STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055141	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ramona Nursing and Rehabilitation Center	11900 Ramona Boulevard El Monte, CA 91732

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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 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** 42781 Based on observation, interview and record review, the facility failed to provide reasonable accommodation of need for three of three sampled residents (Residents 32, 84 and 89) who were assessed as at risk for fall, by failing to ensure the residents call light was within reach as indicated in the facility's Policy and Procedure (P&P), titled Call Light and resident's plan of care. These deficient practices had the potential for Residents 32, 84 and 89 not to receive or received delayed care that could result in a fall or accident. Findings: a. During a review of Resident 89's Admission Record (AR), the AR indicated the facility admitted Resident 89 on 1/23/2024 with diagnoses that included abnormalities of gait (a person's manner of walking) and mobility (the ability to move), need for assistance with personal care and dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning). During a review Resident 89's History and Physical (H&P), dated 1/25/2024, the H&P indicated Resident 89 did not have the capacity to understand and make decisions. During a review of Resident 89's untitled CP dated 1/31/2024, the CP indicated Resident 89 was at risk for falls related to confusion and dementia. The CP interventions indicated for nursing staff ensure Resident 89's call light was within reach and to encourage Resident 89 to use the call light to call for assistance as needed. During a review of Resident 89's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 4/25/2024, the MDS indicated Resident 89 's cognition (mental action or process of acquiring knowledge and understanding) for daily decision making was severely impaired. The MDS indicated Resident 89 required moderate assistance with shower, upper body dressing and putting on/taking off footwear. During a review of Resident 89's Fall Risk Assessment (FRA- method of assessing a patient's likelihood of falling) dated 4/25/2024, the FRA indicated Resident 89 was assessed as moderately at risk for fall due to disorientation, requiring regular assistance with elimination, balance problem while standing and walking and requiring the use of assistive device such as wheelchair. (continued on next page)

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 an observation on 7/19/2024 at 9:22 am, Resident 89 was sitting in a wheelchair. Resident 89's call light was placed on top of Resident 89's bed and tangled on the left side rail. During a concurrent observation and interview on 7/19/2024 at 9:27 am, with Certified Nurse Assistant 4 (CNA 4), CNA 4 pulled Resident 89's call light with force from the left side rail and untangled the cord. CNA 4 stated, Resident 89's call light needed to be within easy reach for Resident 89 to use to seek assistance from staff, and/or during emergency to maintain Resident 89's safety. 40438 b. During a review of Resident 32's AR, the AR indicated Resident 32 was admitted to the facility on [DATE] with diagnoses that included unspecified fracture (a complete or partial break in a bone), muscle weakness (decreased strength in the muscles) and osteoporosis (bone disease that causes bones to become weak). During a review of Resident 32's MDS dated [DATE], the MDS indicated Resident 32 had severely impaired cognition and was totally dependent (helper did all of the effort, resident did none of the effort to complete the activity) with eating, oral and toileting hygiene, upper and lower body dressing and personal hygiene. During a review of Resident 32's CP dated 1/22/2024, the CP indicated Resident 32 was placed on low bed with floor pad due to history of falls and poor safety awareness secondary to dementia (loss of intellectual function) and other behavioral disturbance. The CP interventions included to attach the resident's call light to bed within easy access of the resident. During a concurrent observation and interview on 7/16/2024 at 8:57 am inside Resident 32's room with the Registered Nurse Supervisor (RN 1), Resident 32 was crying. Resident 32's call light was on the floor. RN 1 stated Resident 32's call light was not working. RN 1 stated the call light needed to be clipped on the bed linen close to the resident or resident's clothes to prevent it from getting displaced and prevent the resident from calling when the resident needed help. During an interview on 7/19/2024 at 9:20 am with the Maintenance Supervisor (MS), MS stated all call lights in the residents' rooms were checked every Friday, to ensure the call light was working and fixed immediately if not operational. MS stated an operational call light was important for every resident to be able to call the staff whenever help was needed. During an interview on 7/19/2024 at 9:33 am with the facility's Director of Nursing (DON), the DON stated resident's call light should not be on the floor. The DON stated the resident's call light should be positioned where the resident could access to call for help so that staff would be able to provide care and services the resident needed. During a review of facility's P&P titled, Call Light, reviewed 1/2024, the P&P indicated, Place the call device within resident's reach before leaving the room. If the call light/bell is defective, immediately report this information to the unit supervisor. 40037 (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. During a review of Resident 84's AR, the AR indicated Resident 84 was readmitted to the facility on [DATE] with diagnoses that included epilepsy (a brain condition that causes recurring involuntarily body movements) and dysphagia (difficulty swallowing). During a review of Resident 84's MDS dated [DATE], the MDS indicated Resident 84 had clear speech, had ability to express ideas and wants and had the ability to understand others. The MDS indicated Resident 84 required substantial/maximal assistance (helper does more than half the effort, helper lifts or holds trunk or limbs and provides more than half the effort) for dressing and personal hygiene and was dependent (helper does all of the effort, resident does none of the effort to complete the activity) for chair/bed-to-chair transfer. During an observation on 7/16/2024 at 10:05 am, in Resident 84's room, Resident 84 was sitting in a wheelchair next to the resident's bed. Resident 84's call light was on the floor under Resident 84's bed. Resident 84 stated she was not able to find the call light and not able to reach it. During a concurrent interview, Certified Nursing Assistant 6 (CNA 6) stated Resident 84's call light was not within reach of the resident. CNA 6 stated, the call light was used to alert the staff whenever the resident needed help. CNA 6 stated, if the resident's call light was not within reach, the resident would reach for it or get up by themselves, which would cause falls and injury. During a review of the facility's P&P titled, Call Light, revised 1/2024, the P&P indicated, Place the all device within resident's reach before leaving the room.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40037 Based on interview and record review, the facility failed to provide information on Advance Directive (AD, a written preferences regarding treatment options, a process of communication between individuals and their healthcare agents to understand, reflect on, discuss, and plan for future healthcare decisions for a time when individuals are not able to make their own healthcare decisions) for one of three sampled residents (Resident 48). This failure had the potential for facility staff to provide treatment and services against the resident's will. Findings: During a review of Resident 48's Admission Record (AR), the AR indicated Resident 48 was readmitted to the facility on [DATE] with diagnoses that included dysphagia (difficult swallowing) and dementia (loss of thinking abilities severe enough to interfere with daily life). During a review of Resident 48's Minimum Data Set (MDS, a resident assessment and care screening tool) dated 6/6/2024, the MDS indicated Resident 48 had unclear speech, rarely/never understood others, and rarely/never made self understood. The MDS indicated Resident 48 was dependent (helper does all of the effort) for dressing, personal hygiene, and chair/bed-to-chair transfer. During a review of Resident 48's Medical Record (MR), there was no AD acknowledgement information in Resident 48's MR. During an interview on 7/16/2024 at 1:30 pm, Social Service Director (SSD) stated, SSD did not have documentation that AD information was offered to Resident 48 or Resident 48's responsible party. SSD stated, it was important to have AD information documented in the resident's MR so that staff would know the resident's treatment preferences and not provide treatment against the resident's will. During a review of the facility's Policy and Procedure (P&P) titled, Advance Directives and Associated Documentation, revised 12/2023, the P&P indicated, Prior to, or immediately after admission, a facility staff member shall: provide the resident/family or responsible agent written information, in a manner easily understood by the resident or resident representative, regarding the right to accept or refuse medical or surgical treatment and the right to formulate Advance Directives. Document in the resident health record that, at the time of admission, the resident and/or resident representative have been provided with written information regarding advance directives .

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 residents were provided with a communication device with the language that the resident understood for two of three sampled residents (Residents 50 and 80). These deficient practices had the potential to prevent Residents 50 and 80 from communicating with the staff and had the potential to receive delayed care, treatment, and services. Findings: a. During a review of Resident 50's Admission Records (AR), the AR indicated, Resident 50 was admitted to the facility on [DATE] with diagnoses that included dementia (loss of cognitive functioning, thinking, remembering, and reasoning that interferes with a person's daily life and activities), and cognitive communication deficit (occurs when someone has difficulty with communication due to impaired cognition). During a review of Resident 50's untitled Care Plan (CP), dated 1/4/2024, the CP indicated Resident 50 was at risk for communication problem related to language barrier. The CP interventions included for Resident 50 to be able to communicate by writing, using communication board, gestures, and translator. During a review of Resident 50's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 4/4/2024, the MDS indicated Resident 50's preferred language was Mandarin and needed an interpreter to communicate. The MDS indicated Resident 50 had severely impaired cognition (ability to understand) and required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes the activity) with oral and toileting hygiene, shower, upper and lower body dressing, and personal hygiene. During a concurrent observation and interview on 7/16/2024 at 9:46 am with Certified Nurse Assistant 4 (CNA 4), CNA 4 stated Resident 50 spoke Mandarin. CNA 4 was communicating through gestures to Resident 50. CNA 4 stated the resident and staff sometimes understood each other. CNA 4 stated Mandarin speaking staff were not always available to interpret for Resident 50. CNA 4 stated Resident 50 had no communication board in the room. CNA 4 stated a good communication method was important to communicate and understand the resident's needs and to ensure the resident's needs were met. b. During a review of Resident 80's AR, the AR indicated, Resident 80 was admitted to the facility on [DATE] with diagnoses that included osteoarthritis (joint disease that causes cartilage to break down over time) and history of falling. During a review of Resident 80's untitled CP dated 4/30/2024, the CP indicated Resident 80 was at risk for communication problem related to language barrier. The CP interventions included to assist with word finding as needed and to provide a translator as necessary to communicate with the resident. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 80's MDS, dated [DATE], the MDS indicated Resident 80's preferred language was Taiwanese and needed an interpreter to communicate. The MDS indicated Resident 80 had moderately impaired cognition and required supervision or touching assistance with eating, oral, upper body dressing, and personal hygiene. The MDS indicated Resident 80 required moderate assistance (helper did less than half the effort) with toileting, shower, and lower body dressing. During a concurrent observation and interview on 7/16/2024 at 9:39 am with the Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated Resident 80 was mostly Chinese speaking. LVN 2 stated she communicated with the resident with the use of an in-person translator, language line and communication board. LVN 2 stated Resident 80 had no communication board at bedside. LVN 2 stated the communication board was important to understand the needs of the resident. During an interview on 7/19/2024 at 8:55 am with the facility's Activity Director (AD), the AD stated, all non-English and alert, non-verbal residents should have a communication board in the room and on the resident's wheelchair as options to meet the resident's needs for communication aside from using the language line and in-person translator. The AD stated non-English speaking residents needed to have a communication board to be able to communicate with the staff and be understood, and for staff to meet the resident's needs. During an interview on 7/19/2024 at 9:15 am with the facility's Director of Nursing (DON), the DON stated all non-English speaking residents should have a communication board to be able to communicate their needs to the staff and for staff to be able to address the resident's needs appropriately. During a review of facility's Policy and Procedure (P&P) titled, Non-English & Aphasic Residents, revised 1/2024, the P&P indicated, Social Services will supply residents and/or family members with the use of a communication board that has universally known drawings. Resident, family, and staff caring for the resident will be familiarized with the communication tool. The tool will be kept at the resident's bedside for use. An additional copy will be attached to the resident's wheelchair if the resident is wheelchair bound.

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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** 40037 Based on observation, interview, and record review, the facility failed to apply elbow splint as ordered by the physician for one of four sampled residents (Resident 27) This failure had the potential risk to result in the resident's decline in Range of Motion (ROM, full movement potential of a joint) that cause stiffness (inability to move easily and without pain) and contractures (deformity and joint stiffness). Findings: During a review of Resident 27's Admission Record (AR), the AR indicated Resident 27 was readmitted to the facility on [DATE] with diagnoses that included joint contracture and dysphagia (difficult swallowing). During a review of Resident 27's Minimum Data Set (MDS, a resident assessment and care screening tool) dated 4/23/2024, the MDS indicated Resident 27 had unclear speech, rarely/never understood others, and rarely/never made self-understood. Resident 27 was dependent (helper does all of the effort) for personal hygiene, dressing and rolling left and right. During a review of Resident 27's Order Summary Report (OSR) for active orders as of 7/1/2024, the OSR indicated RNA for application of right elbow splint and right hand roll to Resident 27, up to 5 hours per day, daily, five times a week. During an observation on 7/16/2024 at 9:22 am, in Resident 27's room, Resident 27 was lying in bed with eyes closed. Resident 27 had contracture of the right forearm held close to Resident 27's body. There was a splint wrapped on Resident 27's right forearm, not covering Resident 27's elbow. During an interview on 7/16/2024 at 9:33 am, Restorative Nurse Assistant 1 (RNA 1) stated the splint on Resident 27's right elbow was applied incorrectly. RNA 1 stated, the splint should wrap around the forearm and elbow to prevent Resident 27's right elbow from further contracture. RNA 1 stated, if the splint was applied incorrectly, it defeated its purpose and would not help the resident. During an interview on 7/17/2024 at 10:13 am, the Director of Rehabilitation (DOR) stated, RNAs should apply the splint correctly for Resident 27 to ensure Resident 27's joints would retain some degrees of extension to avoid fixed contractures and to prevent alteration in skin integrity. During a review of the facility's Policy and Procedure (P&P) titled Restorative Program, revised 10/2023, the P&P indicated It is the policy of the facility to provide a restorative program designed to restore or maintain a resident's mobility skills to maximum independence and safety and prevent loss of function in existing functional abilities.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 ensure the resident's environment was free from accidents for two of four sampled residents (Residents 12 and 339) by failing to: a. Implement Resident 12's Medical Doctor (MD) order and care plan to place floor mats at the edge of Resident 12's bed to prevent injury for fall. Implement Resident 12's Care Plan (CP) and Policy and Procedure (P&P) on Seizure Precaution to pad the bed side rails to prevent injury during a seizure (uncontrolled electrical activity in the brain that causes temporary abnormalities in muscle tone or movements) b. Implement the facility's P&P on smoking when Resident 339 was observed to have cigarettes on Resident 339's position on 7/16/2024. These failures had the potential to result in accident and hazard for Residents 12 and 339. Findings: a. During a review of Resident 12's Admission Record (AR), the AR indicated Resident 12 was admitted to the facility on [DATE] with diagnoses that included epilepsy (brain disorder in which a person has repeated seizures [convulsions] over time) and abnormalities of gait and mobility. During a review of Resident 12's History and Physical (H&P) dated 3/4/2024, the H&P indicated Resident 12 had fluctuating capacity to understand and make decisions. During a review of Resident 12's Minimum Data Set (MDS, a standardized assessment and care planning tool) dated 6/20/2024, the MDS indicated Resident 12's cognitive abilities (ability to think, learn, and process information) were intact. During a review of Resident 12's Fall Risk Evaluation (FRE) form dated 6/20/2024 at 1:46 PM, the FRE form indicated Resident 12 was high risk for falls. During a review of Resident 12's untitled CP dated 6/2/2023, the CP indicated Resident 12 had epilepsy and the CP interventions included for staff to apply padding for bilateral 1/4 side rails for seizure precautions. During a review of Resident 12's untitled CP dated 7/18/2023 indicated Resident 12 required a low bed with floor mat for safety. The CP interventions included for staff to place floor mats at bedside for Resident 12. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 12's Order Summary Report (OSR) as of 7/17/2023, the OSR indicated Resident 12 had an active MD order for low bed with floor pad at bedside due to history of falls and poor safety awareness related to dementia (disease that affects ability to remember, think, or make decisions that interfere with doing everyday activities). During a concurrent observation and interview on 7/16/2024 at 12:20 PM with Licensed Vocational Nurse 1 (LVN 1) in Resident 12's room, there was no floor mat at Resident 12's bedside and a silver star was noted on Resident 12's nameplate. LVN 1 stated Resident 12 had a silver star on Resident 12's nameplate to indicate the resident was high fall risk. LVN 1 stated there were no floor mats at Resident 12's bedside as ordered. LVN 1 stated the risk of not placing the floor mats per MD order was that Resident 12 would fall and sustain a serious fracture. During a concurrent observation and interview on 7/17/2024 at 9:25 AM with LVN 1 in Resident 12's room, Resident 12's bed side rails were not padded. LVN 1 stated Resident 12's bed side rails were not padded and should be padded in accordance with the resident's CP. LVN 1 stated the risk of not padding the side rails was that Resident 12 would get hurt if Resident 12 hit the side rails during a seizure. During an interview on 7/17/2024 at 3:35 PM with the Director of Nursing (DON), the DON stated Resident 12's side rails were not padded in accordance with facility policy and CP. The DON stated the risk of not padding the side rails was that the resident would get hurt during a seizure. During an interview on 7/18/2024 at 10:25 AM with Registered Nurse Supervisor 2 (RN Sup 2), RN Sup 2 stated floor mats should be placed if there was an MD order to prevent a serious injury related to a fall. RN Sup 2 stated padded bedrails prevent injury for residents who have seizures. RN Sup 2 stated staff needed to follow the resident's CP to guide staff on the plan of care and interventions for the resident. During an interview on 7/18/2024 at 2:53 PM with the facility's Director of Nursing (DON), the DON stated the resident would sustain a fracture or serious injury if floor mats were not placed as ordered. During a review of the facility's P&P titled Fall Management System revised 12/2023, the P&P indicated the facility will provide each resident with appropriate assessment and interventions to prevent fall and to minimize complications if a fall occurs. The facility's P&P titled Emergency Procedures dated 1/2024 indicated for seizure management to provide a safe environment and pad side rails. 40438 b. During a review of Resident 339's AR, the AR indicated Resident 339 was admitted to the facility on [DATE] with diagnoses that included altered mental status (change in mental condition), major depressive disorder (persistent feeling of sadness and loss of interest) and anxiety disorder (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 339's MDS dated [DATE], the MDS indicated Resident 339 had moderately impaired cognition (ability to understand) and required maximal assistance (helper did more than half the effort) with oral hygiene, upper and lower body dressing, and personal hygiene. The MDS indicated Resident 339 was totally dependent (helper did all of the effort, resident did none of the effort to complete the activity) with toileting and shower. During a review of Resident 339's untitled CP dated 7/15/2024, the CP indicated Resident 339 had the potential for injury related to smoking. The CP interventions included to maintain smoking materials at nurse's station or other designated area. During a concurrent observation and interview on 7/16/2024 at 12:32 pm with Certified Nurse Assistant 1(CNA 1) in the facility's hallway, Resident 339 showed a pack of cigarette in her possession. CNA 1 stated Resident 339's cigarettes needed to be kept with the charge nurse in the nurse's station, given to the resident during smoking and lighted for the resident, only during smoking hours. Staff will provide supervision to Resident 339 while smoking. During an interview on 7/16/2024 at 1:09 pm with the Activity Director (AD), AD stated designated place for smoking and smoking schedules were explained to the residents upon admission. AD stated cigarettes and lighters were given to the nurses and kept in the nurse's station for safe keeping. During an interview on 7/19/2024 at 9:25 am with the DON, the DON stated smoking materials like cigarettes should be kept with the nurses in the nurse's station for resident's safety in the facility. During a review of the facility's P&P titled, Smoking Policy, revised 3/2008, the P&P indicated, If it is determined that a resident is a safe smoker, smoking materials will still be retained by nursing staff, and they may come and request 1 or 2 cigarettes at the time they desire to go out to smoke unsupervised.

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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** 42781 Based on observation, interview and record review, the facility failed to follow the facility's Policy and Procedure (P&P), titled Resident with Indwelling Catheter in Placed and the resident's Care Plan (CP) for three of three sampled residents (Residents 30, 106, and 128) by failing to: a. Ensure Resident 30's indwelling catheter (known as foley catheter [FC], a tube that allows urine to drain from the bladder into a bag that is usually attached to the thigh) was assessed and monitored for the presence of white sediments (visible particles in the urine that may contain red or white blood cells, casts, bacteria, fungi, parasites in the urine that could indicate infection or dehydration [fluid deficit]) in the urine. b. Ensure Resident 106's FC was assessed and monitored for the presence of white sediments in the urine and tubing and was not kinked. c. Ensure Resident 128's FC was assessed and monitored for the presence of white sediments in the urine. These deficient practices had the potential for Residents 30, 106, and 128 to receive no care or delayed care and treatment for urinary tract infection (UTI, condition in which bacteria invade and grow in any part the urinary system). Findings: a. During a review of Resident 30's Admission Record (AR), the AR indicated the facility admitted Resident 30 on 4/28/2024 with diagnoses that included UTI and encounter for attention to gastrostomy (creation of an artificial external opening into the stomach for nutritional support). During a review of Resident 30's untitled CP initiated on 4/28/2024, the CP indicated Resident 30 required an indwelling catheter related to obstructive uropathy (disorder of the urinary tract that occurs due to obstructed urinary flow and can be either structural or functional). The CP interventions included for staff to monitor/record/report to medical doctor (MD/Physician) for signs and symptoms of UTI such as pain, burning, hematuria (blood-tinged urine), cloudiness, no urine output, deepening of urine color, increased pulse, increase temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior and change in eating patterns. During a review of Resident 30's Physicians Order Notes ([NAME]), dated 4/28/2024, the [NAME] indicated for licensed staff to insert indwelling FC, French (a type of catheter) 16 (size of the catheter) to close drainage system for obstructive neuropathy. During a review of Resident 30's Minimum Data Set (MDS- a resident's assessment and care planning tool) dated 5/3/2024, the MDS indicated Resident 30 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 30 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. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 7/16/2024 at 9:45 am, Resident 30 was awake, lying in bed. Resident 30 had FC hanging on the right side of the bed. Resident 30's FC tubing and drainage bag contained white sediments and cloudiness of the urine. During a concurrent observation and interview on 7/16/2024 at 9:46 am with the Infection Prevention Nurse (IPN- a nurse who helps prevent and identify the spread of infectious disease in the healthcare environment), the IPN stated, Resident 30's FC tubing and drainage bag had white sediments and cloudiness. IPN stated Resident 30's FC needed to be monitored for signs and symptoms of UTI such as presence of sediments, cloudiness, hematuria, and fever by licensed nurses every eight hours. During an interview on 7/17/2024 at 9:30 am, with Registered Nurse Supervisor 2 (RN Sup 2), RN Sup 2 stated Resident 30's FC needed to be monitored for signs and symptoms of infection such as burning in urination, presence of sediments, hematuria, confusion, and cloudiness in the urine by licensed nurses every 8 hrs. to prevent UTI. b. During a review of Resident 106's AR, the AR indicated the facility admitted Resident 106 on 6/14/2024 with diagnoses that included neuromuscular dysfunction of the bladder (when a person lacks bladder control due to brain, spinal cord, or nerve problems) and paraplegia (paralysis of the legs and lower body). During a review of Resident 106's untitled CP initiated on 6/14/2024, the CP indicated Resident 106 was at risk for infection due to use of FC for neurogenic bladder (impaired bladder function resulting from damage to the nerves that govern the urinary tract). The CP interventions included for staff to monitor/record/report to medical doctor (physician) for signs and symptoms of UTI such as pain, burning, blood-tinged urine, cloudiness, no urine output, deepening of urine color, increased pulse, increase temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, and change in eating patterns. During a review of Resident 106's [NAME] dated 6/14/2024, the POC indicated for licensed staff to insert indwelling FC, French 16 to close drainage system for neurogenic bladder. During a review of Resident 106's MDS dated [DATE], the MDS indicated Resident 106 had intact cognition for daily decision making. The MDS indicated Resident 106 required maximum assistance with shower, upper/lower body dressing and putting on or taking off footwear. During an observation on 7/16/2024 at 8:52 am, Resident 106 was awake, lying in bed. Resident 106 had foley catheter hanging on the left side of bed. Resident 106's foley catheter tubing contained white sediments. During a concurrent observation and interview on 7/16/2024 at 8:53 am, with IPN, the IPN stated Resident 106's FC tubing was kinked and with white sediments. The IPN stated urine had retained in the kinked FC tubing and would cause UTI to Resident 106. c. During a review of Resident 128's AR, the AR indicated the facility admitted Resident 128 on 6/17/2024 with diagnoses that included dysphagia (difficulty of swallowing) and retention of urine. (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 128's untitled CP initiated on 6/17/2024, the CP indicated Resident 128 was at risk for infection due to use of FC for neurogenic bladder. The CP interventions included for staff to monitor/record/report to physician for signs and symptoms of UTI such as pain, burning, blood-tinged urine, cloudiness, no urine output, deepening of urine color, increased pulse, increase temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, and change in eating patterns. During a review of Resident 128's [NAME] dated 6/17/2024, the [NAME] indicated for licensed staff to insert foley catheter French 16 to close drainage system for urinary retention. During a review of Resident 128's History and Physical (H&P), dated 6/19/2024, the H&P indicated, Resident 128 had fluctuating (continually changing) capacity to understand and make decisions. During a review of Resident 128's MDS dated [DATE], the MDS indicated Resident 128 had severely impaired cognition for daily decision making. The MDS indicated, Resident 128 required total dependence with oral hygiene, toileting hygiene, shower, upper/lower body dressing, putting on or taking off footwear and personal hygiene. During an observation on 7/16/2024 at 9:20 am, Resident 128 was awake, lying in bed. Resident 128 had foley catheter hanging on the left side of bed. Resident 128's foley catheter tubing contained with white sediments. During a concurrent observation and interview on 7/16/2024 at 9:22 am, with IPN, the IPN stated the FC tubing for Resident 128 had white sediments. The IPN stated Resident 128's FC needed to be monitored for signs and symptoms of UTI such as presence of sediments, cloudiness, hematuria, and fever by licensed nurses every shift to prevent UTI. During an interview on 7/18/2024 at 2:14 pm with the facility's Director of Nursing (DON), the DON stated licensed nurses needed to monitor Resident 128 FC for presence of sediments, urine cloudiness, and signs and symptoms of UTI every 8 hours to prevent infection. The DON stated Resident 128's FC needed to be free from kinks and urine should be free flowing to empty the bladder. During a review of the facility's P&P titled, Resident with Indwelling Catheter in Placed, dated 1/2024, the P&P indicated, licensed nurses to assess for signs and symptoms of UTI every shift for a resident with indwelling catheter for gross cloudiness, sediments of urine. The P&P indicated to notify the physician of any signs and symptoms of UTI. During a review of the facility's P&P titled, Catheter Drainage Bag, dated 12/2023, the P&P indicated, to ensure tubing allows for unobstructed drainage of urine.

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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 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** 42781 Based on observation, interview, and record review, the facility failed to ensure two of two sampled residents (Residents 30 and 128) who had gastrostomy tube (GT- a tube inserted through the abdomen that delivers nutrition directly to the stomach) received appropriate treatment and services as indicated in the facility's Policy and Procedure (P&P) titled Enteral Formulas, Administration of Closed System, Gastrostomy Tube Care Management, and the resident's plan of care by: a. Failing to ensure Resident 30's GT formula bottle was labeled with time started. b. Failing to ensure Resident 128 received the recommended amount of GT water flush, as ordered. These deficient practices had the potential to result in adverse consequences for Residents 30 and 128. Findings: a. During a review of Resident 30's Admission Record (AR), the AR indicated the facility admitted Resident 30 on 4/28/2024 with diagnoses that included urinary tract infection (UTI, condition in which bacteria invade the urinary system) and encounter for attention to gastrostomy (creation of an artificial external opening into the stomach for nutritional support). During a review of Resident 30's untitled Care Plan (CP) initiated on 4/28/2024, the CP indicated Resident 30 was dependent on GT feeding for nutrition and hydration related to difficulty swallowing and swallowing problems. The CP interventions included for staff to continue to administer Glucerna (formula) 1.2 at 70 milliliters (ml) for 20 hours to provide 1,400 ml/1,680 calories (a standard unit of measuring energy) in 24 hours via (through) enteral feeding pump. During a review of Resident 30's Physicians Order Notes ([NAME]) dated 4/28/2024, the [NAME] indicated for licensed staff to administer to Resident 30, Glucerna 1.2 at 70 ml/hour(hr.) for 20 hours to provide 1, 400ml/1,680 calories in 24 hours via enteral feeding pump. The [NAME] indicated to turn on the enteral feeding pump at 12 pm and turn off at 8 am or until desired volume was reach. During a review of Resident 30's Minimum Data Set (MDS- a standardized assessment and care planning tool) dated 5/3/2024, the MDS indicated Resident 30 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 30 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 concurrent observation and interview on 7/16/2024 at 10:26 am, with Licensed Vocational Nurse 1 (LVN 1), Resident 30 was awake, lying in bed. Resident 30's GT feeding bottle was not labeled with the start time. LVN 1 stated Resident 30's GT feeding bottle needed to be labeled with the time it was started. (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 7/18/2024 at 2:16 pm, the Director of Nursing (DON) stated GT feeding bottle needed to be labeled with date and time when it was started. b. During a review of Resident 128's AR, the AR indicated the facility admitted Resident 128 on 6/17/2024 with diagnoses that included dysphagia (difficulty of swallowing) and retention of urine. During a review of Resident 128's untitled CP initiated on 6/17/2024, the CP indicated Resident 128 was dependent on GT feeding for nutrition and hydration related to dysphagia. The CP interventions included for staff to flush the GT tubing with 100 ml of water. During a review of Resident 128's [NAME] dated 6/17/2024, the [NAME] indicated for licensed staff to administer to Resident 128 Glucerna 1.2 at 70 ml per hour for 20 hours to provide 1,400 ml/1,680 calories in 24 hours via enteral feeding pump. During a review of Resident 128's [NAME] dated 6/17/2024, the [NAME] indicated for licensed staff to flush Resident 128's GT tubing with 100 ml of water every four (4) hrs. During a review of Resident 128's History and Physical (H&P) dated 6/19/2024, the H&P indicated Resident 128 had fluctuating capacity to understand and make decisions. During a review of Resident 128's MDS dated [DATE], the MDS indicated Resident 128 had severely impaired cognition for daily decision making. The MDS indicated, Resident 128 required total dependence with oral hygiene, toileting hygiene, shower, upper/lower body dressing, putting on or taking off footwear and personal hygiene. During an observation on 7/17/2024 at 4:02 pm, Resident 128 was lying in bed. Resident 128's GT pump water flush was not set to 100 ml every 4 hrs. During a concurrent observation and interview on 7/17/2024 at 4:06 pm, LVN 3 stated Resident 128's GT pump was not set to 100 ml flush every 4 hours. LVN 3 stated, it was important and needed to follow the physician's order for water flush to prevent dehydration (abnormal loss of water from the body) and electrolyte imbalance. During an interview on 7/18/2024 at 2:16 pm, the DON stated GT water flush needed to be accurate to prevent dehydration and electrolyte imbalance and prevent tube clogging. During a review of the facility's P&P titled, Enteral Formulas, Administration of Closed System, dated 1/2024, the P&P indicated to label formula bottle and water flush bag with resident's name, room number, date, starting time, rate at ml/hr and licensed initial. During a review of the facility's P&P titled, Gastrostomy Tube Care Management, dated 12/2023, the P&P indicated to flush feeding tube and adapter, if applicable per physician's order before and after every feeding, and before and after giving any medication by tube. The P&P indicated routine flushing with water remains the best method to prevent tube clogging.

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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. 14330 Based on observation, interview and record review, the facility failed to ensure a resident with breathing problem receive continuous oxygen therapy as ordered by the physician for one of one sampled resident (Resident 4) This deficient practice placed Resident 4 at risk for severe difficulty of breathing. Findings: During a review of Resident 4's Admission Record (AR), the AR indicated the facility readmitted the resident on 8/7/2023, with diagnoses that included chronic obstructive pulmonary disease ([COPD]a group of lung diseases that block airflow and make it difficult to breathe) and diabetes mellitus (a condition that happens when the blood sugar [glucose] is too high). During a review of Resident 4's untitled Care Plan (CP) for oxygen therapy dated 10/12/23, the CP indicated Resident 4 will not have signs and symptoms of poor oxygen by providing continuous oxygen at two liters per minute through nasal cannula to keep oxygen saturation above 92 percent. During a review of Resident 4's Physician Order Sheet (POS) dated 6/20/2024, the POS indicated an order for licensed staff to provide Resident 4 with two liters (unit of measurement) per minute of oxygen continuously through nasal cannula (a flexible soft tube that delivers extra oxygen through a tube and into the nose) to keep oxygen saturation (amount of oxygen circulating in the blood) above 92 percent (%) every shift for diagnosis of COPD. During an observation and concurrent interview on 7/16/2024 at 10:26 a.m., Resident 4 was on left side lying position in low bed with ongoing oxygen inhalation at two liters per minute through nasal cannula. Resident 4 stated he could not feel the oxygen in his nose. Resident 4's nasal prongs (flexible soft two prongs that go inside the nostrils [two holes in the nose] that deliver oxygen) was on the left side of his nasolabial fold (smile lines). Certified Nursing Assistant 7(CNA 7) was present in Resident 4's room and CNA 7 also observed the nasal prongs was on the left side of the resident's nasolabial fold. CNA 7 stated CNAs and licensed staff are responsible for monitoring the proper placement of the oxygen cannula of Resident 4 every shift. CNA 7 stated Resident 4 would have difficulty of breathing if the oxygen does not enter Resident 4's nose. During a review of the facility's Policy and Procedures (P&P) titled, Oxygen Administration dated 1/2024, the P&P indicated oxygen therapy was to be administered as ordered by the physician to provide sufficient oxygen to the resident. The nasal prongs were to be placed in resident's nostrils and tape the nasal cannula on the nose to prevent pull on nasal cannula.

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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** 14330 Based on observation, interview and record review, the facility failed to attempt the use of appropriate alternatives to bed rails before its installation for two of two sampled residents (Residents 26 and 99). These deficient practices placed Residents 26 and 99 at risk for entrapment and injury from the use of bed rails. Findings: a. During a review of Resident 99's Admission Record (AR), the AR indicated the facility readmitted the resident on 6/10/2024, with diagnoses that included diabetes mellitus (a condition that happens when the blood sugar [glucose] is too high) and anxiety disorder (a type of mental condition that cause fear, panic and other symptoms that are out of proportion to the situation). During an observation and concurrent interview on 7/18/2024 at 9:10 a.m., Resident 99 was lying on her back in bed with half-length bed rails up on both sides. Resident 99 was watching the television, alert and coherent. Resident 99 stated she did not know why both sides of her bed rails were always up since the first day of readmission to the facility. Resident 99 was able to get out of bed independently and she used the front wheel walker to walk going to the activity room. During an observation and concurrent interview on 7/19/2024 at 9:13 a.m., Resident 99's half-length bed rails were up on both sides while the resident was asleep in bed. Certified Nursing Assistant 7(CNA7) stated CNA 7 was the regular CNA of Resident 99. CNA 7 stated a female Charge Nurse (unidentified) told her that Resident 99's bed rails should be up at all times. CNA 7 stated Resident 99 already had bed rails installed on the first day of readmission to the facility. During a concurrent interview and record review on 7/19/2024 at 9:28 a.m., the Director of Nursing (DON) stated Resident 99's medical record did not contain information that appropriate alternatives to bed rails were attempted before the bed rails were used for Resident 99. The DON stated bed rails were made of metal material that could cause serious injury and/or death of a resident from entrapment of limbs or head in between the gap or open space in between the bed rails and mattress. The DON further stated appropriate alternatives to bed rails such as low bed, non-skid mat, foam bumpers and concave mattress were to be attempted by the staff to evaluate if it did not meet Resident 99's needs before the bed rails were to be installed. b. During a review of Resident 26's AR, the AR indicated the facility readmitted the resident on 6/28/2024, 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 chronic obstructive pulmonary disease ([COPD]a group of lung diseases that block airflow and make it difficult to breathe). (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 review of Resident 26's Physician Order Sheet (POS) dated 7/16/2024, the POS indicated for licensed staff to give Olanzapine (antipsychotic drug [a type of drug used to treat symptoms of psychosis]) disintegrating tablet 5 milligram ([mg]unit of measurement) by mouth every 12 hours to Resident 26 for diagnosis of psychosis (a collection of symptoms that happen when a person has trouble telling the difference between what is real and what is not) as manifested by striking out staff during care. During an observation and concurrent interview on 7/16/2024 at 10:14 a.m., Resident 26 was lying on her back in bed with half-length bed rails up on both sides. Resident 26 was alert with periods of confusion. Resident 26 did not know why her bed rails were up when she was in bed. Resident 26 stated her bed rails were up upon readmission to the facility. During a concurrent interview and record review on 7/19/2024 at 9:32 a.m., the DON stated Resident 26's medical record did not have documented evidence of alternatives attempted by the staff before the bed rails were used for Resident 26. The DON stated she thought bed rails could be installed as an enabler for resident's bed mobility without attempting the use of appropriate alternatives to bed rails. The DON stated Resident 26 had behavioral problem of striking out staff during care which could cause serious injury such as fracture of the limb or head when Resident 26 hit her body part on the bed rails. The DON further stated bed rails were an accident hazard for a resident who would attempt to climb over the bed rails or over the foot board by preventing the resident to safely get out of bed. During a review of the facility's Policy and Procedures (P&P) titled, Bedrail assessment dated ,d+[DATE], the P&P indicated appropriate alternatives to bed rails were to be attempted by the staff before the installation of bed rails for the resident. When the appropriate alternatives to bed rails failed to meet the assessed needs of the resident, the interdisciplinary team (IDT) would assess the resident for risks of entrapment and possible benefits of using the bed rail.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. 48905 Based on observation, interview and record review, the facility failed to post actual nursing information in one of one sampled location (Hallway) by failing to: a. Post actual number of nursing staff at the beginning of each shift on 7/17/2024 and 7/18/2024. b. Post accurate numbers of nursing staff who worked on 7/15/2024 morning shift (7:00 AM to 3:00 PM) and evening shift (3:00 PM to 11:00 PM); on 7/16/2024 morning and evening shift; on 7/17/2024 morning shift and on 7/18/2024 evening shift and night shift (11:00 PM to 7AM). These failures had the potential to result in posting inaccurate staffing information and affect the quality of care for the residents. Findings: During an observation on 7/17/2024 at 10:04 AM in the hallway, the facility's Federal Posting (FP) form was dated 7/16/2024. During a concurrent interview and record review on 7/18/2024 at 10:41 AM with Human Resources (HR), the FP form dated 7/18/2024 was reviewed. The FP form indicated a date of 7/18/2024 and no information indicating actual number of nursing staff working. HR stated the actual number of nursing staff for the morning of 7/18/2024 was not listed in the FP form. During an interview on 7/18/2024 at 2:56 PM with the Director of Nursing (DON), the DON stated the purpose of posting actual nursing staff numbers was to indicate that the facility had enough staff to provide care and services to the residents. During an interview and record review on 7/18/2024 at 3:06 PM with the Director of Staff Development (DSD), the FP form dated 7/15/2024 to 7/18/2024 and staff sign in sheets dated 7/15/2024 to 7/18/2024 were reviewed. The FP forms indicated the following: - On 7/15/2024 morning shift, six Licensed Vocational Nurses (LVN) worked instead of eight and 13 Certified Nursing Assistants (CNA) worked instead of 15 during the evening shift. - On 7/16/2024 morning shift, one Registered Nurse (RN) worked instead of two and eight LVN's worked instead of nine. On 7/16/2024 evening shift, one RN worked instead of two. - On 7/17/2024 morning shift, one RN worked instead of two. - On 7/18/2024 evening shift, 14 CNAs worked instead of 15 and on the night shift, 12 CNAs worked instead of 13. The DSD stated the FP form was not accurate and was not consistent with the actual number of staff who worked. The DSD stated the purpose of posting actual staffing numbers was to inform the residents and resident's family how many staff were working to provide care to the residents. (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	During a review of the facility's Policy and Procedure (P&P) titled, Nursing Services revised 2/2024, the P&P indicated a per patient day (PPD) will be kept and posted daily for proper compliance regarding staffing during each shift accordingly.

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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. 40037 Based on observation, interview, and record review, the facility failed to follow proper food sanitation and safe handling practices by: a. Placing a container of raw meat for thawing next to the container of ready to eat carrots, at the lowest shelf inside one of one facility walk-in refrigerator. b. Placing spoons with food particles in one of one clean knife holding rack. These failures had the potential to result in contamination and food borne illnesses (illness caused by consuming contaminated food or beverages) to the residents. Findings: During an observation on 7/16/2024 at 8:32 am, in the facility's kitchen, there was one container with raw meat placed on the lowest shelf inside the facility's walk-in refrigerator. There was a container with ready to eat chopped carrots next to the meat container. During a concurrent interview, Certified Dietary Manager (CDM) stated, the packed meat inside the container was raw ground turkey for defrosting. CDM stated ready-to-eat food should be placed above the thawing meat. The CDM stated, kitchen staff should not place ready to eat food container next to the container containing raw meat for thawing to prevent possible food contamination which might cause food borne illness to the residents. During an observation on 7/16/2024 at 8:55 am, in the facility's kitchen, there were two spoons with food particles placed in the same rack with four clean knifes. The CDM stated, kitchen staff should not place used spoons together with clean knifes. The CDM stated, this practice would cause cross contamination causing food borne illness to the residents. During a review of the facility's Policy and Procedure (P&P) titled, Thawing of Meats, dated 2023, the P&P indicated, Thaw meat on the bottom shelf below prepared, ready-to-eat food. Store cooked or ready-to-eat food above raw meat, poultry, and fish, if these items are stored in the same unit. This will prevent raw-product juices from dripping onto the prepared food causing food borne illness. During a review of the facility's P&P titled, Sanitation, dated 2023, the P&P indicated, All utensils, counters, shelves, and equipment shall be kept clean .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055141	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ramona Nursing and Rehabilitation Center	11900 Ramona Boulevard El Monte, CA 91732

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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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48905 Based on interview and record review, the facility failed to implement a hospice (program that gives special care to residents who are near the end of life and have stopped treatment to cure or control disease) diet order for one of two sampled residents (Resident 68). Resident 68 had an order of puree diet (food that has been ground, blended, or chopped into a thick paste or liquid for easier swallowing and digestion) with thin liquids from the hospice physician but Resident 68 was currently receiving mechanical soft diet (foods that are soft in texture) with thin liquids. This failure had the potential to result in adverse consequences for Resident 68 including weight loss. Findings: During a review of Resident 68's Admission Record (AR), the AR indicated Resident 68 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included leukemia (cancer that causes large numbers of abnormal blood cells that enter the bloodstream), Alzheimer's disease (progressive disease affecting thought, memory, and language) and dysphagia (difficulty in swallowing). During a review of Resident 68's History and Physical (H&P) dated 8/6/2023, the H&P indicated Resident 68 does not have the capacity to understand and make decisions. During a review of Resident 68's Minimum Data Set (MDS, a standardized assessment and care planning tool) dated 4/30/2024, the MDS indicated Resident 68 required set up or clean up assistance with feeding. During a review of Resident 68's Order Summary Report (OSR) dated 6/5/2023, the OSR indicated Resident 68 had a physician's order for regular diet with mechanical soft texture diet and thin liquids. During a review of Resident 68's untitled care plan (CP) dated 6/15/2023, the CP indicated Resident 68 was admitted to hospice with terminal diagnosis of leukemia. The CP indicated for facility staff to initiate an intervention to work cooperatively with the hospice team to ensure Resident 68's spiritual, emotional, intellectual, physical, and social needs were met. During a concurrent interview and record review on 7/17/2024 at 11:07 AM with the Social Services Director (SSD), Resident 68's Hospice Plan of Care (POC) Summary dated 7/8/2024, was reviewed. The Hospice POC Summary indicated Resident 68 had an order for a puree diet with thin liquids, dated 5/15/2024. The SSD stated the hospice nurse needed to communicate with facility staff if there were new physician's orders. The SSD stated staff needed to follow hospice orders for residents on hospice. The SSD stated Resident 68 was currently on mechanical soft textured diet with thin liquids. The SSD stated if the orders from hospice and the facility were not consistent, the risk was that the resident would experience weight loss. (continued on next page)

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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/17/2024 at 11:52 AM with the facility's Registered Dietician Consultant (RD), the RD Consultant stated if there was a change in diet texture, Speech Language Pathologist (SLP, a speech therapist who diagnoses and treats communication and swallowing problems) needed to do an evaluation of the resident. The RD Consultant stated the purpose of mechanical soft diet was to help the resident chew or swallow by chopping food into smaller pieces for easier swallowing. The RD Consultant stated a puree diet was a downgrade in texture and stated if the resident was unable to tolerate small pieces, then the diet was changed to a puree diet for easier swallowing. During an interview on 7/17/2024 at 1:39 PM with the SLP, the SLP stated if there was a change in diet order, nursing staff would notify the SLP team to do an assessment of the resident. The SLP stated the SLP team was unaware of the hospice diet order for Resident 68 and was not aware why the diet change was not communicated to the SLP team. During an interview on 7/18/2024 at 2:43 PM with the Director of Nursing (DON), the DON stated Resident 68 was currently on a mechanical soft diet. The DON stated the hospice nurse did not notify the facility staff of the new hospice diet order. The DON stated if residents were on hospice, staff would need to follow hospice orders. The DON stated the risk of not following the hospice dietary order was that the resident could have difficulty tolerating the diet. During a review of the facility's Policy and Procedure (P&P) titled End of Life Care; Hospice and or Palliative Care revised 12/2023, the P&P indicated hospice services will be offered and as ordered by the physician.