STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055119	A. Building B. Wing	02/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Pico Terrace Healthcare & Wellness Centre LP	6070 W. Pico Boulevard Los Angeles, CA 90035

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454 Based on interview and record review, the facility failed to ensure two of six sampled residents, (Resident 3 and Resident 29)'s clinical record was updated per facility's policy and procedure by failing to: 1. Ensure Resident 3's Physician Orders for Life-Sustaining Treatment (POLST - is a form designed to improve patient care by creating a portable medical order form that records patients' treatment wishes so that emergency personnel know what treatments the patient wants in the event of a medical emergency) were complete and accurate. 2. Ensure Resident 29's Advance Healthcare Directives (AHCD - written statement of a person's wishes regarding medical treatment made to ensure those wishes are carried out should the person be unable to communicate them to a doctor) were followed up and discussed with the residents and/or responsible parties. These deficient practices had the potential to cause conflict with resident's wishes regarding health care decisions. Findings: I. During record review, the Admission Record indicated Resident 3 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including epilepsy (a disorder in which nerve cell activity in the brain is disturbed causing seizures), encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition-such as viral infection or toxins in the blood) and aphasia (a disorder that makes it difficult to speak). During record review, the Minimum Data Set (MDS - resident assessment tool) dated [DATE], indicated Resident 3's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 10 required maximal assistance from staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During record review, Resident 3's POLST, date prepared on [DATE], the POLST form was incomplete with no documentation regarding Resident 3's wishes such as cardiopulmonary resuscitation (CPR - medical procedure involving repeated compression of a patient's chest, performed in an attempt to restore the blood circulation and breathing of a person who has suffered cardiac arrest), medical interventions and artificially administered nutrition, the POLST does not have signatures of resident and/or legally recognized decisionmaker if the POLST was discussed and reviewed. II. During record review, the Admission Record indicated Resident 29 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including metabolic encephalopathy (a chemical imbalance in the blood affecting the brain), Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities), and muscle wasting and atrophy (characterized by a significant shortening of the muscle fibers and a loss of overall muscle mass). During record review, the MDS dated [DATE], indicated Resident 29's cognitive skills for daily decisions were severely impaired. The MDS indicated Resident 10 was dependent from staff for ADLs. During record review, Resident 29's Advance Directive Acknowledgement (ADA) Form, dated [DATE], indicated, Yes, I (Resident 29) have executed an Advance Directive, the form did not indicate if facility requested a copy of the actual AHCD. During record review, Resident 29's electronic medical record and paper medical record as of [DATE], there are no ADHD recorded in the chart. During a concurrent interview and record review with Social Services Director Interim (SSDI) on [DATE] at 3:04 p.m., SSDI reviewed Resident 3's medical record and stated and confirmed, the POLST is incomplete and it does not have information if Resident 3 is a Full Code (if a person's heart stopped beating or breathing, the person will allow all medical measures to be taken to maintain and resuscitate life) or DNR (do not resuscitate- a medical order written by a doctor to instruct health care providers NOT to do cardiopulmonary resuscitation (CPR) if breathing stops or the heart stops beating). SSDI 1 also reviewed Resident 29's ADA form and stated and confirmed, Resident 29 has an AHCD but there was no indication if the facility followed up and requested the copy. During an interview with Director of Nursing (DON) on [DATE] at 6:10 p.m., DON stated, facility should have followed up with the actual copy of residents' AHCD they formulated one so they can honor their wishes. DON further stated, the POLST must be completed with information if they are Full Code or DNR. During record review, the facility's policy and procedure (P&P) titled, Advance Directive, reviewed on [DATE] indicated, The Facility will respect a resident's advance directive and will comply with the resident's wishes expressed in an advance directive . Upon admission, the Admission Staff or designee will obtain a copy of a resident's advance directive. If the resident has an Advance Directive, the facility shall obtain a copy of the document and place it in the resident's medical record. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During record review, the facility's P&P titled, Physician Orders for Life-Sustaining Treatment (POLST), reviewed [DATE], the P&P indicated, A completed and signed POLST form is a legal physician order that is immediately actionable . Completion of a POLST form will reflect a process of careful decision making by the resident, the resident's legally recognized health care decision maker if the resident lacks decision making capacity, and the attending physician, physician assistance or nurse practitioner, regarding the resident's medical condition and known treatment preferences.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454 Based on observation, interview, and record review, the facility failed to ensure that one out of three sampled residents (Resident 10) was free from physical restraint by failing to ensure the physician's order for bilateral bed siderails was in placed and the proper use of use rails are appropriate according to facility's policy and procedure. This deficient practice had the potential to result in entrapment and injury with the use of restraints. Cross Reference F656 Findings: During record review, the Admission Record indicated Resident 10 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including cerebral infarction (lack of blood flow resulting in severe damage to some of the brain tissue), Parkinson's disease (a chronic brain disorder that causes movement problems, and can also affect mental health, sleep, and pain), Type II Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and muscle wasting and atrophy (characterized by a significant shortening of the muscle fibers and a loss of overall muscle mass). During record review, the Minimum Data Set (MDS - resident assessment tool) dated 2/6/2025, indicated Resident 10's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions was intact. The MDS indicated Resident 10 required maximal assistance from staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During the initial tour of the facility and observation of Resident 10 on 2/7/2025 at 6:23 p.m., Resident 10 was observed in bed, lying on a bed with a bilateral (both) siderails up. Resident 10 was observed asking staff for assistance on opening food container. During record review of Resident 10's Order Summary Report as of 2/9/2025, indicated there was no physician order for the use of bilateral bed siderails. During record review of Resident 10's Care Plan (CP) as of 2/9/2025, indicated there are no CP developed for the use of bilateral siderails. During an interview with Director of Nursing (DON) on 2/9/2025 at 6:14 p.m., DON stated, the bed side rails are used as an enabler. DON stated there should be a physician's order and CP for the use of bed siderails as it limits resident movements and can be a restraint. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During record review of the facility's policy and procedures (P&P) titled, Bed Rails, reviewed on 6/20/2024, the P&P indicated, A bed rail is an assistive device and must be used in accordance with the following regulations: . are classified as a physical restrain when bed rails are used to limit a Resident's freedom of movement . A detailed order by a healthcare provider is required before any restrains can be utilized.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44253 Based on interview, and record review, the facility failed to provide a bed hold notification (holding or reserving a resident's bed while the resident is absent from the facility for therapeutic leave or hospitalization) in writing at the time of transfer to the hospital for one of three sampled residents (Resident 38). This deficient practice denied Resident 38 or the Responsible Party (RP) of being informed of resident's right to have the facility hold and reserve his bed while absent from the facility. Findings: During record review of Resident 38's Admission Record (Face Sheet) indicated Resident 38 was initially admitted to the facility on [DATE], and was readmitted on [DATE], with diagnoses including metabolic encephalopathy (brain damage that causes severe confusion and forgetfulness), bladder cancer and chronic kidney failure (a condition in which the kidneys suddenly can't filter waste from the blood). During record review of Resident 38's Bed Hold Agreement form, dated 12/6/24 indicated the form had three sections, the first was To be Completed upon Admission or Return to Facility, the second was Notification of Bed Hold option upon transfer/therapeutic leave and the third was 24 Hour Notification of Bed Hold Decision. A review of the Bed Hold Agreement form also indicated Under the section To be Completed upon Admission, indicated Resident 38's responsible party (RP) was informed that the resident or RP had the right to request the facility hold the bed for seven days should the resident be transferred to an acute hospital and the resident or RP must notify the facility within 24 hours of transfer/leave if the resident wished to have the bed held. This section of the form was signed by the RP on 12/6/24. A further review of Bed Hold Agreement form indicated the second and third sections were not filled out and were unsigned. During record review, Resident 38's Minimum Data Set (MDS- a resident assessment tool) dated 12/30/24, indicated the resident's cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was intact. The MDS indicated Resident 38 required substantial assistance (helper does less than half to more than half the effort) from staff for toileting hygiene, showering/bathing and lower body dressing. During record review, Resident 38's Physician Order, dated 2/5/25, indicated to transfer Resident 38 to the Emergency Department (ED) via 911 for further evaluation of hypotension (low blood pressure). During record review, Resident 38's Progress Note dated 2/5/25 indicated at 9:10 AM the resident had a blood pressure of 80/60 (normal 120/80) and the nurse practitioner ordered the resident transferred to General Acute Care Hospital (GACH) 1. The progress note also indicated Resident 38 was transferred via 911 (a telephone number used to reach emergency medical, fire, and police services) to GACH 2. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During record review of Resident 38's Skilled Nursing Home/Nursing Home (SNF/NF) to Hospital Transfer Form, dated 2/5/25, indicated the resident was transferred to GACH 2. During a concurrent interview and record review on 2/9/25 at 12:38 PM with Registered Nurse Supervisor (RNS) 1, Resident 38's electronic health record was reviewed. RNS 1 stated Resident 38 was transferred to a general acute care hospital on 2/5/25 for low blood pressure and high heart rate. RNS 1 stated the facility did not notify Resident 38 or the responsible party of the resident's right to a bed hold during or after the transfer. RNS 1 stated a bed hold notification is required to be offered upon transfer in order to guarantee the resident has a bed to return to upon readmission. During an interview with on 2/09/25 at 5:59 PM, the Director of Nursing (DON) stated, the policy is to inform the resident of their right to a bed hold upon transfer. During record review, the facility's policy and procedures (P&P) titled, Bed Hold, revised 7/2017, indicated, the facility notifies the resident and/or representative, in writing, of the bed hold option, any time the resident is transferred to an acute care hospital or request therapeutic leave. During record review, the facility's P&P titled, Discharge and Transfer of Residents, revised 2/2018, indicated, the purpose of the policy was to ensure that discharge planning is complete and appropriate and that necessary information is communicated to the continuing care provider. The P&P also indicated upon transfer to the acute hospital the resident/resident representative will be given an opportunity to execute a bed hold.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition 45528 Based on interview and record review, the facility failed to complete a change of condition (COC -a sudden deviation from person/patient's baseline in physical, cognitive, behavioral or function) in accordance with the facility's policy and procedures (P&P) titled Change of Condition Notification reviewed 6/20/2024 for one out of six residents (Resident 23) This deficiency practice had the potential to result in the delay of care for Resident 23. Findings: During record review, Resident 23's Admission Record indicated the facility admitted Resident 23 on 7/3/2023 with diagnoses including dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough), personal history of transient ischemic attack (TIA - a temporary blockage of blood flow to the brain) and cerebral vascular accident (CVA- Stroke) without residuals, and hypertension (HTN - elevated blood pressure). During record review of Resident 23's Minimum Data Set (MDS - resident assessment tool) dated 1/10/2025, indicated Resident 23 had cognitive impairment (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 23 required extensive staff assistance with activities of daily living (ADL -tasks of everyday life). During a concurrent interview and record review, on 2/9/2025, at 8:45 a.m., with Registered Nurse Supervisor 1 (RNS 1), Resident 23's electronic chart was reviewed. RNS 1 stated there was no documented evidence that a COC was completed for Resident 23 on 9/15/2025. RNS 1 stated A COC is done to see if there is any new or continuous change in the resident's condition and since residents 23 continued to have aggressiveness, combativeness and continuously refused to allow staff to collect the urine sample ordered by the physician, a COC documentation should have been done. RNS 1 stated lack of completion of the coc leads to lack of recommendations needed on how to deal with the changes. During an interview, on 2/9/2025, at 4:04 p.m., with the Director of Nursing (DON), the DON stated that a COC is done to so residents can be monitored, and the Interdisciplinary team can be involved in providing resident with the care needed and if not done no one will know or monitor what is going on. During record review of the facility's P&P, titled, Change of Condition Notification reviewed 6/20/2024, indicated, Purpose: To ensure residents, family, legal representatives, and physicians are informed of changes in the resident's condition in a timely manner . A. A need to alter treatment significantly (e.g. based on labs/x-ray results, a need to discontinue an existing form of treatment due to change of condition).

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 45528 Based on interview and record review, the facility failed to immediately develop and implement a baseline care plan according to their Policy and Procedures (P&P) in accordance with the facility's policy and procedures (P&P) titled Comprehensive Person-Centered Care planning revised 11/2018 for one of four sampled residents (Resident 6), by failing to: 1. Address the inclusion of activity programs that are tailored to Resident 6's interests and to Resident 6's cognitive, physical/functional and social abilities to stimulate and facilitate Resident 6's social engagement. 2. Outline a personalized treatment strategy for Resident 6's hearing loss within 48 hours of admission. These deficient practices had the potential to negatively affect the delivery of necessary care and services for Resident 6. Findings: During record review, Resident 6's Admission Record indicated the facility admitted Resident 6 on 11/23/2024 with diagnoses including dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough), generalized weakness (a feeling of weakness in most parts of the body), and adult failure to thrive (a noticeable decline in health). During record review, the physician order dated 11/23/2024, indicated audiology (a medical study of hearing and balance, and treatment of related disorders) consult with follow up treatment as indicated for Resident 6. During record review, the history and physical (H&P -a physician's examination of the patient) dated 11/25/2024 at 10:46 a.m., indicated .past medical history . hard of hearing for Resident 6. During record review, Resident 6's Minimum Data Set (MDS - resident assessment tool) dated 11/30/2024, indicated Resident 6 had mild cognitive impairment (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 6 required extensive staff assistance with activities of daily living (ADL -tasks of everyday life). The MDS further indicated Resident 6 had moderate difficulty with hearing and severely impaired vision. During an interview, on 2/8/2025, at 2:21 p.m., with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 6 was hard of hearing, and that facility staff have to go very close to her ear and speak very loud for Resident 6 to hear. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review, on 2/9/2025, at 10:04 a.m., with Registered Nurse Supervisor (RNS) 1, Resident 6's electronic chart was reviewed. RNS 1 stated a care plan for activities is for staff to know what interventions to take to achieve the goal for the resident to participate in the activities that the resident prefers. RNS 1 stated Resident 6 did not have documented evidence of an activity care plan in her chart. RNS 1 further stated that lack of an activity care plan for Resident 6, facility staff will not know her activity preference. During a concurrent interview and record review, on 2/9/2025, at 1:47 p.m., with Activities Director (AD), Resident 6's electronic chart was reviewed. AD stated, a care plan provides residents with the services that the residents needs and for other facility staff to know what activities needs the resident has before even meeting the resident. AD stated Resident 6 did not have a documented activity care plan and that and that Resident 6 needed to have one. AD further stated, if the resident does not have a care plan for activities, the team members will nots know how to handle the resident in regard to their activities which may lead to the residents feeling sad and neglected. During an interview, on 2/9/2025, at 4:14 p.m., with Director of Nursing (DON), DON stated base line care plans are supposed to be initiated within 48 hours of admission which includes a personalized activity care plan for the team to know how to take care of the resident. DON stated potential adverse outcome of not having an activity care plan is that the staff may not know the type of activities the Resident prefers and may lead resident to be sad and depressed (sadness, hopeless and loss of interest). During record review, the facility's policy and procedures, titled, Comprehensive Person-Centered Care Planning revised 11/2018, indicated, Purpose: To ensure that a comprehensive person-centered care plan is developed for each resident . 1. Baseline Care plan . b. The baseline care plan will be developed and implemented, using necessary combination of problem specific care plans, within 48 hours of the resident admission . c. The baseline care plan must reflect the resident's stated goals and objectives and include interventions that address his or her needs.

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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** 43454 Based on interview and record review, the facility failed to implement a comprehensive care plan (CP) that met the care/services based on the resident's individual assessed needs for one of six sampled residents (Resident 10), by failing to ensure that a comprehensive CP was developed with the use of Resident 10's bilateral (both) bed siderails, when Resident 10 was hospitalized on [DATE], 7/22/2024, and 12/27/2024. This deficient practice had the potential to result in a negative impact on residents' health and safety, as well as the quality of care and services received. Findings: A review of the Admission Record indicated Resident 10 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including cerebral infarction (lack of blood flow resulting in severe damage to some of the brain tissue), Parkinson's disease (a chronic brain disorder that causes movement problems, and can also affect mental health, sleep, and pain), Type II Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and muscle wasting and atrophy (characterized by a significant shortening of the muscle fibers and a loss of overall muscle mass). A review of Resident 10's Minimum Data Set (MDS - resident assessment tool) dated 2/6/2025, indicated Resident 10's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions was intact. The MDS indicated Resident 10 required maximal assistance from staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During the initial tour of the facility and observation of Resident 10 on 2/7/2025 at 6:23 p.m., observed resident 10 in bed, lying on a bed with a bilateral siderails up. Observed Resident 10 asking staff for assistance on opening food container. A review of Resident 10's CP as of 2/9/2025, indicated there are no CP developed for the use of bilateral siderails. Furthermore, there are no CP when Resident 10 was hospitalized due to altered mental status on 6/29/2024, chest pain on 7/22/2024 and productive cough and generalized weakness on 12/27/2024. During an interview with Registered Nurse (RN) 1 on 2/8/2025 at 3:39 p.m., RN 1 reviewed Resident 10's chart and stated and confirmed, there are no CP developed for the use of bilateral bed siderails. RN 1 further stated, there are also no CP when Resident 10 had a change of condition (COC) and was hospitalized on [DATE], 7/22/2024 and 12/27/2024. RN 1 stated, a CP should be developed when residents had COC, so that they can update the plan of care and manage the problems. (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 with Director of Nursing (DON), on 2/9/2025 at 6:14 p.m., the DON stated, the bed side rails are used as an enabler. DON stated there should be a physician's order and CP for the use of bed siderails as it limits resident movements and can be a restraint. DON further stated, there should also be CP for each hospitalization and COC so that all staff are on the same page on managing resident's plan of care. A review of the facility's policy and procedure (P&P) titled, Comprehensive Person-Centered Care Planning, reviewed on 6/20/2024, the P&P indicated, Is it the policy of this facility to provide person-centered, comprehensive and interdisciplinary care that reflects best practice standards for meeting health, safety, psychosocial, behavioral, and environmental needs of residents in order to obtain or maintain the highest physical, mental, and psychosocial well-being . The comprehensive care plan will also be reviewed and revised at the following times: onset of new problems; change of condition.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055119	A. Building B. Wing	02/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Pico Terrace Healthcare & Wellness Centre LP	6070 W. Pico Boulevard Los Angeles, CA 90035

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 44253 Based on observation, interview, and record review, the facility failed to revise the enteral feeding care plan to meet the individual needs for one of two sampled residents (Resident 22). This deficient practice had the potential to prevent Resident 22 from receiving care to address specific needs, which could lead to a decline in her nutrition. Findings: A review of Resident 22's Admission Record indicated the facility admitted Resident 22 on 10/9/24 with diagnoses including cerebrovascular accident (CVA-stroke, loss of blood flow to a part of the brain) dysphagia (difficulty swallowing) and heart failure (a disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). A review of Resident 22's Minimum Data Set [MDS - a resident assessment tool] dated 1/8/25 indicated the resident had severely impaired cognition (never/rarely made decisions) and was totally dependent upon staff for eating, oral hygiene, toileting hygiene, lower body dressing and personal hygiene. The MDS also indicated Resident 22 had a feeding tube. A review of Resident 22's physician order dated 1/16/25, indicated to give Jevity 1.5 at 65 milliliters (ml, unit of measurement) per hour (hr) via gastrostomy tube (GT - a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) for dysphagia (difficulty swallowing). During an observation on 2/7/25 at 6:08 PM at Resident 22's bedside, Resident 22 was observed lying in bed awake with Jevity 1.5 calorie formula bottle infusing at 65 ml/hr. During a record review on 2/8/25 at 12:22 PM, Resident 22's Requires tube feeding care plan, initiated 10/9/24, was reviewed. The care plan indicated Resident 22's current enteral feeding order was for Jevity 1.5 to infuse at 40 ml/hr. The care plan indicated the goal was for the resident to maintain adequate nutritional and hydration status. A further review of the care plan indicated the care plan did not include the resident's current enteral feeding order. During a concurrent interview and record review on 2/8/25 at 1:08 PM, Resident 22's physician orders and care plans were reviewed with Registered Nurse Supervisor (RN) 1. RN 1 stated Resident 22's current enteral feeding order was Jevity 1.5 at 65 ml/hr. RN 1 stated Resident 22's enteral feeding care plan was not updated with the current physician order. RN 1 stated should have been updated in order for all staff to know the current interventions in place. RN 1 further stated not updating the care plan could lead to the Resident not receiving the proper care. During an interview on 2/9/25 at 5:57 PM, the Director of Nursing (DON) stated the staff update the care plan when the changes in the resident's care, medication or enteral feeding occurs. The DON confirmed the findings and stated the care plan should be updated so the resident receives appropriate care. (continued on next page)

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	055119	A. Building B. Wing	02/09/2025

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure (P&P) titled, Comprehensive Person-Centered Care Planning, revised 11/2018, the P&P indicated, the comprehensive care plan will the comprehensive care plan will be periodically reviewed and revised by the interdisciplinary team (IDT, - a group of healthcare professionals from different disciplines [nurses, social worker, therapist, physician, etc.] that provide care for the residents) after each assessment which means after each MDS assessments as required, accept discharge assessments. In addition, the comprehensive care plan will also be reviewed and revised at the following times: i. onset of new problems; ii. change of condition; iii. in preparation for discharge; iv. to address changes in behavior and care; v. other times as appropriate or necessary.

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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. 45528 Based on interview and record review, the facility failed to notify the physician when they were unable to collect urine sample for urinalysis, culture and sensitivity (UA [a test to check if the urine has an infection, kidney problem, diabetes or liver disease] and C&S [test to find germs & the type of antibiotics they respond to]) for one of three sampled residents (Resident 23) per physician's orders. This deficient had the potential to result in the delay of the appropriate instructions needed from the physician to prevent infection and hospitalization . Findings: A review of Resident 23's Admission Record indicated the facility admitted Resident 23 on 7/3/2023 with diagnoses including dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough), personal history of transient ischemic attack (TIA - a temporary blockage of blood flow to the brain), and cerebral vascular accident (CVA- Stroke) without residuals, and hypertension (HTN - elevated blood pressure). A review of Resident 23's Minimum Data Set (MDS - a resident assessment tool) dated 1/10/2025, indicated Resident 23 had cognitive impairment (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 23 required extensive staff assistance with activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). A review of Resident 23's change of condition (COC -a sudden deviation from person/patient's baseline in physical, cognitive, behavioral or function) effective 9/12/2024 at 2:48 p.m., indicated Licensed Vocational Nurse (LVN) documented that on 9/12/2024 Certified Nursing Assistant (CNA) informed LVN that Resident 23 was aggressive/combative during ADL care. The COC indicated that on 9/12/2024 at 2:40 p.m., the LVN relayed Resident 23's condition to the physician who gave an order to collect a urine sample for UA, C&S via straight catheter. A review of the physician order dated 9/15/2024 at 11:04 a.m., indicated transfer to General Acute Care Hospital (GACH) for further evaluation and treatment possible Urinary Tract Infection (UTI-an infection of the urinary tract, which includes the kidneys, ureters, bladder, and urethra). (continued on next page)

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	055119	A. Building B. Wing	02/09/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 2/9/2025, at 8:45 a.m., with Registered Nurse Supervisor (RNS) 1, Resident 23's electronic chart was reviewed. RNS 1 stated that the facility's process for an order for a routine (a standard or regular way of doing something) urine sample collection, was that the facility needs to attempt collection of the urine sample three times and if not successful, then they need to notify the doctor. RNS 1 stated the COC on 9/12/2024 indicated that Resident 23 was aggressive and combative while performing ADL care. RNS 1 stated aggressiveness and combativeness maybe a sign (something a doctor, or other person, notices) and symptoms (is what a person/patient feels) of a UTI and if the urine sample was not collected, there would not be any lab results to treat the resident. RNS 1 further stated if the UTI was left untreated, it may lead to sepsis (a life threatening blood infection) and possibly prolonged hospitalization . RNS 1 stated there was no documented evidence that Resident 23's physician was notified when the facility failed to collect the urine sample after three attempts. During an interview with the Director of Nursing (DON), on 2/9/2025, at 4:04 p.m., the DON stated that the urine sample was supposed to be collected as soon as possible when the order was received. The DON stated if the urine sample was not able to be collected after trying three consecutive shifts, then the physician needs to be notified. The DON stated a UA, C&S is a urine sample that is ordered when a resident is suspected of having a UTI. The DON further stated if a UTI was left untreated, it could lead to sepsis. A review of the facility's policy and procedures (P&P), titled, Refusal of Treatment revised 1/1/2012, the P&P indicated, Procedure . IV. The attending Physician will be notified of refusal of treatment in a time frame determined by the resident's condition and potential serious consequences of the refusal. VI. When the residents refusal brings about a significant change in the resident's condition, a reassessment is made, and new information is incorporated into the residents care plan.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. 45528 Based on interview and record review, the facility failed to provide outside services as required by physician orders in accordance with the facility's policy and procedures (P&P) titled Referral to Outside Services revised on 12/1/2013, by failing to refer one of four sampled residents (Resident 6) to an audiologist (a healthcare professional that specializes in evaluating and treating hearing problems, like hearing loss). This deficient practice had the potential to negatively affect the delivery of necessary care and services for Resident 6. Findings: A review of Resident 6's Admission Record indicated the facility admitted Resident 6 on 11/23/2024 with diagnoses including dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough), generalized weakness (a feeling of weakness in most parts of the body), and adult failure to thrive (a noticeable decline in health). A review of Resident 6's physician order dated 11/23/2024, indicated audiology (a medical study of hearing and balance, and treatment of related disorders) consult with follow up treatment as indicated. A review of Resident 6's History and Physical (H&P -a physician's examination of the patient) dated 11/25/2024 at 10:46 a.m., indicated .past medical history . hard of hearing. A review of Resident 6's Minimum Data Set (MDS - a resident assessment tool) dated 11/30/2024, indicated Resident 6 had mild cognitive impairment (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 6 required extensive staff assistance with activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The same MDS further indicated Resident 6 had moderate difficulty with hearing and severely impaired vision. During an interview with Certified Nursing Assistant (CNA) 1, on 2/8/2025, at 2:21 p.m., CNA 1 stated Resident 6 was hard of hearing. CNA 1 further stated that the facility staff had to go very close to Resident 6's ear and speak very loud for Resident 6 to hear. During a concurrent interview and record review, on 2/9/2025, at 10:18 a.m., with Registered Nurse Supervisor (RNS) 1, Resident 6's electronic chart was reviewed. RNS 1 stated Resident 6 had a referral to audiology on 11/23/2024 however, there was no documented evidence in Resident 6's chart that the resident was seen by audiology. RNS 1 further stated that social services was responsible for making the appointment. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review, on 2/9/2025, at 11:09 a.m., with the Social Services Director Interim (SSDI), Resident 6's electronic chart was reviewed. SSDI stated, facility process was that when there was a physician's order for referral to ancillary (extra or supporting services that are added onto the main service) services, the referral to the requested specialty was sent the day of admission or the day that the order was received. SSDI stated Resident 6 had an order for audiology consult on 11/23/2024 however, there was no documented evidence that a referral to audiology was made. SSDI stated Resident has hard of hearing and has a hard time hearing the staff which may lead her to get frustrated. The SSDI confirmed and stated that it had been 13 weeks since the order was given. During an interview with the Director of Nursing (DON), on 2/9/2025, at 4:14 p.m., the DON stated that the facility's process for an audiology or ancillary order, was that the social services was notified, the social services then notifies the audiologist of the order right away. The SSDI then puts the resident on the audiology or ancillary list and the resident will be seen when the audiologist comes into the facility. The DON further stated if the audiologist was not notified of the referral order, there will be a delay in the care and the evaluation of the resident. The DON further stated delaying the evaluation of Resident 6 would ultimately affect the overall communication with the resident, and the resident may end up feeling depressed (sadness, hopeless). A review of the facility's policy and procedures (P&P), titled, Referral to Outside Services revised 12/1/2013, the P&P indicated, To provide residents with outside services as required by physician orders or the care plan .The Director of Social Services coordinates the referral of residents to outside agencies/programs to fulfill resident needs for services not offered by the Facility .

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	055119	A. Building B. Wing	02/09/2025

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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** 43454 Based on interview, observation, and record review, the facility failed to maintain a safe, functional and comfortable environment for one of six sampled residents (Resident 4), by failing to ensure the exit pathway was clear of geriatric (relating to old people, especially with regard to their healthcare) recliner chairs (geri-chair - large, padded chairs with wheeled bases, and are designed to assist seniors with limited mobility) and clutter. This failure had the potential to place Resident 4 at risk of fire hazards injury and accidents. Findings: A review of the Admission Record indicated Resident 4 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including pneumonia (lung infection that inflames air sacs with fluid or pus), acute respiratory failure (condition in which your blood does not get enough oxygen or has too much carbon dioxide), hemiplegia and hemiparesis (total paralysis of the arm, leg, and trunk on the same side of the body) following cerebral infarction (lack of blood flow resulting in severe damage to some of the brain tissue) affecting left dominant side. A review of Resident 4's Minimum Data Set (MDS - resident assessment tool) dated 12/20/2024, indicated Resident 4's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions was intact. The MDS indicated Resident 4 required maximal to total dependent from staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a concurrent observation and interview with Resident 4 on 2/7/2025 at 7:13 p.m., Resident 4 stated, her exit door pathway is obstructed with geri-chairs and it's blocking her view to the outside. Resident 4 stated, she asked the staff to have it move because she's scared that if they need to evacuate her due to fire, it will be blocking the way, and she also feels uncomfortable because she doesn't like how it's blocking her view. Observed six geri-chairs outside her door which completely blocked the exit pathway. During an interview with Maintenance Supervisor (MS) on 2/8/2025 at 11:40 a.m., MS stated, they put the geri-chair outside Resident 4's room because of the recent rains. MS stated, he was aware of Resident 4's complaint about the geri-chair and how it is blocking the pathway but he has not moved the equipment away. MS stated the exit pathway is not a storage area and it should be clear of any equipment. During an interview with Director of Nursing (DON) on 2/9/2025 at 6:01 p.m., DON stated, the exit pathway should be clear in case of fire, earthquake and any emergency. DON stated, resident might feel unsafe when the exit pathway is blocked and obstructed. (continued on next page)

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	055119	A. Building B. Wing	02/09/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure (P&P) titled, Resident Rooms and Environment, reviewed on 6/20/2024, the P&P indicated, The facility provides residents with a safe, clean, environment, and homelike environment. Facility Staff will provide residents with a pleasant environment and person-centered care that emphasizes the residents' comfort, independence, and personal needs and preferences. A review of the facility's P&P titled, Resident Safety, reviewed on 6/20/2024, the P&P indicated, Purpose: To provide a safe and hazard free environment . Any facility staff member who identifies an unsafe situation, practice or environment risk factor should immediately notify their supervisor or charge nurse.

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	055119	A. Building B. Wing	02/09/2025

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 44253 Based on observation, interview, and record review, the facility failed to ensure one of two sampled residents' (Resident 22) enteral feeding (refers to any method of feeding that uses the gastrointestinal (stomach/intestines) tract to deliver nutrition and calories) bottle was changed after 24 hours. This deficient practice had the potential for the residents to develop tube feeding associated complications such as infection. Findings: During record review, Resident 22's Admission Record indicated the facility admitted Resident 22 on 10/9/24 with diagnoses including cerebrovascular accident (CVA-stroke, loss of blood flow to a part of the brain) dysphagia (difficulty swallowing), and heart failure (a disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). During record review, Resident 22's Requires Tube Feeding care plan, initiated 10/9/24, indicated the resident had dysphagia. The care plan indicated a goal was for the resident to not have side effects or complication related to tube feeding. The interventions indicated staff were to monitor for signs or symptoms of infection, assist/supervise/cue the resident with tube feeding and water flushes and to see physician orders for current feeding orders. During record review, Resident 22's Minimum Data Set (MDS - a resident assessment tool), dated 1/8/25, indicated the resident had severely impaired cognition (never/rarely made decisions) and was totally dependent upon staff for eating, oral hygiene, toileting hygiene, lower body dressing and personal hygiene. The MDS also indicated Resident 22 had a feeding tube. During record review, Resident 22's physician order dated 2/4/25, indicated to give Jevity 1.5 at 65 milliliters (ml-unit of measurement) per hour (ml/hr) via gastrostomy tube (GT - a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) for dysphagia (difficulty swallowing) via pump for 20 hours for 20 hours to provide 1300 milliliters (ml) per day, and to start the infusion at 12 PM and turn off at 8 AM. During an observation on 2/7/25 at 6:08 PM at Resident 22's bedside, Resident 22 was observed lying in bed awake with Jevity 1.5 calorie formula bottle (1500cc) infusing at 65 ml/hr. Resident 22's tube feeding was dated 2/6/25 at 9 AM. During a concurrent observation and interview on 2/7/25 at 6:11 PM, Resident 22's tube feeding was observed with Licensed Vocational Nurse (LVN) 1. LVN 1 stated Resident 22's tube feeding was dated 2/6/25 at 9 AM. LVN stated the maximum hang time (amount of time formula can stay at room temperature before it's used) for an enteral feeding is 24 hours. LVN 1 stated leaving the tube feeding hanging for more than 24 hours cold lead to infection. (continued on next page)

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	055119	A. Building B. Wing	02/09/2025

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/9/25 at 5:55 PM, the Director of Nursing (DON) stated staff change entering feeding bottles every day for infection control. The DON further stated we follow manufacturer's instructions when administering tube feeding. During record review, the facility's policy and procedures titled, Enteral Feeding - Closed, revised 1/1/2012, indicated ,as part of the procedure staff should: VII. Connect container and tubing. Formula may 'hang' for 24-48 hours, depending on manufacturer guidelines. VIII. Label the formula container and tubing with date and time hung. XI. Change feeding formula and tubing every 24-48 hours or as required by manufacturer guidelines. According to the National Library of Medicine liquid ready to hang (RTH) formulas offer increased hang times of up to 48 hours. However, most closed containers are discarded after 24 hours due to current manufacturer recommendations to change enteral feeding sets every 24 hours and to spike each closed container only once https://pmc.ncbi.nlm.nih. gov/articles/PMC7519612/#:~:text=Sterile%20liquid%20RTH%20formulas%20offer, each%20closed%20container%20only%20once.

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	055119	A. Building B. Wing	02/09/2025

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454 Based on observation, interview, and record review, the facility failed to provide necessary respiratory care services for one of three sampled residents (Resident 30), by failing to ensure the nasal cannula (NC -a connector attached to oxygen) tubing and humidifier (a device used to make supplemental oxygen moist) for oxygen (O2) therapy was changed per facility's policy. This deficient practice had the potential to cause complications associated with oxygen therapy. Findings: During record review, the Admission Record indicated Resident 30 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including acute bronchospasm (a sudden narrowing of the airways [bronchi] in the lungs, caused by the contraction of muscles lining the airways), pulmonary embolism (a blood clot gets stuck in an artery in the lung, blocking blood flow to part of the lung), Type II Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and chronic kidney disease (CKD-a longstanding disease of the kidneys leading to renal failure). During record review, the Minimum Data Set (MDS - resident assessment tool) dated 12/13/2024, indicated Resident 30's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions was intact. The MDS indicated Resident 30 required set-up assistance from staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During record review, Resident 30's Order Summary Report dated 11/7/2022, the physician ordered, Change O2 NC tubing and humidifier every Monday for oxygen use, label and date properly. During a concurrent observation and interview with Resident 30 on 2/7/2025 at 6:03 p.m., Resident 30 stated that he was having some shortness of breath (SOB) and on oxygen therapy. Resident 30 was observed with an oxygen concentrator machine connected to a NC tubing and humidifier at bedside. Resident 30's NC tubing and humidifier bottle did not have a written label with date attached. During a concurrent observation and interview with Licensed Vocational Nurse (LVN) 3 on 2/7/2024 at 6:10 p. m., LVN 3 observed Resident 30's NC tubing and humidifier bottle and stated and confirmed, there are no written date labeled on the NC tubing and humidifier. LVN 3 further stated, he did not know when the NC was last changed. During an interview with Registered Nurse (RN) 1 on 2/8/2025 at 4:04 p.m., RN 1 stated, the NC tubing and humidifier is to be changed every seven days, and it must be labeled with the date so they know when it was last changed. During an interview with Director of Nursing (DON) on 2/9/2025 at 6:04 p.m., DON stated, the NC tubing and humidifier is replaced once a week and as needed for infection control. DON stated, if the humidifier bottle and NC tubing does not have any label, it must be changed to a new set-up and dated. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055119	A. Building B. Wing	02/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Pico Terrace Healthcare & Wellness Centre LP	6070 W. Pico Boulevard Los Angeles, CA 90035

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During record review, the facility's policy and procedures (P&P) titled, Oxygen Therapy, reviewed on 6/20/2024, the P&P indicated, Oxygen is administered under safe and sanitary conditions to meet resident needs . The humidifier and tubing should be changed no more than seven days and labeled with the date of change.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454 Based on observation, interview and record review, the facility failed to: 1. Ensure to label an open date of one of five sampled residents (Resident 19)'s ipratropium-albuterol inhalation solution (used to prevent and treat difficulty breathing, wheezing, shortness of breath, coughing, and chest tightness) inhalation solution that can expire once opened with an open date according to manufacturer guidelines. 2. Ensure Resident 30's medications were not left unattended at the bedside. These deficient practices had the potential to compromise the therapeutic effectiveness of the stored medications and cause unintended accident concerning medication use. Findings: 1. A review of the Admission Record indicated Resident 19 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including metabolic encephalopathy (a chemical imbalance in the blood affecting the brain), type II Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and muscle weakness (weakening, shrinking, and loss of muscle). A review of the Minimum Data Set (MDS - resident assessment tool) dated 12/12/2024, indicated Resident 19's cognitive (relating to mental action or process of acquiring knowledge and understanding) skills for daily decisions was moderately impaired. A review of Resident 19's Order Summary Report dated 12/9/2023 indicated, the physician ordered, ipratropium-Albuterol solution 0.5-2.5 milligram (mg)/3 millimeter (ml) - 1 vial inhale orally every 6 hours as needed for SOB (shortness of breath). During a concurrent observation and interview with Licensed Vocational Nurse (LVN 2) on 2/8/2025 at 11:49 a.m., Resident 19's ipratropium-albuterol medication was observed in Medication Cart 1 with an opened foil pouch while the unit-dose vials were visible; however, there were no labels of date to indicate when the medication was first opened. LVN 2 stated, the medication should be labeled when it was first opened. A review of The Ritedose Corporation (manufacturer) guidelines for Ipratropium Bromide and Albuterol Sulfate Inhalation Solution, indicated, Once removed from the foil pouch, the individual vials should be used within two weeks. A review of the facility's policy and procedure (P&P) titled, Medication Storage in the Facility, reviewed on 6/20/2024, indicated, The nurse shall place a date opened sticker on the medication and enter the date opened . The expiration date of the vial or container will be 30 days unless the manufacturer recommends another date or regulations/guidelines require different dating. (continued on next page)

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	055119	A. Building B. Wing	02/09/2025

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. A review of the Admission Record indicated Resident 30 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including acute bronchospasm (a sudden narrowing of the airways [bronchi] in the lungs, caused by the contraction of muscles lining the airways), pulmonary embolism (a blood clot gets stuck in an artery in the lung, blocking blood flow to part of the lung), DM, and chronic kidney disease (CKD-a longstanding disease of the kidneys leading to renal failure). A review of the MDS dated [DATE], indicated Resident 30's cognitive skills for daily decisions was intact. The MDS indicated Resident 30 required set-up assistance from staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). A review of Resident 30's Order Summary Report as of 2/8/2025 indicated, there was no physician's order that Resident 30 may self-administer own medications. During a concurrent observation and interview with Resident 30 on 2/7/2025 at 6:03 p.m., a medication cup full of medications was observed at Resident 30's bedside table. Resident 30 stated, the medications were protonix (used to treat heartburn and certain other conditions caused by too much acid in the stomach), fish oil supplements (protect the heart, ease inflammation, improve mental health, and lengthen life) vitamins and medications for his bowels. During an interview with Licensed Vocational Nurse (LVN 3) on 2/7/2025 at 6:10 p.m., LVN 3 confirmed Resident 30's medications was left at bedside and stated, it is not acceptable to leave medications at bedside. LVN 3 further stated Resident 30 sometimes refuses medications, but it is not acceptable to leave medications for residents to take them whenever they want to. During an interview with Director of Nursing (DON) on 2/9/2025 at 6:06 p.m., the DON stated, medications should not be left at bedside as other residents may take the medications and may cause accidents and interactions with other medications. The DON further stated, if residents refuse medications, they need to reoffer and document. The DON also stated, the manufacturer guidelines must be followed and the inhalation solution must be labeled when it was first opened so they know when the medication needs to be discarded. A review of the facility's P&P titled, Medication - Administration, reviewed on 6/20/2024, the P&P indicated, Medications may be administered one hour before or after the scheduled medication administration time . Medications must be given to the resident by the Licensed Nurse preparing the medication . If a resident is refusing to take medication, time of refusal must be documented in the MAR (Medication Administration Record) stating the reason for the refusal. The Licensed Nurse will attempt to give the medications, make more than one attempts, and if the resident continues to refuse, the refused medications will be destroyed. Licensed Nurse will notify Medical Doctor (MD) and document in the medical record.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454 Based on observation, interview and record review, the facility failed to properly store one of five sampled residents (Resident 43)'s levalbuterol (used to prevent or relieve the wheezing, shortness of breath, coughing, and chest tightness caused by lung disease) inhalation solution medication that expires once opened according to manufacturer guidelines. This deficient practice had the potential to compromise the therapeutic effectiveness of the stored medications given to the residents because of inappropriate storage of medications. Findings: A review of the Admission Record indicated Resident 43 was admitted to the facility on [DATE] with diagnoses including acute respiratory failure (condition in which your blood does not get enough oxygen or has too much carbon dioxide), congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling) and acute kidney failure (a condition in which the kidneys suddenly can't filter waste from the blood). A review of the Minimum Data Set (MDS - resident assessment tool) dated 12/16/2024, indicated Resident 43's cognitive (relating to mental action or process of acquiring knowledge and understanding) skills for daily decisions was mild impaired. The MDS indicated Resident 43 required moderate assistance from staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). A review of Resident 43's Order Summary Report, dated 12/11/2024, indicated, the physician ordered levalbuterol inhalation nebulization solution 1.25 milligram /3 millimeter (mg/ml - unit of measurement) - 1 vial inhale orally via nebulizer (a device for producing a fine spray of liquid, used for example for inhaling a medicinal drug) four times a day. During a concurrent observation and interview with Licensed Vocational Nurse (LVN 2) on 2/8/2025 at 11:49 a.m., Resident 43's levalbuterol inhalation solution medications was observed in Medication Cart 1 with the opened foil pouch while the medication box was labeled 1/11/2025. LVN 2 stated, the date labeled was when the medication was first opened. During an interview with Director of Nursing (DON) on 2/9/2025 at 6:25 p.m., the DON stated, the manufacturer guidelines must be followed, if the medications were being used after the date and time given by manufacturer guidelines, the medications might not be effective. A review of The Ritedose Corporation (manufacturer) guidelines Levalbuterol Inhalation Solution, indicated, Once the foil pouch is opened, the vials should be used within two weeks. Once removed from the foil pouch, the individual vials should be used within one week. (continued on next page)

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	055119	A. Building B. Wing	02/09/2025

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure (P&P) titled, Medication - Administration, reviewed on 6/20/2024, indicated, Medications may be administered one hour before or after the scheduled medication administration time . Medications must be given to the resident by the Licensed Nurse preparing the medication . If a resident is refusing to take medication, time of refusal must be documented in the MAR (Medication Administration Record) stating the reason for the refusal. The Licensed Nurse will attempt to give the medications, make more than one attempts, and if the resident continues to refuse, the refused medications will be destroyed. Licensed Nurse will notify Medical Doctor (MD) and document in the medical record. A review of the facility's P&P titled, Medication Storage in the Facility, reviewed on 6/20/2024, indicated, The nurse shall place a date opened sticker on the medication and enter the date opened . The expiration date of the vial or container will be 30 days unless the manufacturer recommends another date or regulations/guidelines require different dating.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44253 Based on observation, interview and record review, the facility failed to ensure boxed food items were not stored directly on the floor. This deficient practice had a potential to cause food contamination, which placed the residents of the facility at risk for foodborne illnesses (refers to illness caused by the ingestion of contaminated food or beverages). Findings: During a concurrent interview and observation in the dry storage on 2/5/25 at 5:32 PM with [NAME] 1 (CK1), the following food items were observed stacked directly on the floor: a. One box of Thickened dairy drink b. One box of thickened lemon-flavored water c. 25- pound bag of sugar CK1 stated these food items in boxes were delivered earlier in the day and were not placed on the racks. CK1 stated the boxes should be stored at least 6 inches off the floor to prevent contamination and not to spread infection to the residents. During an interview on 2/8/25 at 4:02 PM, the Dietary Supervisor (DS1) stated boxes are to be stored 6 inches off the floor for infection control. During an interview on 2/9/25 at 5:59 PM, the Director of Nursing (DON) stated food in the kitchen is to be stored in sanitary manner. A review of the facility provided storage guidelines, under Section A- Sanitary Conditions in Storage of Food, indicated shelving should be mounted at least 6 inches from the floor, preferably on castors for ease of cleaning and 18 inches from the ceiling and foods should be stored off the floor.

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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** 43454 Based on observation, interview and record review, the facility failed to 1. Ensure one of 12 sampled residents (Resident 4) who tested negative for coronavirus (COVID-19 - an infectious disease that can cause respiratory illness in humans) was not cohorted with a resident who tested positive with COVID-19. 2. Ensure the Physician's order for transmission-based precaution was updated for Resident 30. These deficient practices had the potential to transmit infectious diseases and increase the risk of infection to the residents, staff, and visitors. Findings: 1a. A review of the Admission Record indicated Resident 4 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including pneumonia (lung infection that inflames air sacs with fluid or pus), acute respiratory failure (condition in which your blood does not get enough oxygen or has too much carbon dioxide), hemiplegia and hemiparesis (total paralysis of the arm, leg, and trunk on the same side of the body) following cerebral infarction (lack of blood flow resulting in severe damage to some of the brain tissue) affecting left dominant side. A review of the Minimum Data Set (MDS - resident assessment tool) dated 12/20/2024, indicated Resident 4's cognitive (relating to mental action or process of acquiring knowledge and understanding) skills for daily decisions was intact. The MDS indicated Resident 4 required maximal to total dependent from staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a concurrent observation and interview with Resident 4 on 2/7/2025 at 7:13 p.m., Resident 4 was cohorted and placed in the same room with Resident 29. Resident 4 stated, she tested negative for COVID-19. 1b. A review of the Admission Record indicated Resident 29 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including metabolic encephalopathy (a chemical imbalance in the blood affecting the brain), Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities), and muscle wasting and atrophy (characterized by a significant shortening of the muscle fibers and a loss of overall muscle mass). A review of the MDS dated [DATE], indicated Resident 29's cognitive skills for daily decisions were severely impaired. A review of Resident 29's COVID-19 antigen (generally a protein on the surface of a virus) test dated 2/6/2025, indicated, Resident 29 tested positive for COVID-19 infection. A review of facility's census on 2/7/2025, 2/8/2025, 2/9/2025 indicated, Resident 4 had been placed in a room cohorted with Resident 29. (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 with Registered Nurse 1 (RN 1) on 2/8/2025 at 4:23 p.m., RN 1 stated, Resident 29 tested positive for COVID-19 and Resident 4 tested negative. RN 1 stated, both residents (Resident 4 and Resident 29) were placed in the same room but there were no documentations to indicate the reason why they (facility) did not separate Resident 4 and Resident 29. RN 1 further stated, Resident 4 did not want to move to another room, but there were no documentations for explanation of the risk of Resident 29 refusing to be moved. RN 1 stated, if a resident with negative COVID test is placed with a resident who is tested positive for COVID-19, it places the resident at risk of transmitting the infection to another resident. During an interview with Infection Preventionist (IPN) on 2/9/2024 at 3:10 p.m., IPN stated Resident 4 was not moved to another room because the resident refused to be moved. IPN stated, there were no documentation that Resident 4 was offered to be moved as her roommate, Resident 29 who tested positive with COVID-19. IPN stated, this (practice) placed other residents at risk of contracting COVID-19 infection. A review of the facility's Public Health Letter titled, Viral Respiratory Illness Outbreak Notification Letter, dated 2/7/2025 indicated, Based on the preliminary investigation, the Department of Public Health required that the following control measures and actions be implemented, as applicable to the setting: identify symptomatic individuals so that they can be separated from those affected by the illness. A review of the facility's policy and procedure (P&P) titled, Management of COVID-19, reviewed date 6/20/2024 indicated, Centers will have a plan based on CDC/CMS/State/local recommendation to prevent transmission, such as having a dedicated space in the facility for cohorting and managing care for patients with COVID-19 . Cohorting of patient within the Center will be in accordance with the Cohorting Policies. A review of Centers for Disease Control and Prevention (CDC - national public health agency of the United States) titled, Infection Control Guidance: SARS-SoV-2, dated 12/2023, indicated, Placement of residents with suspected or confirmed SARS-CoV-2 infection: Ideally, residents should be placed in a single-person room as described. 2. A review of the Admission Record indicated Resident 30 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including acute bronchospasm (a sudden narrowing of the airways [bronchi] in the lungs, caused by the contraction of muscles lining the airways), pulmonary embolism (a blood clot gets stuck in an artery in the lung, blocking blood flow to part of the lung), Type II Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and chronic kidney disease (CKD-a longstanding disease of the kidneys leading to renal failure). A review of the MDS dated [DATE], indicated Resident 30's cognitive skills for daily decisions was intact. The MDS indicated Resident 30 required set-up assistance from staff for ADLs. A review of Resident 30's Order Summary Report dated 1/29/2025, indicated the physician ordered for the resident to be on, Contact/droplet precaution (contact precautions are used for patients with infections that can be transmitted by contact, while droplet precautions are used for patients with infections that can be transmitted by droplet). (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 concurrent observation and interview with Resident 30 on 2/7/2025 at 6:03 p.m., Resident 30 stated, he was having some shortness of breath (SOB) and on oxygen therapy. Resident 30 was observed in a room with no transmission-based precaution (TBP) signage outside his door; there were no personal protective equipment (PPE-a barrier precaution which includes the use of gloves, gown, mask, face shield, when anticipating coming in contact with blood, body fluids or other communicable toxins or agents) observed outside the door for staff and visitors to use. During an interview with RN 1 on 2/8/2025 at 4:23 p.m., RN 1 stated, Resident 30 was on TBP room while he was taking antibiotic (ABX) for pneumonia. RN 1 reviewed Resident 30's medical record and confirmed, the Physician's order for contact/droplet precaution is still in place. RN 1 stated, it (the precaution) should have been discontinued as Resident 30 was done with ABX therapy. During an interview with IPN on 2/9/2024 at 9:16 a.m., IPN stated Resident 30 was no longer on TBP room, and they should have discontinued the order for precaution. IPN stated, she did not discontinue the order timely after physician had ordered to discontinue the TBP room. A review of the facility's P&P titled, Infection Control- Policies & Procedures, reviewed date 6/20/2024, indicated, The facility's infection control policies and procedures are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections.

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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** 45528 Based on observation, interview and record review, the facility failed to provide at least 80 square feet (sq. ft. -unit of measurement for space) per resident in multiple resident bedrooms for three (3) of 23 resident rooms (rooms [ROOM NUMBER]). This deficient practice had the potential to result in inadequate usable living space for all the residents and working space for the health caregivers, which could affect the quality of care and the quality of life for the residents. Findings: A review of the Request for Room Size Waiver letter submitted by the Administrator, dated 2/9/2025, indicated three (3) resident rooms in the facility do not meet the requirement of at least 80 square feet per resident per federal regulation. The letter also indicated the rooms do not pose any kind of risk to the care and services the facility provides to the residents. Each room has access to the outside and provides ample sunlight and ventilation. The following rooms provided are less than 80 sq.ft. pr resident: Room # Room Size Floor Area (sq.ft.) #of beds 7 19.1 x 10.91 217.21 3 14 20.1 x 10.83 217.68 3 15 20 x 11 220 3 According to the federal regulation, the minimum square footage for a two bedroom is at least 160 sq. ft and three bedroom is at least 240 sq. ft. During the recertification Survey on 2/9/2025, staff interviews indicated there were no concerns regarding the size of the rooms. During multiple observations of the resident's rooms from 2/7/2025 to 2/9/2025, the residents had ample space to move freely inside the rooms. There were sufficient spaces to provide freedom of movement for the residents and for nursing staff to provide care to the residents. There were also sufficient spaces for bedside tables, side tables and resident care equipment. During a concurrent observation and interview on 2/8/2025, at 4:26 p.m., the maintenance Supervisor (MS) used tape measurer to measure the size of the room from the window to the door for the length, then measured from wall to the start of the closet horizontally for the width to determine the room area. The MS stated, this is how I measure to verify the size of the rooms. (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on 2/8/2025 at 5:52 p.m., the [NAME] President of Operations (VPO) stated the facility submitted a written request for the continued room waiver although the room sizes do not impede resident care.