Plan and Summary (BCPS) dated 4/4/2024 at 5:52 AM, the BCPS indicated Resident 274 needs two or more persons for transferring. During an interview on 4/9/2024 at 11:53 AM with CNA 2, CNA 2 stated two people were supposed to be present while using the Hoyer Lift. CNA 2 stated one staff member controls the Hoyer Lift and the second staff member was supposed to be by the resident. CNA 2 stated there was no other staff member by Resident 274 when he lifted Resident 274 from the resident's bed. CNA 2 stated he walked away from Resident 274 while Resident 274 was suspended in the air. CNA 2 stated staff needed to be staff members by the resident when the resident was in the Hoyer Lift. CNA 2 stated the risk of using the Hoyer Lift alone and leaving the resident unsupervised in the Hoyer Lift could result in the resident falling out of the sling as the machine can still move. During an interview on 4/9/2024 at 11:54 AM with LVN 3, LVN 3 stated two people are required when using the Hoyer Lift. LVN 3 stated she was looking for help to place the LAL mattress. LVN 3 stated by the time she got back to Resident 274's bedside, Resident 274 was already suspended in the air. During an interview on 4/12/2024 at 10:01 AM with the Assistant Director of Nursing (ADON), the ADON stated two staff members were always required when using the Hoyer Lift because it moves. The ADON stated one staff member operated the machine and the other staff member was by the resident to make sure the resident was not moving in different directions. The ADON stated it was not acceptable for one staff member to operate the machine, and to leave the resident alone suspended in the air. The ADON stated a staff member needed to be with the resident because the resident could fall and possibly sustain a serious injury. The ADON stated the resident would be at risk for an accident because staff did not follow P&P and left Resident 274 suspended in the air unsupervised. During an interview on 4/12/2024 at 10:46 AM with the Director of Staff Development (DSD), the DSD stated from start to finish there should always be two staff members during the Hoyer Lift transfer because anything could happen to the resident during lifting or transferring with the Hoyer Lift. The DSD stated, it is not acceptable to have one staff member operating the Hoyer Lift, and to leave the resident suspended in the air unsupervised. The DSD stated the resident can be scared being suspended in the air, and stated something could happen to the resident when left unsupervised. During a review of Span Owner's Manual (OM) for Model F500P, undated, the OM indicated to never leave the patient unattended during lifting. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Safe Resident Handling/Transfers, dated 12/19/2022, the P&P indicated two staff members must be utilized when transferring residents with a mechanical lift. The P&P indicated staff will perform mechanical lifts and or transfers according to the manufacturer's instructions.

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Sunset Manor Conv Hosp	2720 Nevada Avenue El Monte, CA 91733

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40438 Based on observation, interview, and record review, the facility failed to provide appropriate care and services for the resident's suprapubic catheter (a hollow, flexible tube used to drain urine from the bladder through a cut in the abdomen) and indwelling catheter (a medical device that helped drain urine from the bladder) as ordered by the physician and as indicated in the resident's plan of care for two of four sampled residents selected for catheter care area (Resident 15 and Resident 11). These failures had the potential to result in catheter-related complications for Resident 15 and Resident 11. Findings: a. During a review of Resident 15's Admission Record (AR), the AR indicated, the facility admitted Resident 15 to the facility on [DATE], and readmitted the resident on 11/6/2023, with diagnoses that included hydroureter (a condition where the ureter became larger than normal due to urine backup), chronic kidney disease (longstanding disease of the kidneys leading to renal failure), and retention of urine (difficulty urinating and completely emptying the bladder). During a review of Resident 15's untitled Care Plan (CP), dated 11/30/2023, the CP indicated, Resident 15 had an indwelling catheter related to urinary retention secondary to distal urethral obstruction (a blockage in the urethra) and hydroureter. The CP goal indicated Resident would remain free from catheter-related trauma through the review date. During a review of Resident 15's Minimum Data Sheet (MDS, a resident assessment and care screening tool), dated 2/29/2024, the MDS indicated, Resident 15 had severely impaired cognitive skills (ability to understand) for daily decision making and was completely dependent (helper does all the effort, resident does none of the effort to complete the activity) on staff for oral and toileting hygiene, shower, upper and lower body dressing, and personal hygiene. The MDS indicated, Resident 15 had an indwelling catheter (including suprapubic catheter and nephrostomy tube). During a concurrent observation and interview on 4/9/2024 at 11:26 am with the Licensed Vocational Nurse (LVN) 1 inside Resident 15's room, Resident 15 had an indwelling catheter dangling on the left side of the bed. Resident 15 had a strap-free catheter stabilization device on his right thigh. The indwelling catheter was not connected to the stabilization device. LVN 1 stated the indwelling catheter tubing needed to be connected to the stabilization device to prevent the catheter from pulling which could cause injury or trauma to the urethra (a tube that carries urine out of the body and bladder). b. During a review of Resident 11's AR, the AR indicated, the facility initially admitted Resident 11 to the facility on [DATE], and readmitted the resident on 11/8/2023, with diagnoses that included neuromuscular dysfunction of bladder (loss of bladder control due to damage to the brain, spinal cord, or nerve problem) and urinary tract infections (UTI, an illness in any part of the urinary tract). (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 11's untitled CP, dated 3/1/2022, the CP indicated, Resident 11 had a suprapubic catheter due to neuromuscular dysfunction of bladder. The CP indicated, Resident 11 was at risk for dislodgement/malfunctioning due to a behavior of pulling out mechanical device and at risk for UTI occurrence. The CP goal indicated, Resident 11 to remain free from catheter-related trauma and minimize recurrent UTI and septicemia (a medical emergency that occurs when bacteria, viruses, or fungi enter the blood stream and causes blood poisoning) through the review date. The CP intervention indicated for staff to provide catheter (suprapubic) care. During a review of Resident 11's Order Summary Report (OSR), dated 11/8/2023, the OSR indicated, Resident 11 had an order for suprapubic catheter care daily to cleanse site with normal saline (NS, salt water) and apply dry dressing daily and as needed. During a review of Resident 11's MDS, dated [DATE], the MDS indicated, Resident 11 had severely impaired cognitive skills for daily decision making and was completely dependent on staff for oral and toileting hygiene, shower, upper and lower body dressing, and personal hygiene. The MDS indicated, Resident 11 had an indwelling catheter (suprapubic catheter and nephrostomy tube). During a concurrent observation and interview on 4/9/2024 at 10:44 am with LVN 1 inside Resident 11's room, Resident 11 had a suprapubic catheter dangling on the right side of the bed. Resident 11 was touching the catheter site with his right hand. The suprapubic catheter site was not covered with a dressing. The suprapubic catheter tubing was not secured with a stabilization device. LVN 1 stated the suprapubic catheter site needed to be covered with a dressing to prevent Resident 11 from touching it and to prevent infection. LVN 1 stated the suprapubic catheter tubing should be secured with a stabilization device to prevent pulling and cause injury or trauma to the urethra. During an interview on 4/12/2024 at 8:17 am with the Infection Preventionist Nurse (IPN), the IPN stated suprapubic catheter tubing needed to be anchored to prevent pulling and dislodgement during peri-care (the cleaning of the patient's private areas, including the genitals and anal area) and turning/repositioning (shifting weight to enhance circulation). The IPN stated the suprapubic catheter site needed to be cleaned and covered with dry gauze daily and as needed as ordered by the physician. During an interview on 4/12/2024 at 10:05 am with the Assistant Director of Nursing (ADON), the ADON stated the catheter stabilization device held the suprapubic and indwelling catheter tubing in place. The ADON stated the suprapubic and indwelling catheter tubing needed to be connected to the catheter stabilization device to prevent accidental pulling, injury, trauma, and possible hospitalization . The ADON stated suprapubic catheter site needed to be covered to prevent infection or contamination to the site. During a review of the facility's policy and procedure (P&P) titled, Indwelling Catheter Use and Removal, revised on 12/19/2022, the P&P indicated, keep the catheter anchored to prevent excessive tension on the catheter, which could lead to urethral tears or dislodgement of the catheter; and secure the catheter to facilitate flow of urine, prevention of kinks in the tubing and positioning below the level of the bladder.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40913 Based on observation, interview, and record review, the facility failed to provide supervision or touching assistance during meals for one of one sampled resident (Resident 19) with weight loss. This deficient practice had the potential to lead to further weight loss for Resident 19. Findings: During a review of Resident 19's Admission Record(AR), the AR indicated the facility admitted the resident on 7/1/2022 with diagnoses that included dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning) and Parkinson's disease (disease that affects the nerve cells in the brain that produces symptoms that include muscle rigidity, tremors, and changes in speech and gait.) During a review of Resident 19's Minimum Data Set (MDS - a standardized assessment and care planning tool) dated 3/8/2024, the MDS indicated Resident 19 had severe cognitive impairment. The MDS indicated Resident 19 was dependent with sit to lying, lying to sitting on side of the bed for bed mobility. The MDS indicated Resident 19 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) with eating and personal hygiene. The MDS indicated Resident 19 had functional limitation in range of motion to bilateral (both) upper extremities and lower extremities. During an observation on 4/9/2024, the following were observed: At 12:42 pm, Resident 19 ate by herself, holding the coffee cup with both hands, hands with noticeable tremors while holding the cup. At 12:46 pm, Resident 19 was still holding on to the cup of coffee using her hands, with noticeable tremors. At 12:54 pm, Resident 19 drank a white liquid from the cup an on the lunch tray, mac and cheese, green peas and beef were untouched. At 12:57 pm, Dietary Supervisor was at Resident 19's doorway and stood at the door. DSS did not ask Resident 19 about the food that was still untouched. At 12:59 pm, mac and cheese, beef, green peas, and juice were untouched on Resident 19's lunch tray. At 1:03 pm, Restorative Nursing Assistant 2 (RNA 2) removed Resident 19's lunch tray. At 1:05 pm, there was one nutritional supplement drink in front of Resident 19 that was unopened. Resident 19 tried to open the nutritional supplement drink but couldn't because of tremors on her hands. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 4/11/2024, the following were observed: At 12:32 pm, Certified Nursing Assistant 5 (CNA5) brought lunch tray to Resident 19 and assisted the resident by opening the lids and opened a nutritional drink. At 12:34 pm, Resident 19 drank the nutritional drink. At 12:50 pm, Resident 19's food on the plate was left untouched. At 12:57 pm, CNA 5 was observed in Room A assisting another resident. At 1:00 pm, CNA 5 went inside Room B and encouraged another resident to eat. At 1:06 pm, CNA 5 went inside Room C to reposition another resident. At 1:09 pm, CNA 5 removed Resident 19's lunch tray and left the nutritional drink on top of Resident 19's table. CNA 5 stated Resident 19 only ate 10% of her meal. During an interview on 4/11/2024 at 1:15 pm, Resident 19 stated, if she was assisted with meals she would eat more. Resident 19 stated it was hard to hold the utensils because of the tremors on her hands. During an interview on 4/11/2024 at 1:17 pm, the Director of Staff Development stated there were multiple reasons why a resident would not be eating well. The DSD stated pain, a swallowing problem or a resident's mobility would affect eating patterns. During an interview on 4/12/2024 at 1:14 pm, CNA 5 stated she was not familiar with Resident 19. CNA 5 stated the way for her to find out if a resident needed assistance with feeding would be through the resident's meal ticket. CNA 5 stated Resident 19's meal ticket indicated Resident 19 required partial assistance (set-up). CNA 5 stated Resident 19 had tremors on her hands that would affect Resident 19's ability to feed herself. During a review of Resident 19's CNA documentation of food eaten, the documentation indicated Resident 19 ate less than 25% of lunch on 4/9/2024 and 4/11/2024. During a review of Resident 19's Occupational Discharge Summary with Service Dates from 3/18/2024 to 3/29/2024, the discharge summary indicated Resident 19 required minimum assistance with self-feeding. During a concurrent interview with the Director of Rehabilitation (DOR) on 4/12/24 12:22 pm, the DOR stated residents with diagnosis of Parkinson's disease would have rigidity and the rigidity affect coordination. The DOR stated minimum assistance with self-feeding would still require staff assistance of about 21-25% which would mean the staff would provide intermittent touch assistance. During a review of Resident 19's weight log, the log indicated the following: 10/6/2023 162 pounds (lb.) 12/4/2023 159 lb. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/2/2024 145 lb. 2/5/2024 141 lb. 3/4/2024 134 lb. 4/5/2024 133 lb. During a review of Resident 19's care plan for nutritional problem, revised on 3/13/2024, the care plan indicated to monitor resident's ability to feed self. During a review of Resident 19's Nutritional assessment dated [DATE], the Nutritional Assessment indicated the resident needed a lot of encouragement to eat her meals. During a review of the facility's Policy and Procedure (P&P) titled Weight Management Policy revised 12/19/2022, the P&P indicated information gathered from the nutritional assessment and current dietary standards of practice are used to develop an individualized care plan to address the resident's specific nutritional concerns and preferences. The care plan should address the following, to the extent possible, if nutritional goals are not achieved, care planned interventions will be reevaluated for effectiveness and modified as appropriate. During a review of the facility's P&P titled Meal Supervision and Assistance revised 12/19/2022, the P&P indicated the resident will be provided supervision and assistance to prevent accidents, provide adequate nutrition.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40438 Based on observation, interview, and record review, the facility failed to follow the facility's Policy and Procedure (P&P) for enteral feeding (tube feeding that supplies nutrients and fluids to the body if unable to safely chew or swallow) for two of three sampled residents (Residents 2 and 274) when: a. Gastrostomy tube (G-tube, feeding tube that is surgically placed through an opening into the stomach from the abdominal wall) dressing for Resident 2 was not changed per protocol. b. Enteral feeding was left ongoing while Resident 274 was lying flat on the bed. These failures had the potential for infection for Resident 2 and complication of aspiration (when food/liquid enter a resident's airway and lungs by accident) for Resident 274 . Findings: a. During a review of Resident 2's Admission Record (AR), the AR indicated, the facility admitted Resident 2 to the facility on [DATE], and readmitted the resident on 2/20/2024, with diagnoses that included dysphagia (difficulty swallowing) and attention to gastrostomy (an opening into the stomach from the abdominal wall, made surgically for the introduction of food). During a review of Resident 2's untitled Care Plan (CP), dated 2/22/2024, the CP indicated, Resident 2 had the potential for impaired skin integrity due to percutaneous endoscopic gastrostomy (PEG, feeding tube insertion) tube site. The CP goal indicated Resident 2 would remain free from infection related to PEG tube. The CP intervention indicated to cleanse the PEG tube site with normal saline (NS, salt water), pat to dry, and apply a T-drain sponge (a type of sponge shaped in a T-configuration, allowing to wrap around the drainage tube and effectively absorb excess fluids to help keep patients dry and comfortable) one facing towards the face and one facing towards the toes. During a review of Resident 2's Order Summary Report (OSR), dated 2/23/2024, the OSR indicated, Resident 2 had an order to cleanse GT site with NS, pat dry, apply T-drain sponge, and secure with tape every evening shift. During a review of Resident 2's Minimum Data Set (MDS, a resident assessment and care-screening tool), dated 3/11/2024, the MDS indicated, Resident 2 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making, was dependent (helper does all the effort, resident does none of the effort to complete the activity) on staff for eating, oral hygiene, toileting, shower, upper and lower body dressing, and personal hygiene. The MDS indicated, Resident 2 had a feeding tube for nutrition. During a review of Resident 2's Treatment Administration Record (TAR) for 4/2024, the TAR indicated, treatment was done for Resident 2's GT site every evening shift on 4/7/2024 to 4/9/2024 as indicated by a checked mark and nurse initials. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 4/9/2024 at 11:12 am with Licensed Vocational Nurse (LVN) 1 inside Resident 2's room, Resident 2 had a T-drain dressing with a tape which was loose, dirty, and dated 4/6/2024. LVN 1 stated, The dressing doesn't look clean to me. LVN 1 stated GT dressing needed to be changed daily to prevent infection. During a concurrent interview and record review on 4/12/2023 at 9:02 am with Registered Nurse Supervisor (RN Sup) 1, Resident 2's TAR for 4/2024 was reviewed. The TAR indicated, treatment was done for Resident 2's GT site on 4/7/2024 to 4/9/2024 as indicated by the check marks and nurse initials. RN Sup 1 stated GT site needed to be cleaned and dressed daily as ordered by the physician to prevent infection. During an interview on 4/12/2024 at 10:08 am with the Assistant Director of Nursing (ADON), the ADON stated GT dressing needed to be changed daily as ordered to prevent infections and complications. During a review of the facility's policy and procedure (P&P) titled, Gastrostomy Site Care, revised on 12/19/2022, the P&P indicated, the facility performed gastrostomy site care as ordered and per current standards of practice. The P&P indicated, verify there was a physician order for gastrostomy site care. Apply dressing as ordered. Secure or otherwise position tube to prevent dislodgement, as needed. The P&P indicated, document the procedure once completed, or when resident refused, document why and any intervention taken. 48905 b. During a review of Resident 274's Admission Record (AR), the AR indicated Resident 274 was admitted to the facility on [DATE] with diagnoses that included gastrostomy tube and tracheostomy tube (trach tube, surgical procedure in which a tube is inserted from an opening in the neck into the trachea [windpipe]. During a review of Resident 274's History and Physical (H&P) dated 4/5/2024, the H&P indicated Resident 274 had fluctuating capacity to understand and make decisions. During a review of Resident 274's Interdisciplinary Team (IDT, team that comprises of professionals from various disciplines who work in collaboration to address the resident's needs) Note dated 4/4/2024 at 4:55 PM, the IDT note indicated Resident 274 required assistance with daily care. During a review of Resident 274's Order Summary Report (OSR) dated 4/3/2024 to 4/11/2024, the OSR indicated Resident 274 had an order dated 4/4/2024 for Nil Per Os (NPO, nothing by mouth) and indicated on 4/4/2024 an order for continuous enteral feeding of Novasource Renal (type of enteral feeding) at 40 milliliters (mL) per hour. During a review of Resident 274's untitled care plan (CP) dated 4/9/2024, the CP indicated to keep Resident 274's head of bed (HOB) at 30 to 45 degrees during feeding. During a concurrent observation and interview on 4/10/2024 at 10:32 AM in Resident 274's room, Resident 274 was lying flat while Certified Nursing Assistant 2 (CNA 2) changed Resident 274's linen with ongoing enteral feeding. CNA 2 stated the enteral feeding was running while CNA 2 was changing Resident 274. CNA 2 stated staff needed to place the residents flat while changing linens and gown. CNA 2 stated only licensed nurses can stop the enteral feeding. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/10/2024 at 11:07 AM with Licensed Vocational Nurse (LVN) 3, LVN 3 stated enteral feeding needs to be paused when changing residents because residents need to lay flat. LVN 3 stated staff are to notify licensed nurses to pause the enteral feeding and notify us again to restart it when they are finished. During an interview on 4/11/2024 at 9:22 AM with the Director of Nursing (DON), DON stated enteral feedings needed to be paused prior to changing the resident's clothing or bed linens. The DON stated enteral feeding should not be running if the resident was lying flat on the bed as the resident would be at risk for aspiration. During a review of the facility's P&P titled, Care and Treatment of Feeding Tubes dated 12/19/2022, the P&P indicated the resident's plan of care will direct staff regarding proper positioning of the resident that is consistent with the resident's individual needs. During a review of the facility's P&P titled, Care of Resident on Feeding Tubes dated 12/29/2022, the P&P indicated a resident who is fed by enteral means receives the appropriate treatment and services to restore and to prevent complications of enteral feeding, such as, aspiration.

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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** 42781 Based on observation, interview and record review, the facility failed to label and date the midline intravenous catheter (a long, thin, flexible tube that is inserted into a large vein in the upper arm used to administer medication into the bloodstream) for one of one sampled resident (Resident 45) in accordance with the facility's policy titled Peripheral Intravenous Catheter Insertion, Maintenance and Removal and resident's care plan. This failure had the potential to result in infection to Resident 45 and worsen the residents' health condition. Findings: During a review of Resident 45's Admission Record (AR), the AR indicated Resident 45 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus a disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in elevated levels of glucose/sugar in the blood and urine) with hyperglycemia (high blood sugar). During a review of Resident 45's History and Physical (H&P), dated 3/20/2024, the H&P indicated Resident 45 had fluctuating capacity to understand and make decisions. During a review of Resident 45's Minimum Data Set (MDS- a standardized assessment and care planning tool), dated 3/24/2024, the MDS indicated Resident 45 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 45 required total dependence (totally dependent with staff for assistance of activities of daily living) with toileting hygiene, shower, lower body dressing and putting on or taking off footwear. During a review of Resident 45's Physician's Order dated 3/20/2024, the physician's order indicated midline catheter site maintenance to change the dressing every seven days. During a review of Resident 45's untitled care plan dated 4/1/2024, the care plan indicated Resident 45 required intravenous therapy. The care plan indicated for nursing staff to change the dressing of the right upper arm midline catheter every seven days and as needed using a transparent dressing. During a concurrent observation and interview on 4/9/2024 at 10:424 am with Infection Preventionist Nurse (IPN), Resident 45 was awake lying in bed with midline intravenous site, not dated when the dressing was changed. The IPN stated Resident 45's midline site needed to be labeled with date to determine when the dressing was changed for infection control. During an interview with the facility's Assistant Director of Nursing (ADON) on 4/12/2024 at 8:54 am, the ADON stated IV site should be labeled with date and licensed nurse's initial to identify when it was changed to prevent infection. (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 and procedure (P&P) titled, Peripheral Intravenous Catheter Insertion, Maintenance and Removal, dated 12/19/2022, the P&P indicated to label dressing with date, time and initials.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42781 Based on observation, interview, and record review, the facility failed to ensure two of two sampled residents (Residents 30 and 274) receiving oxygen therapy were provided respiratory care and resident safety in accordance with the facility's policy and procedure titled Oxygen Administration and Sudden Respiratory Distress Differential Diagnosis, by failing to: a. Ensure Resident 30's nasal cannula tubing (flexible plastic tubing used to deliver oxygen through the nostrils) was kept in covered in plastic bag when not in use and not rolled and inserted to the handle of the oxygen concentrator (a medical device that concentrates oxygen from environmental air and delivers it to the resident in need of supplemental oxygen). b. Ensure Resident 274 had a spare tracheostomy tube (tube inserted from an opening in the neck into the trachea [windpipe]) readily available at bedside. These deficient practices had the potential for infection for Resident 30 and failure to maintain a patent (open) airway during an emergency dislodgement or malfunction of tracheostomy tube for Resident 274. Findings: a. During a review of Resident 30's Admission Record, the admission record indicated the facility admitted Resident 30 on 3/14/2023 with diagnoses that included history of falling and Chronic Obstructive Pulmonary Disease (COPD - type of obstructive lung disease characterized by long-term poor airflow). During a review of Resident 30's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 3/13/2024, the MDS indicated, Resident 30 's cognition (mental action or process of acquiring knowledge and understanding) for daily decision making was intact. The MDS indicated Resident 30 required moderate assistance with shower and lower body dressing and Resident 30 was dependent with putting on or taking off footwear. During a review of Resident 30's Physician's Order dated 10/20/2023, the physician's order indicated for Resident 30 to receive oxygen at two liters per minute (L/min) via nasal cannula as needed to maintain oxygen saturation (amount of oxygen carried in blood) above or equal to 92% for shortness of breath related to COPD. During an observation on 4/10/2024 at 9:18 am, Resident 30's nasal cannula tubing was rolled and inserted at the handle of the oxygen concentrator. During a concurrent observation and interview on 4/10/2024 at 9:20 am with Director of Staff and Development (DSD), the DSD stated, nasal cannula tubing was rolled and inserted to the handle of Resident 30's oxygen concentrator. The DSD stated, nasal cannula tubing needed to be placed inside a storage bag when not in use for infection control. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/12/2024 at 8:47 am with the facility's Assistant Director of Nursing (ADON), the ADON stated if nasal cannula was not in use, it needed to be stored in the storage bag for infection control and to avoid cross contamination (the process by which bacteria or other microorganisms are unintentionally transferred from one substance or object to another, with harmful effect). During a review of the facility's Policy and Procedure (P&P) titled, Oxygen Administration, revised 12/19/2022, the P&P indicated to change oxygen tubing and mask or cannula as needed if it becomes soiled or contaminated. The P&P indicated to keep delivery devices covered in plastic bag when not in use. 48905 b. During a review of Resident 274's Admission Record (AR), the AR indicated Resident 274 was admitted to the facility on [DATE] with diagnoses that included dependence on a ventilator (machine that helps a person breathe) and chronic obstructive pulmonary disease (COPD, disease that causes blockage of airflow in the lungs). During a review of Resident 274's History and Physical (H&P) dated 4/5/2024, the H&P indicated Resident 274 had fluctuating capacity to understand and make decisions. During a review of Resident 274's Order Summary Report (OSR) dated 4/3/2024 to 4/11/2024, the OSR indicated an active Medical Doctor (MD) order dated 4/4/2024 for a Portex (type of trach tube) trach tube, size eight, to be changed as needed for cuff failure or dislodgement. During a review of Resident 274's untitled care plan (CP), dated 4/4/2024, the CP indicated Resident 274 was ventilator dependent and had the potential for a ventilator associated pneumonia ([NAME], lung infection that developed when a person was on a ventilator). The CP indicated for staff to maintain a spare trach tube at the bedside. During a concurrent observation and interview on 4/10/2024 at 11:05 AM with Respiratory Therapist 2 (RT 2) in Resident 274's room, there was no spare trach tube at Resident 274's bedside. RT 2 stated there was no emergency Portex, size eight, located at Resident 274's bedside. RT 2 stated an emergency trach needed to be easily accessible at Resident 274's bedside. During an interview on 4/11/2024 at 9:06 AM with Respiratory Supervisor (RT Sup), RT Sup stated if a spare trach tube was not at the bedside, then Resident 274 was at risk to maintain a patent airway during an emergency. RT Sup stated close proximity of the resident was to be within arm's reach of staff. During a review of the facility's undated Policy and Procedure (P&P) titled, Sudden Respiratory Distress Differential Diagnosis , the P&P indicated emergency airway management supplies, such as, a replacement trach tube of the same make, model, and size the patient was using and a replacement trach one size smaller than the one the patient was using should be already at the resident's bedside, on the healthcare worker, or close proximity of the resident.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40913 Based on observation, interview, and record review, the facility failed to attempt appropriate alternatives prior to installing a side or bed rail for two of two sampled residents (Residents 17 and 170). This deficient practice had the potential for accidents that could lead to injury. Findings: a. During a review of Resident 17's Admission Record, the Admission Record indicated the facility admitted the resident on 3/2/2023, with diagnoses that included dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning) and epilepsy (brain disorder in which a person has repeated seizures [convulsions] over time) During a review of Resident 17's Minimum Data Set (MDS - a standardized assessment and care planning tool) dated 3/5/2024, the MDS indicated Resident 17 had severely impaired cognitive (ability to understand) skills for daily decision making. The MDS indicated Resident 17 was totally dependent with all activities of daily living. During an observation on 4/9/2024 at 10:47 am, Resident 17 was lying in bed with both upper siderails up. The siderails were padded on both sides. During a concurrent record review and interview on 4/11/2024 at 11:02 am, Resident 17's Bedrails assessment dated [DATE] was reviewed. The bedrail assessment indicated alternatives attempted prior to the installation of bed rails, were to lower the bed and the use of pillows. The assessment did not indicate how the use of these alternatives failed to meet the needs of the resident and the assessment did not indicate what other appropriate alternatives was attempted. The MDS Nurse Coordinator (MDS C) stated other alternative that would be attempted would be the use of bolsters or bumpers. During an interview on 4/11/2024 at 11:10 am, the Director of Nursing (DON) stated the facility have bolsters or bumpers that could be used as alternatives to the use of bedrails. b. During a review of Resident 170' s Admission Record, the Admission Record indicated the facility admitted the resident on 10/12/2023 with diagnoses that included dementia and epilepsy. During a review of Resident 170's MDS dated [DATE], the MDS indicated the resident had severe cognitive impairment. The MDS indicated the resident was dependent with toileting and shower/baths and required maximal assistance (helper lifts or holds trunk or limbs and provides more than half the effort) with rolling left to right. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent record review and interview on 4/11/2024 at 11:04 am, Resident 170's Bedrails assessment dated [DATE] was reviewed. The bedrail assessment indicated an alternative attempted prior to the use of bedrails was to use pillows. The assessment did not indicate how the use of pillows failed and was ineffective. The MDS C stated other alternative that would be attempted would be the use of bolsters or bumpers. During an interview on 4/11/2024 at 11:10 am, the Director of Nursing (DON) stated the facility have bolsters or bumpers that could be used as alternatives to the use of bedrails. During a review of the facility's Policy and Procedure (P&P) titled Proper Use of Bedrails revised 12/19/2022, the P&P indicated to utilize a person-centered approach when determining the use of bed rails. Appropriate alternative approaches are attempted prior to installing or using bed rails. The facility will attempt to use appropriate alternatives prior to installing or using bed rails. Alternatives include, but are not limited to roll guards, foam bumpers, lowering the bed, concave mattresses. Alternatives that are attempted should be appropriate for the resident, safe and address the medical conditions, symptoms, or behavioral patterns for which a bed rail was considered. If no appropriate alternatives are identified, the medical record should include evidence of the following: purpose for which the bed rail was intended and evidence that alternatives were tried and were not successful.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40913 Based on observation, interview, and record review, the facility failed to provide a safe, sanitary and comfortable environment and prevent the development and transmission of communicable diseases and infection for five of five sampled residents (Residents 35, 8, 61, 42 and 274), when the facility failed to: a. Ensure wound care was performed to Resident 35 in a manner that would prevent introduction of potentially contaminated material into the wound. b. Ensure curtains were changed during deep cleaning for two (Residents 8 and 61) of 28 rooms in the facility. c. Ensure the IPN changed gloves and perform hand hygiene after touching Resident 42's indwelling catheter (foley catheter - a tube inserted in the bladder to drain urine into a drainage bag). d. Ensure the Nurse Practitioner (NP) wore the required Personal Protective Equipment (PPE, equipment worn to minimize exposure to hazards and illnesses) prior to performing a physical assessment (examination) of Resident 274 who was placed on Enhanced Barrier Precaution (EBP, infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDRO, bacteria that are resistant to one or more classes of antibiotics]). These failures had the potential to expose Residents 35, 8, 61, 42 and 274 and other residents in the facility to infection. Findings: a. During a review of Resident 35's Admission Record (AR), the AR indicated the facility admitted the resident on 8/1/2023 with diagnoses that included type 2 diabetes mellitus (a disease in which the body's ability to produce or respond to the hormone insulin was impaired, resulting in elevated levels of glucose/sugar in the blood and urine) and need for assistance with personal care. During a review of Resident 35's Minimum Data Set (MDS - a standardized assessment and care planning tool) dated 1/23/2024, the MDS indicated Resident 35 had moderate cognitive (ability to understand) impairment. During an observation on 4/11/2024 at 9:59 am, LVN 7 performed wound dressing change on Resident 35. Licensed Vocation Nurse 7 (LVN 7) took a paper ruler from inside the treatment cart. The paper ruler was placed on a plastic container without any covering. Inside the treatment cart were other wound care supplies. LVN 7 removed the foam dressing from Resident 35's wound, removed her gloves, then washed her hands. Using new gloves, LVN 7 sprayed normal saline inside the wound to clean the wound. LVN 7 removed her gloves then washed her hands. Using new gloves, LVN 7 patted the inside of the wound using gauze. LVN 7 measured the wound using the disposable measuring guide (ruler) by inserting the measuring guide inside the wound. LVN 7 placed collagen into the wound, removed her gloves and then washed her hands. Using new gloves, LVN 7 applied foam dressing to the wound, removed her gloves, then washed her hands. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/11/2024 at 10:10 am, LVN 7 stated she needed to use the cotton swab to measure the wound because the cotton swab was individually packed and sterile and the disposable measuring guide (ruler) would be contaminated because it was stored without any cover with other wound care supplies inside the treatment cart. During an interview on 4/12/2024 at 11:40 am, the Infection Prevention Nurse (IPN) stated whatever was inserted into the wound needed to be sterile or clean. The disposable measuring guide (ruler) would be used to measure outside the wound but should not be used and inserted into the wound because the disposable measuring guide could be contaminated since it was stored openly with other supplies. During a review of the facility's Policy and Procedure (P&P) titled Wound Care revised date 12/19/2022, the P&P indicated to provide wound care in a manner to decrease potential for infection and/or cross-contamination. b. During a review of Resident 8's AR, the AR record indicated the facility admitted the resident on 11/3/2023 with diagnoses that included enterocolitis (inflammation throughout the intestines) due to clostridium difficile (bacteria that can infect the intestines) and personal history of urinary tract infections. During a review of Resident 8's MDS dated [DATE], the MDS indicated Resident 8 was cognitively intact. The MDS indicated Resident 8 required setup or clean-up assistance with eating and required moderate assistance (helper does less than half the effort) with rolling left and right. During a review of Resident 61's AR, the AR indicated the facility admitted the resident on 2/15/2024 with diagnoses that included type 2 diabetes mellitus and chronic obstructive pulmonary disease (COPD- type of obstructive lung disease characterized by long-term poor airflow). During a review of Resident 61's MDS dated [DATE], the MDS indicated Resident 61 was cognitively intact. During an interview on 4/10/2024 at 8:43 am, Resident 8 stated the curtains that separated his bed from the next bed had not been changed since he was admitted at the facility. During an interview on 4/10/2024 at 2:54 pm, Housekeeping 1 (HK 1) stated there would be one room for deep cleaning everyday and the curtains would be changed during deep cleaning. HK 1 stated Room A had been deep cleaned today. HK 1 stated HK 1 was not responsible for changing the curtains. During an interview on 4/10/2024 at 3:12 pm, Housekeeping Supervisor (HKS) stated, the facility had been changing the curtains everyday when the room was deep cleaned. During a review of the deep cleaning schedule, the schedule indicated Room B was deep cleaned on 4/8/2024. During an interview on 4/10/2024 at 3:15 pm, with the HKS present, Resident 61 from Room B stated the curtains inside his room had not been changed since he was admitted at the facility. Resident 61 stated he could tell from the tear on top of the curtain that it was the same curtain since he was admitted . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the deep cleaning schedule provided by the HKS, the schedule indicated Resident 8's room would be cleaned every 15th of the month. During a review of the facility floor plan on 4/12/2024 at 1:41 pm, with the IPN, the floor plan indicated 22 out of 28 rooms had residents on enhanced standard precautions. During a concurrent interview on 4/12/24 at 1:41 pm, the IPN stated the curtains in the room needed to be changed with the deep cleaning to prevent the spread of infections. The IPN stated the curtains would be one of the highly touched areas inside the resident's room. During a review of the facility's Deep Clean Check-Off List, the Deep Clean Check-Off List indicated to inspect the curtains for spills or damage and alert management so they get replaced. During a review of the facility's Policy and Procedure (P&P) titled Infection Control Procedures for Housekeeping revised 9/1/2021, the P&P did not indicate the frequency for changing the curtains. The P&P indicated cubicle curtains will be checked on a regular basis for stains and soiled areas and are to be replaced as necessary. During a review of the facility's P&P titled Cleaning Duties dated 9/1/2021, the P&P indicated the Weekly Housekeeping Duties and Monthly Housekeeping Duties did not indicate when the curtains needed to be changed. 42781 c. During a review of Resident 42's AR, the AR indicated Resident 42 was admitted to the facility on [DATE] with diagnoses that included acute and chronic respiratory failure (a condition when the lungs cannot get enough oxygen into the blood) and neuromuscular dysfunction of the bladder (impaired bladder function resulting from damage to the nerves that govern the urinary tract). During a review of Resident 42's MDS dated [DATE], the MDS indicated Resident 42 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated, Resident 42 required total dependence (totally dependent with staff for assistance of activities of daily living) with eating, oral hygiene, toileting hygiene, shower, upper/lower body dressing and putting on/taking off footwear and personal hygiene. During a review of Resident 42's History and Physical (H&P) dated 3/13/2024, the H&P indicated Resident 42 did not have the capacity to understand and make decisions. During a concurrent observation and interview on 4/9/2024 at 10:12 am with Infection Prevention Nurse (IPN), Resident 42 was asleep in bed. IPN touched Resident 42's indwelling catheter and did not change gloves and did not perform hand hygiene before touching Resident 42's breathing treatment mask and tube. IPN stated she needed to change gloves and perform hand washing before touching Resident 42's breathing treatment mask and tube because Resident 42's foley catheter was contaminated and can cause cross contamination (the process by which bacteria or other microorganisms are unintentionally transferred from one substance or object to another, with harmful effect). During an interview on 4/12/2024 at 9:00 am with the facility's Assistant Director of Nursing (ADON), the ADON stated, staff needed to change gloves and perform hand hygiene before and after touching contaminated equipment. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review of the facility's Policy and Procedure (P&P) titled, Infection Prevention and Control Program, dated 9/2/2022, the P&P indicated all staff shall assume that all residents are potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services. The P&P indicated hand hygiene shall be performed in accordance with out facility's established hand hygiene procedures. 48905 d. During a review of Resident 274's Admission Record (AR), the AR indicated Resident 274 was admitted to the facility on [DATE] with diagnoses that included pressure injuries (PI, injuries to the skin and tissues that are due to prolonged pressure) of the sacral region, right and left buttocks, right ankle, right heel stage one (intact skin with non-blanchable [skin temporality turning white when pressed] redness over a bony area) PI, open wound on right and left foot, dependence on a ventilator (machine that helps a person breathe), gastrostomy tube (G-tube, feeding tube that is surgically placed through an opening into the stomach from the abdominal wall), and tracheostomy tube (trach tube, surgical procedure in which a tube is inserted from an opening in the neck into the trachea [windpipe]). During a review of Resident 274's History and Physical (H&P) dated 4/5/2024, the H&P indicated Resident 274 had fluctuating capacity to understand and make decisions. During a review of Resident 274's Physician Orders (PO), the PO indicated Resident 274 had an active order dated 4/4/2024 for Enhanced Barrier Precaution. During a review of Resident 274's untitled care plan (CP) dated 4/4/2024, the CP indicated Resident 274 was on EBP related to the presence of a trach tube and feeding tube. During an observation on 4/11/2024 at 3:07 PM in Resident 274's room, NP entered Resident 274's room without wearing PPE during wound care treatment with the Wound Care Nurse (WCN). NP performed a physical assessment on Resident 274 and pulled Resident 274's gown up to palpate (to feel the body with hands) Resident 274's abdomen (stomach) with bare hands. During an interview on 4/11/2024 at 3:11 PM with NP, NP stated she did not have a gown or gloves on while doing a physical assessment on Resident 274. NP stated did not know what EBP was nor the policy regarding EBP. NP stated facility staff did not tell her that she was required to wear prior to entering Resident 274's room. During an interview on 4/11/2024 at 4:04 PM with Registered Nurse Supervisor 2 (RN Sup 2), RN Sup 2 stated EBPs were placed when the resident had bacteria such as Methicillin-resistant Staphylococcus Aureus (MRSA, an infection cause by a type of bacteria, resistant to many types of antibiotics) or when the resident was on a ventilator machine. RN Sup 2 stated anyone entering an EBP room to perform care or in close contact with the resident, needed to wear a gown and gloves. RN Sup 2 stated the risk of not donning proper PPE would spread bacteria to other residents and breaking infection control. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/12/2024 at 8:24 AM with the Infection Preventionist (IP), IP stated EBPs were used for residents with medical devices such as G-tube, chronic wounds, on a ventilator machine, or residents with trach tube. IP stated, EBP prevent MDRO's to be transferred to other residents. IP stated gloves and gown were needed each time staff or visitor touch the resident on EBP. IP stated, if physicians and NPs entered an EBP room and performed a physical assessment without wearing required PPE, they were not following infection prevention procedures. During an interview on 4/12/2024 at 9:37 AM with the Medical Director (MD), MD stated physician or NP needed to follow the facility's policy and procedure and if physicians and NPs needed to wear PPE prior to entering the room when doing a physical assessment on residents, they needed to follow the proper precautions. MD stated the risk of not following precautions would put other residents at risk for infections. During a review of the facility's P&P titled, Enhanced Barrier Precautions revised 2/23/2024, the P&P indicated the purpose of implementing EBP is for the prevention of transmission of MDRO's. The P&P indicated EBP should be followed when anticipating close physical contact, assisting with transfers and mobility, or any high-contact activity.

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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** 42781 Based on observation, interview and review of the facility's room waiver request, the facility failed to ensure one of 28 residents' room, accommodated no more than four residents in a multiple resident room (room [ROOM NUMBER]). room [ROOM NUMBER] had five beds to accommodate five residents in the Sub Acute Unit. This deficient practice had the potential risk for privacy concerns and crowded condition in the room. Findings: During an entrance conference with the facility Administrator (ADM) on 4/9/2024 at 9:54 am, the ADM stated, room [ROOM NUMBER] had more than four residents occupying the room. The ADM stated, the facility would continue to request a room waiver for room [ROOM NUMBER]. During the Health Recertification Survey from 4/9/2024 to 4/12/2024, room [ROOM NUMBER] was observed with beds, side tables, dresser, and resident care equipment. Staff were able to move freely inside room [ROOM NUMBER]. During an observation on 4/12/2024 at 9:10 am, there were 28 residents' rooms in the facility. One of the 28 residents' rooms (room [ROOM NUMBER]) had five beds in the room and four beds were occupied by residents. During an interview on 4/12/2024 at 9:14 am with Licensed Vocational Nurse 6 (LVN 6), the LVN 6 stated there were five beds in room [ROOM NUMBER] and there was enough space to provide care and treatment to the residents in room [ROOM NUMBER] with ventilators (machine that supports breathing) with no issues. During a review of the facility's letter to request for room waiver dated 4/9/2024, the room waiver request letter indicated room [ROOM NUMBER] contained five beds and had 494 square footage (sq. ft, unit of measurement). The waiver indicated the room was in accordance with special needs of the residents and there was no adverse effect to the health and safety of the residents nor impede the ability of any resident to attain highest practicable well-being. The waiver indicated, residents' safety was not compromised by the existing square footage and the room size did not affect the care provided including resident's safety.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42781 Based on observation, interview and record review, the facility failed to ensure 14 of 28 rooms (Rooms 15, 16, 17, 19, 20, 21, 22, 23, 25, 26, 27, 32, 33 and 35) met the square footage requirement of 80 square feet (sq. ft.) per resident in multiple resident rooms. This deficient practice had the potential to impact resident's safety and the ability of staff to provide safe nursing care and privacy to the residents. Findings: During an interview with the facility Administrator (ADM) on 4/9/2024 at 9:54 am, the ADM stated the facility would request a room waiver (a document recording the waiving of a right or claim) for Rooms 15, 16, 17, 19, 20, 21, 22, 23, 25, 26, 27, 32, 33 and 35. The ADM stated there was no change and the number of bed occupancy in Rooms 15, 16, 17, 19, 20, 21, 22, 23, 25, 26, 27, 32, 33 and 35 remained the same. During a review of the facility's letter to request for room waiver dated 4/9/2024, the letter to request for room waiver indicated the rooms were in accordance with special needs of the residents and there was no adverse effect to the health, and safety or impede the ability of any residents to attain their highest practicable wellbeing. The waiver indicated, the residents' safety was not compromised by the existing square footage and room size did not affect the care provided and residents safety. During a review of the Client Accommodations Analysis dated 4/9/2024, the analysis indicated the following: Room Sq. Ft. Beds 15 152.6 2 16 129.5 2 17 163.9 2 19 214.7 3 20 146.3 2 21 214.7 3 22 133.4 2 23 219.3 3 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055104	A. Building B. Wing	04/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Manor Conv Hosp	2720 Nevada Avenue El Monte, CA 91733

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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	25 146.3 2 26 144.7 2 27 139.6 2 32 234.3 3 33 246.3 3 35 232.3 3 During the Health Recertification Survey, from 4/9/2024 to 4/12/2024, Rooms 15, 16, 17, 19, 20, 21, 22, 23, 25, 26, 27, 32, 33 and 35 had adequate space, nursing care, comfort, and privacy to the residents. The residents were observed to have enough space to move freely inside the rooms. Each resident inside the affected rooms had beds and bedside tables with drawers. There was an adequate room for the operation and use of the wheelchairs (a chair fitted with wheels for use as a means of transport by a person who is unable to walk as a result of illness, injury, or disability) and walkers (is a device that gives additional support to maintain balance or stability while walking,). The room size did not affect the care and services provided to the residents when nursing staff were observed providing care to the residents. During an interview on 4/9/2024 at 10:20 am with Certified Nurse Assistant 4 (CNA 4), CNA 4 stated, there was enough space in the rooms and staff were able to provide care to the residents. CNA 4 stated, she was able to move wheelchairs and walkers inside the rooms with no issues. During an interview on 4/12/2024 at 9:14 am with Licensed Vocational Nurse 6 (LVN 6), LVN 6 stated there was enough space to provide care and treatment to the residents with ventilators (machine that supports breathing) with no issues. During a concurrent observation and interview with Resident 30 on 4/12/2024 at 10:15 am, Resident 30 was sitting in his wheelchair in the Activity Room. Resident 30 stated, he was staying in room [ROOM NUMBER], and he was able to move his wheel himself in and out of the room with no concerns. Resident 43 stated, the room space was ok with him.