| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055142 | A. Building<br>B. Wing | 04/27/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Magnolia Gardens Convalescent Hospital | 17922 San Fernando Mission Rd<br>Granada Hills, CA 91344 |

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|---|---|
| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39550<br><br>Based on observation, interview and record review, the facility failed to provide care in a manner that maintained a resident's dignity and respect by failing to ensure a staff member knocked on a resident's door prior to entering a resident's room for four of four sample residents (Resident 77, Resident 70, Resident 2, and Resident 49).<br><br>This deficient practice had the potential to affect Resident 77, Resident 70, Resident 2, and Resident 49's self-esteem and self-worth.<br><br>a. During a review of Resident 77's Admission Record, the Admission Record indicated the facility admitted the resident on 6/19/2024 with diagnoses that included unspecified dementia (a group of thinking and social symptoms that interferes with daily functioning), unspecified severity, without behavioral disturbance, psychotic (a mental disorder characterized by a disconnection from reality) disturbance, mood disturbance, and anxiety (intense, excessive, and persistent worry and fear about everyday situations).<br><br>During a review of Resident 77's Minimum Data Set (MDS- a resident assessment tool) dated 4/2/2025, the MDS indicated that Resident 77's cognitive skills (cognition refers to conscious mental activities, and includes thinking, reasoning, understanding, learning, and remembering) for daily decision making were severely impaired. The MDS indicated that Resident 29 required setup or clean up assistance with eating, required substantial/maximal assistance with toileting hygiene and personal hygiene.<br><br>b. During a review of Resident 70's Admission Record, the Admission Record indicated the facility readmitted the resident on 12/11/2024 with diagnoses that included unspecified atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow).<br><br>During a review of Resident 70's MDS dated [DATE], the MDS indicated that Resident 70's cognitive skills for daily decision making were intact. The MDS indicated that Resident 70 was independent with eating, required setup or clean up assistance with oral hygiene, and required partial/moderate assistance with toileting hygiene and personal hygiene.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | c. During a review of Resident 2's Admission Record, the Admission Record indicated the facility readmitted the resident on 3/11/2025 with diagnoses that included cerebral palsy (a group of conditions that affect movement and posture), epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures), and unspecified intellectual disabilities (a term used when a person has certain limitations in cognitive functioning and skills).<br><br>During a review of Resident 2's MDS dated [DATE], the MDS indicated that Resident 2's cognitive skills for daily decision making were intact. The MDS indicated that Resident 2 was independent with eating, required setup or clean up assistance with oral hygiene, and required partial/moderate assistance with toileting hygiene and personal hygiene.<br><br>d. During a review of Resident 49's Admission Record, the Admission Record indicated the facility admitted the resident on 2/8/2024 with diagnoses that included epilepsy, morbid (severe) obesity due to excess calories, and unspecified intellectual disabilities.<br><br>During a review of Resident 49's MDS dated [DATE], the MDS indicated that Resident 49's cognitive skills for daily decision making were severely impaired. The MDS indicated that Resident 49 required supervision or touching assistance with eating, required partial/moderate assistance with personal hygiene, and dependent with toileting.<br><br>During an observation on 4/25/2025 at 8:15 p.m., observed the Infection Preventionist (IP) enter Resident 77, Resident 70, Resident 2, and Resident 49's room and did not knock prior to entering their room.<br><br>During an interview on 4/25/2025 at 8:18 p.m., with the IP, the IP stated that she did not knock prior to entering Resident 77, Resident 70, Resident 2, and Resident 49's room. The IP continued to state that she should have knocked prior to entering Resident 77, Resident 70, Resident 2, and Resident 49's room. and should have informed the residents that she was entering prior to entering the room. When asked about the importance of knocking prior to entering Resident 77, Resident 70, Resident 2, and Resident 49's room, the IP stated that knocking prior to entering is important to show respect to the residents.<br><br>During a review of the facility's policy and procedure titled, Dignity, revised date 2/2022, indicated each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life and feeling of self-worth and self-esteem. Staff are expected to knock and request permission before entering residents' room. |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Reasonably accommodate the needs and preferences of each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47883<br><br>Based on observation, interview, and record review, the facility failed to ensure that a call light (a device used by a patient to signal his or her need for assistance from a professional staff) was within reach for two out of two sampled residents (Resident 13 and Resident 6) investigated under the environment care area.<br><br>This deficient practice had the potential to result in the residents being unable to ask health care workers for assistance with care and services as needed.<br><br>Findings:<br><br>a. During a review of Resident 13's Admission Record, the Admission Record indicated the facility admitted the resident on 12/19/2014 and readmitted on [DATE] with diagnoses including end stage renal disease (final, permanent stage of chronic kidney disease, where kidney function has declined to the point that the kidneys can no longer function on their own), heart failure (heart muscle cannot pump enough blood to meet the body's needs), and bipolar disorder (a serious mental illness that causes unusual shifts in mood, ranging from extreme high manic episodes to low depression episodes).<br><br>During a review of Resident 13's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 3/30/2025, the MDS indicated the resident had moderately impaired cognition (a moderate damaged mental abilities, including remembering things, making decisions, concentrating, or learning). The MDS indicated Resident 13 was unable to walk and required moderate- to -maximal assistance from staff for most activities of daily living (ADLs - activities such as bathing, dressing, and toileting a person performs daily).<br><br>During a review of Resident 13 History and Physical (H&P), dated 1/22/2025, the H&P indicated Resident 13 had the capacity to understand and make decisions.<br><br>During a review of Resident 13's Care Plan (a document that outlines the actions and interventions needed to address a resident's health and care needs) dated 12/02/2020 for ADL, the Care Plan indicated that the resident required two persons assist to start and complete most ALDs task. The care plan indicated an intervention to ensure call light is within easy reach.<br><br>During a concurrent observation and interview on 4/25/2025 at 8:45 p.m. with Certified Nursing Assistant 3 (CNA 3) in Resident 13's room, CNA 3 stated that the resident could not reach the call light, when the call light was located on right side of bed side rail and hanging under the bed. CNA 3 stated if Resident 13 is not able to call for assistance, the resident would be at risk for delayed care.<br><br>b. During a review of Resident 6's Admission Record, the Admission Record indicated the facility admitted the resident on 7/22/2022 and readmitted on [DATE] with diagnoses including hypertensive chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood well), major depression (a mood disorder that causes a persistent feeling of sadness and loss of interest)and essential hypertension (when the pressure in your blood vessels is too high).<br><br>(continued on next page) |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of Resident 6's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 4/8/2025, the MDS indicated the resident had severely impaired cognition (severely damaged mental abilities, including remembering things, making decisions, concentrating, or learning). The MDS indicated Resident 6 was unable to walk and required maximal assistance from staff for most activities of daily living (ADLs - activities such as bathing, dressing, and toileting a person performs daily).<br><br>During a review of Resident 6's History and Physical (H&P), dated 9/4/2024, the H&P indicated Resident 6 had the capacity to understand and make decisions.<br><br>During a concurrent observation and interview on 4/25/2025 at 8:40 a.m. in Resident 6's room, observed the resident lying in bed, the call light was located on the wall and Resident 6 stated she could not reach the call light. CNA 3 stated if Resident 6 was not able to call for assistance, the resident would be at risk for delayed care.<br><br>During an interview on 4/27/2023 at 5:33 p.m. with the Director of Nursing (DON), the DON stated the call light should be placed within reach for the residents to be able to call for assistance in case of emergency and for staff to meet their needs.<br><br>During a review of the facility's policy and procedure titled, Call System, Resident last reviewed on 1/15/2025, the policy indicated the facility will provide a means to call staff for assistance through a communication system that directly calls a staff member or centralized workstation. |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44309<br><br>Based on interview and record review, the facility failed to develop a complete baseline care plan within 48 hours of a resident`s admission to the facility by failing to address the resident`s indwelling catheter (a hollow tube inserted into the bladder to drain or collect urine) care interventions for one of one sampled resident (Resident 85) reviewed under the indwelling catheter care area.<br><br>This deficient practice had the potential for Resident 85 not to receive appropriate care and treatment in the facility.<br><br>Findings:<br><br>During a review of Resident 85's Admission Record (face sheet), the Admission Record indicated that the facility originally admitted the resident on 1/23/2025 and readmitted on [DATE] with diagnoses including type two (2) diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), obstructive uropathy (a blockage in the urinary tract that prevents urine from draining normally), and reflux uropathy (when urine flows backward into the kidneys).<br><br>During a review of Resident 85`s Admission assessment dated [DATE], the Admission Assessment indicated that Resident 85 had an indwelling catheter.<br><br>During a review of Resident 85's Minimum Data Set (MDS - a resident assessment tool) dated 1/29/2025, the MDS indicated that 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 (decisions consistent/reasonable). The MDS indicated that Resident 85 required staff substantial/maximal assistance (helper does more than half the effort) for oral hygiene, toileting hygiene, upper and lower body dressing, showering/bathing, and personal hygiene. The MDS further indicated that Resident 85 had an indwelling catheter.<br><br>During a review of Resident 85's physician Order Summary Report (physician orders) dated 2/16/2025, the Order Summary report indicated an order for an indwelling catheter due to obstructive uropathy. The order summary report indicated to provide indwelling catheter care during every day shift.<br><br>During a concurrent interview and record review on 4/26/2025 at 5:30 p.m., with MDS Coordinator 1 (MDSC 1), Resident 85`s baseline care plan was reviewed. MDSC 1 stated that Resident 85 was readmitted to the facility on [DATE] with an indwelling catheter. MDSC 1 stated that Resident 85`s baseline care plan initiated on 2/16/2025, indicated that the resident had an indwelling catheter. However, the care plan did indicate any nursing interventions regarding the care and monitoring of Resident 85`s indwelling catheter. MDSC 1 stated that residents` baseline care plans must be completed thoroughly reflecting a problem, initial care plan outcome, and nursing interventions. MDSC 1 stated that the potential outcome of not thoroughly completing a resident`s baseline care plan is the inability to meet the resident`s immediate care needs and lack of care.<br><br>(continued on next page) |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 4/27/2025 at 6:15 p.m., with the Director of Nursing (DON), the DON stated a resident`s baseline care plan is required to be completed within 48 hours of resident`s admission to the facility. The DON stated upon admission, licensed staff are required to develop a complete and thorough baseline care plan for each resident indicating a problem and all nursing interventions to be done for that problem. The DON stated Resident 85`s baseline care plan developed on 2/16/2025 was not completed thoroughly. The DON stated the potential outcome is the inability to meet the resident`s immediate care needs and the delivery of necessary services to the resident.<br><br>During review of the facility`s Policy and Procedure (P&P) titled Care Plans-Baseline, last reviewed on 3/12/2025, the P&P indicated that a baseline plan of care to meet the resident`s immediate health and safety needs is developed for each resident within 48 hours of admission. The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care and must include minimum healthcare information necessary to properly care for the resident. The resident and/or representative are provided with a written summary of the baseline care plan that includes but is not limited to any services and treatment to be administered by the facility and personnel acting on behalf of the facility. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39550<br><br>Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan (a written course of action that helps a resident achieve outcomes that improve their quality of life) for two of two sampled residents (Resident 25 and Resident 15), who were observed with a bed pad alarm (a device that uses a pressure-sensitive pad placed underneath the resident to alert caregivers when a person attempts to get up without assistance<br><br>This deficient practice had the potential to negatively affect the delivery of care and services to Resident 25 and Resident 15.<br><br>Findings:<br><br>a. During a review of Resident 25's Admission Record, the Admission Record indicated the facility readmitted Resident 25 on 8/20/2017 with diagnoses that included chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) and unspecified dementia (a progressive state of decline in mental abilities).<br><br>During a review of Resident 25's Minimum Data Set (MDS- an assessment and screening tool) dated 4/7/20225, the MDS indicated Resident 25's cognitive skills (cognition refers to conscious mental activities, and includes thinking, reasoning, understanding, learning, and remembering) for daily decision making were severely impaired. The MDS indicated that Resident 25 required substantial/maximal assistance with eating, oral hygiene, toileting hygiene, and personal hygiene.<br><br>During a review of Resident 25's Fall Risk assessment dated [DATE] at 4:05 p.m., the Fall Risk Assessment indicated Resident 25 was at a high risk for fall.<br><br>During an observation on 4/26/2025 at 9:16 a.m., in Resident 25's room, Resident 25 observed on bed laying on top of a bed sensor pad (pad connected to the alarm monitor to alert caregivers when residents move or attempt to get up from the bed unassisted).<br><br>During a concurrent observation and interview on 4/26/2025 at 9:17 a.m. with Licensed Vocational Nurse 2 (LVN 2) in Resident 25's room, LVN 3 stated that Resident 25 was laying on top of a sensor pad. The bed pad alarm is used because Resident 25 is at high fall risk.<br><br>During a concurrent interview and record review on 4/26/2025 at 5:47 p.m. with the Infection Preventionist (IP), the IP reviewed Resident 25's care plans and stated that there was no care plan created addressing the use of a bed pad alarm. The IP stated that Resident 25 should have a specific care plan for Resident 25's bed pad alarm so that interventions can be implemented for the use of the bed pad alarm.<br><br>b. During a review of Resident 15's Admission Record, the Admission Record indicated the facility readmitted Resident 15 on 1/14/2015 with diagnoses that included history of falling.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of Resident 15's Minimum Data Set (MDS-resident assessment tool) dated 1/21/20225, the MDS indicated Resident 15's cognitive skills for daily decision making were severely impaired. The MDS indicated that Resident 15 required substantial/maximal assistance with eating, oral hygiene, toileting hygiene, and personal hygiene.<br><br>During a review of Resident 15's Fall Risk assessment dated [DATE] at 11:24 a.m., the Fall Risk assessment indicated Resident 15 was at a high risk for fall.<br><br>During an observation on 4/26/2025 at 9:10 a.m., in Resident 15's room, observed Resident 15 in bed laying on top of bed sensor pad (pad connected to the alarm monitor to alert caregivers when residents move or attempt to get up from the bed unassisted)<br><br>During a concurrent observation and interview on 4/26/2025 at 9:18 a.m. with LVN 2 in Resident 15's room, LVN 2 stated that Resident 15 was laying on top of a sensor pad. The bed pad alarm is used because Resident 15 has a high fall risk.<br><br>During a concurrent interview and record review on 4/26/2025 at 5:47 p.m. with the Infection Preventionist (IP), the IP reviewed Resident 15's care plans and stated that there was no care plan created addressing the use of a bed pad alarm. The IP stated that Resident 15 should have a specific care plan for Resident 15's bed pad alarm so that interventions can be implemented for the use of the bed pad alarm.<br><br>During a review of the facility's policy and procedure titled Care plans, Comprehensive Personal-Centered, review date 3/12/2025, the policy and procedure indicated a comprehensive, person-centered care plan that includes, measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs developed and implemented for each resident. |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38469<br><br>Based on interview and record review the facility failed to ensure residents receive treatment and care in accordance with professional standards of practice by failing to rotate (a method to ensure repeated injections are not administered in the same area) subcutaneous (beneath the skin) injection sites to one of one sampled residents (Resident 41) reviewed under the unnecessary medication- anticoagulant (medications that help prevent blood clots from forming or getting bigger) care area.<br><br>The deficient practice had the potential for adverse effect (unwanted, unintended result) of same site subcutaneous administration of anticoagulant such as lipodystrophy (abnormal distribution of fat), bruising and pain.<br><br>Findings:<br><br>During a review of Resident 41's Admission Record, the Admission Record indicated the resident was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including muscle weakness, chronic obstructive pulmonary disease (COPD-a lung disease that block airflow and make it difficult to breathe) and hypertension (high blood pressure).<br><br>During a review of Resident 41`s Minimum Data Set (S - a standardized assessment and care screening tool), dated 3/26/2025, the MDS indicated the resident`s cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was intact. The MDS also indicated that the resident required assistance from staff with performing activities of daily living (ADLs - activities related to personal care).<br><br>During a review of Resident 41`s Physician`s orders, the Physician's Orders indicated the following order:<br><br>-Enoxaparin Sodium (Lovenox-) Solution 40 milligram (mg-unit of measurement) per 0.4 milliliter, inject 40 mg subcutaneously (SQ-applied under the skin) one time a day for deep vein thrombosis (a blood clot in a deep vein, usually in the legs) prophylaxis (an attempt to prevent disease).<br><br>During a review of Resident 41`s Medication Administration Record (MAR- is used to document medications taken by each individual) for the month of March 2025 and April 2025 indicated the following subcutaneous injection administration sites used for the Lovenox 40mg/0.4 ml:<br><br>1. 3/15/2025 to 3/31/2025 (17 days)- injection site indicated abdomen with no specific area in the abdomen.<br><br>2. 4/1/2025 to 4/8/2025 (8 days)- injection site indicated abdomen with no specific area in the abdomen.<br><br>3. 4/102025 to 4/21/2025 (12 days)- injection site indicated abdomen with no specific area in the abdomen.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview and record review on 04/27/25 at 1:50 p.m., with Registered Nurse 1 (RN 1), reviewed Resident 41`s physician`s order and MAR for 3/2025 and 4/2025. RN 1 verified that there were multiple days in 3/2025 and 4/2025, when the Lovenox administration site only indicated abdomen. RN 1 stated that when using subcutaneous route of injection, the injection site had to be rotated to prevent tissue damage. RN 1 stated that repeated use of the same subcutaneous injection site can be very painful and distressing to the resident. RN 1 stated that although the abdomen has multiple regions or quadrants, the nurse should document the specific injection site to ensure other nurses are aware of where the last injection was administered to prevent repeated injections at the same site.<br><br>During a review of the Enoxaparin (Lovenox) manufacturer`s instruction provided by the facility, the instructions indicated that you should alternate between the left or right side of your stomach each time you give yourself an injection. |

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| F 0676<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.<br><br>39550<br><br>Based on observation, interview, and record review, the facility failed to provide a resident with a communication board (a device that can help residents communicate with care providers and family using symbols, photos, or illustrations) for one of two sampled residents (Resident 15) whose primary language was not English.<br><br>This deficient practice had the potential to prevent the resident from communicating with the staff and had the potential to delay receiving care/treatment the resident needed.<br><br>Findings:<br><br>During a review of Resident 15's Admission Record, the Admission Record indicated the facility readmitted Resident 15 on 1/14/2015 with diagnoses that included history of falling. Resident 15's Admission Record indicated primary language: Arabic (foreign language).<br><br>During a review of Resident 15's Minimum Data Set (MDS- a resident assessment tool) dated 1/21/2025, the MDS indicated Resident 15's cognitive skills (cognition refers to conscious mental activities, and includes thinking, reasoning, understanding, learning, and remembering) for daily decision making were severely impaired. The MDS indicated that Resident 15 required substantial/maximal assistance with eating, oral hygiene, toileting hygiene, and personal hygiene.<br><br>During a review of Resident 15's Care Plan (a document that summarizes a resident's needs, goals, and care/treatment) titled, Resident is at risk for having needs unmet due to difficulty in communication ., the care plan indicated the resident's main language is Arabic.<br><br>During an interview on 4/26/2025 at 9:28 a.m., with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated that Resident 15's primary language is not English and does not know Resident 15's primary language.<br><br>During a concurrent observation and interview on 4/26/2025 at 9:30 a.m., with LVN 2, in Resident 15's room, observed Resident 15 on his bed. LVN 2 was unable to find a communication board at Resident 15's bedside. LVN 2 stated that Resident 15 should have a communication board at bedside to assist with communication.<br><br>During an interview on 4/27/2025 at 5:48 p.m., with the Director of Nursing (DON), the DON stated that Resident 15's primary language is not English. The DON stated that staff should use a communication board to communicate with Resident 15 to ensure that staff understand Resident 15's needs. The DON stated that a communication board is a tool in communicating with a resident if there is a language barrier. The DON stated that a communication board makes communication easier between the resident and facility staff.<br><br>(continued on next page) |

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| | 055142 | A. Building<br>B. Wing | 04/27/2025 |

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| Magnolia Gardens Convalescent Hospital | 17922 San Fernando Mission Rd<br>Granada Hills, CA 91344 |

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| F 0676<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of the facility's policy and procedure titled, Translation and/or Interpretation of Facility Services, review date 3/12/2024, the policy indicated the facility's language access program will ensure that individuals with limited English proficiency (LEP) shall have meaningful access to information and services provided by the facility. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47883<br><br>Based on observation, interview, and record review, the facility failed to:<br><br>1. Provide an environment free from accidents and hazards for one of seven residents (Resident 7) reviewed under the accidents care area by failing to ensure Resident 7 did not store medications at bedside readily accessible to other residents.<br><br>This deficient practice had the potential to result in residents obtaining medication without staff knowledge resulting in accidental ingestion causing harm to residents.<br><br>2. Implement the facility's policy on personal alarms as evidence by the facility not presenting documented evidence of checking the residents' bed pad alarm (a device that uses a pressure-sensitive pad placed underneath the resident to alert caregivers when a person attempts to get up without assistance) daily for functionality for two of seven residents (Resident 15 and Resident 25) reviewed under the accidents care area.<br><br>This deficient practice has the potential to place Resident 15 and Resident 25 at risk for injuries and falls.<br><br>Findings:<br><br>1. During a review of Resident 7's Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE] and readmitted [DATE] with diagnoses including heart failure (when heart muscle cannot pump enough blood to meet the body's needs), chronic obstructive pulmonary disease (a group of diseases that cause airflow blockage and breathing-related problems), and major depression (a mood disorder that causes a persistent feeling of sadness and loss of interest).<br><br>During a review of Resident 7' s Minimum Data Set (MDS, a resident assessment tool), dated 1/18/2025, the MDS indicated Resident 7 had intact cognition (undamaged mental abilities, including remembering things, making decisions, concentrating, or learning).The MDS indicated Resident 7 was dependent (helper does all the effort) on staff for toileting hygiene and shower, and required moderate assistance with dressing and bed mobility.<br><br>During a review of Resident 7's Order Summary Report, the Order Summary Report indicated the following:<br><br>1. Cranberry (supplement) gives 2 gummies by mouth in morning, dated 12/5/2024.<br><br>2. Magnesium Citrate (mineral)100 mg by mouth in morning, dated 4/4/2024.<br><br>3. Pure Iron-C 175mg-15 mg (supplement treats iron deficiency anemia) in the morning every Monday, Wednesday and Friday, dated 11/18/2024.<br><br>4. Vitamin C (supplement) 400 mg by mouth one time a day, dated 4/9/2024.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 5. Vitamin K2 (supplement) 1 tab by mouth at bedtime, dated 2/17/2024.<br><br>6. Cholecalciferol (Vitamin D 3- supplement) 5000 Units give 1 tab by mouth at bedtime, dated 1/28/2024.<br><br>During a review of Resident 7's Self-administration of Drug assessment, the Self-administration Drug assessment dated [DATE] indicated Resident 7 is not safe to self-administer medications and requires assistance with all medication administration.<br><br>During a review of Resident 7's Care plan (a document that outlines the actions and interventions needed to address a resident's health and care needs) dated 1/3/2025, the care plan indicated that Resident 7's family requested to have supplements at bedside. The care plan goal indicated that Resident 7's rights will be respected daily until the next assessment. The care plan interventions indicated to provide medications per order as tolerated.<br><br>During an observation on 4/25/2025 at 8:02 p.m., in Resident 7's room, observed Resident 7 in bed. Observed a plastic bag at bedside containing bottles of the following:<br><br>1. Iron-C 60 capsules<br><br>2. Cranberry Gummies 60 gummies<br><br>3. Vitamin D3 5000 Units 30 gummies<br><br>4. Magnesium Gummies 60 gummies<br><br>5. Ultra C 400 mg 60 tablets<br><br>6. Vitamin K 2 30 vegetable capsules<br><br>Resident 7 stated that all the medications are her supplements and were brought by a family member. Resident 7 stated that the nurses have been giving her all her medications all the time.<br><br>During a concurrent observation and interview on 4/25/2025 at 8:12 p.m., with the Director of Social Service (DSS), the DSS observed and concurred that following medications were in plastic bag at bedside:<br><br>1. Iron-C 60 capsules<br><br>2. Cranberry Gummies 60 gummies<br><br>3. Vitamin D3 5000 Units 30 gummies<br><br>4. Magnesium Gummies 60 gummies<br><br>5. Ultra C 400 mg 60 tablets<br><br>6. Vitamin K 2 30 vegetable capsules<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 4/27/2025 at 5:33 p.m., the Director of Nursing (DON) stated that Resident 7 did not want to comply with facility policy regarding not storing medication at bedside. The DON stated according to Resident 7's assessment for self-administration of medications, Resident 7 could not administer medications by herself. The DON stated that all medications are being administered by nurses according to physician orders. The DON stated keeping medications at the bedside of Resident 7's poses a risk, as confused residents might enter Resident 7's room and consume the medications resulting in the residents experiencing adverse effects.<br><br>During a review of the facility's policy and procedure titled, Medication Storage in the Facility last reviewed on 3/12/2025, the policy and procedure indicated: Medication and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized.<br><br>39550<br><br>2.a. During a review of Resident 15's Admission Record, the Admission Record indicated the facility readmitted Resident 15 on 1/14/2015 with diagnoses that included history of falling.<br><br>During a review of Resident 15's Minimum Data Set (MDS-resident assessment tool) dated 1/21/20225, the MDS indicated Resident 15's cognitive skills for daily decision making were severely impaired. The MDS indicated that Resident 15 required substantial/maximal assistance with eating, oral hygiene, toileting hygiene, and personal hygiene.<br><br>During a review of Resident 15's Fall Risk assessment dated [DATE] at 11:24 a.m., the Fall Risk assessment indicated Resident 15 was at a high risk for fall.<br><br>During an observation on 4/26/2025 at 9:10 a.m., in Resident 15's room, observed Resident 15 in bed laying on top of bed sensor pad (pad connected to the alarm monitor to alert caregivers when residents move or attempt to get up from the bed unassisted)<br><br>During a concurrent observation and interview on 4/26/2025 at 9:18 a.m. with LVN 2 in Resident 15's room, LVN 2 stated that Resident 15 was laying on top of a sensor pad. The bed pad alarm is used because Resident 15 has a high fall risk.<br><br>During a concurrent observation and interview on 4/26/2025 at 9:19 a.m., with LVN 2 in Resident 15's room, LVN 2 was asked how to check the functionality of Resident 15's bed pad alarm. Observed LVN 2 handle Resident 15's bed pad alarm monitor (device that is connected to the sensor pad that alarms which may be a sound, a visual indicator or both detects a change in pressure when a resident moves off the sensor pad) and stated the bed pad alarm monitor should just beep. LVN 2 stated that Resident 15's bed pad alarm does not function.<br><br>During a concurrent interview and record review on 4/27/2024 at 11:31 a.m. with Registered Nurse 1 (RN 1), RN 1 reviewed Resident 13's April 2025 Medication Administration Record (MAR), April 2025 Treatment Administration Record (TAR), and April 2025 progress notes, and was not able to find documented evidence licensed nurses were checking the functionality of Resident 15's bed pad alarm. RN 1 stated is important that licensed nurses document the monitoring of the bed pad alarm as part of monitoring interventions for fall prevention and safety.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 2.b.During a review of Resident 25's Admission Record, the Admission Record indicated the facility readmitted Resident 25 on 8/20/2017 with diagnoses that included chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) and unspecified dementia (a progressive state of decline in mental abilities).<br><br>During a review of Resident 25's Minimum Data Set (MDS- an assessment and screening tool) dated 4/7/20225, the MDS indicated Resident 25's cognitive skills (cognition refers to conscious mental activities, and includes thinking, reasoning, understanding, learning, and remembering) for daily decision making were severely impaired. The MDS indicated that Resident 25 required substantial/maximal assistance with eating, oral hygiene, toileting hygiene, and personal hygiene.<br><br>During a review of Resident 25's Fall Risk assessment dated [DATE] at 4:05 p.m., the Fall Risk Assessment indicated Resident 25 was at a high risk for fall.<br><br>During an observation on 4/26/2025 at 9:16 a.m., in Resident 25's room, Resident 25 observed on bed laying on top of a bed sensor pad.<br><br>During a concurrent observation and interview on 4/26/2025 at 9:17 a.m. with Licensed Vocational Nurse 2 (LVN 2) in Resident 25's room, LVN 3 stated that Resident 25 was laying on top of a sensor pad. The bed pad alarm is used because Resident 25 is at high fall risk.<br><br>During a concurrent observation and interview on 4/26/2025 at 9:22 a.m., with LVN 2 in Resident 25's room, LVN 2 was asked how to check the functionality of Resident 25's bed pad alarm. Observed LVN 2 handle Resident 25's bed pad alarm monitor. LVN 2 stated that Resident 15's bed pad alarm does not function just like Resident 15's bed pad alarm.<br><br>During a concurrent interview and record review on 4/27/2024 at 11:41 a.m. with RN 1, RN 1 reviewed Resident 25's April 2025 MAR, April 2025 TAR, and April 2025 progress notes, and was not able to find documented evidence that licensed nurses were checking the functionality of Resident 25's bed pad alarm.<br><br>During an interview on 4/27/2025 at 5:59 p.m. with the Director of Nursing (DON), the DON stated that the bed pad alarm is a nursing intervention implemented for the safety of the residents. The DON stated that staff are to check and document the functionality of a bed pad alarm. The DON further stated that he does not know where the licensed staff document the bed pad alarm's functionality.<br><br>During a review of the facility's policies and procedures (P&P) titled Personal Alarm, with a review date of 3/12/2025, indicated the facility will use, as indicated, a sensor pad that conveniently sounds as audible alarm when the sensor detects a patient rising out of the bed/wheelchair reminding the resident to return to a safe position while alerting staff to a potential fall. Check alarm system every day for proper functioning. Nursing will monitor proper functioning and positioning of personal alarm. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44309<br><br>Based on observation, interview, and record review, the facility failed to:<br><br>1. Ensure that residents receive continuous oxygen as ordered by their physician for two of five sampled residents (Resident 16 and Resident 39) reviewed under the respiratory care area.<br><br>This deficient practice had the potential to cause Resident 16 and Resident 39 to have shortness of breath that could lead to hypoxemia (a low level of oxygen in the blood).<br><br>2. Ensure residents' oxygen tubing was dated as indicated in the facility's policy and procedure for two of five sampled residents (Resident 39 and 87) reviewed under the respiratory care area.<br><br>This deficient practice had the potential to place the residents at increased risk of developing an infection.<br><br>Findings:<br><br>1.a. During a review of Resident 16's Admission Record (face sheet), the Admission Record indicated that the facility originally admitted the resident on 6/11/2023 and readmitted on [DATE], with diagnoses including acute (appear rapidly) respiratory failure (a serious condition that makes it difficult to breathe on your own) with hypoxia (a medical condition where there is an inadequate supply of oxygen to the body's tissues), and COVID-19 (Coronavirus disease 2019- a highly contagious viral infection that spread from person-to-person affecting the respiratory system).<br><br>During a review of Resident 16's Minimum Data Set (MDS - a resident assessment tool) dated 3/22/2025, the MDS indicated that 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 (decisions consistent/reasonable). The MDS indicated that Resident 16 was dependent on staff (helper does all of the effort) for toileting hygiene, showering and bathing, lower body dressing, and putting on/talking off footwear. The MDS further indicated that Resident 16 was receiving continuous oxygen therapy on admission and while a resident in the facility.<br><br>During a review of Resident 16's physician Order Summary Report (physician orders) dated 3/17/2025, the order summary report indicated to administer oxygen at three liters per minute via nasal cannula (NC-a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) continuously for respiratory failure during every shift.<br><br>During a review of Resident 16's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) from 4/1/2-25-4/26/2025, the MAR indicated that licensed nurses documented that they changed the oxygen nasal canula and humidifier every Sunday on 4/5/2025, 4/12/2025, and 4/20/2025.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of Resident 16`s Care Plan (a document outlining a detailed approach to care customized to an individual resident's need) for risk for respiratory distress (the condition where someone has difficulty breathing) initiated on 3/16/2025, the care plan indicated a goal that the resident will have no sign and symptoms of respiratory distress through the next assessment date. The care plan interventions were to administer oxygen as ordered by the physician, elevate the resident`s head of bed as needed and to monitor the resident`s oxygen saturation (a measurement of how much oxygen your blood is carrying compared to its maximum capacity-for healthy adults, normal oxygen saturation is between 95% and 100%).<br><br>During a concurrent observation and interview on 4/26/2025 at 7:50 a.m., inside Resident 16`s room, Resident 16 was observed sitting on her bed, and eating breakfast. There was no oxygen machine present at Resident 16's bedside. Resident 16 stated that she has not been using oxygen lately.<br><br>During a concurrent interview and record review on 4/26/2025 at 8:00 a.m., with Licensed Vocational Nurse 1 (LVN 1), Resident 16`s physician orders were reviewed. LVN 1 stated that Resident 16`s physician ordered to administer continuous oxygen at three liters per minute via NC to the resident, however, Resident 16 was not provided oxygen as ordered by her physician. LVN 1 stated Resident 16 tested positive for COVID-19 and may need oxygen. LVN 1 stated that she (LVN 1) does not know why oxygen was not available to Resident 16 at her bedside.<br><br>During a concurrent interview and record review on 4/26/2025 at 5:40 p.m., with the MDS Coordinator 1 (MDSC 1), Resident 16`s physician orders were reviewed. MDSC 1 stated that there was a physician order to administer continuous oxygen at three liters per minute via NC to Resident 16. MDSC 1 stated licensed nurses should follow physician orders for oxygen administration. MDSC 1 stated staff did not provide oxygen to Resident 16 as ordered by her physician. MDSC 1 stated if a resident`s oxygen saturation is normal and he or she no longer needs oxygen therapy, licensed nurses are required to contact the physician and receive an order to discontinue the administration of oxygen. MDSC 1 stated the potential outcome of not administering oxygen to a resident as per physician order is the increased risk for shortness of breath and hypoxemia.<br><br>During a review of the facility's Policy and Procedure (P&P) titled Oxygen Administration, last reviewed on 3/12/2025, the P&P indicated the purpose of this guideline is to provide guidelines for safe oxygen administration. Verify that there is a physician`s order for this procedure. Review the physician`s order or facility protocol for oxygen administration. Review the resident`s care plan to assess any special needs of the resident.<br><br>39550<br><br>1.b. During a review of Resident 39's Admission Record, the Admission Record indicated the facility readmitted the resident on 12/29/2024 with diagnoses including acute respiratory failure (a serious condition where the lungs cannot adequately supply oxygen to the blood or remove carbon dioxide) with hypoxia and chronic obstructive pulmonary disease (COPD-a group of lung diseases that block airflow and make it difficult to breathe).<br><br>During a review of Resident 39's MDS dated [DATE], the MDS indicated Resident 39's cognition was severely impaired. The MDS also indicated Resident 39 was dependent on staff with oral hygiene, toileting hygiene, and personal hygiene.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of Resident 39's physician orders, the physician's order indicated an order dated 4/22/2025 to administer oxygen at two liters per minute (LPM) via nasal canula every shift for COPD. May titrate up to 4 LPM for oxygen saturation (measurement of how much oxygen is being carried by red blood cells in the blood) less than 88%.<br><br>2. a. During a review of Resident 39's physician's orders, the physician's order indicated the following orders dated 4/22/2025:<br><br>-Change nasal canula/mask as needed when soiled and every night shift every Sunday.<br><br>-Change oxygen tubing as needed, and every night shift every Sunday.<br><br>During a review of Resident 39's care plan titled Oxygen, revised on 4/23/2025, the care plan indicated Resident 39 is receiving oxygen therapy due to respiratory failure. The care plan interventions were to change oxygen tubing weekly or as needed and provide oxygen as ordered.<br><br>During an observation on 4/25/2025 at 8:30 p.m., in Resident 39's room, observed Resident 39 in bed. Observed an oxygen concentrator (a medical device that delivers concentrated oxygen to residents with breathing difficulties by separating nitrogen from room air) at bedside, with Resident 39's nasal canula connected to the oxygen concentrator, however, Resident 39 was not wearing the nasal canula. Observed Resident 39's oxygen tubing and oxygen tubing bag, undated.<br><br>During a concurrent observation and interview on 4/25/2025 at 8:53 p.m., with Licensed Vocational Nurse 3 (LVN 3) in Resident 39's room, observed an oxygen concentrator at bedside, with Resident 39's nasal canula connected to the oxygen concentrator, however, Resident 39 was not wearing the nasal canula. LVN 3 stated Resident 39 should have been using the nasal canula. Observed LVN 3 place Resident 39's nasal canula on Resident 39. LVN stated that Resident 39's oxygen tubing was not dated and should have been dated.<br><br>During an interview on 4/27/2025 at 1:35 p.m. with the Assistant Director of Nursing (ADON) the ADON stated that the oxygen tubing should be replaced every week and as needed. The ADON stated that central supply staff is responsible for replacing oxygen tubing and placing dates on the oxygen tubing bag and oxygen tubing when changed. The ADON stated that it is important to change residents' oxygen tubing weekly to prevent bacterial growth.<br><br>During a follow up interview on 4/27/2025 at 2:53 p.m. with the ADON, the ADON stated oxygen is important to administer to residents to ensure oxygen saturation is above 95%. If oxygen is not provided as ordered by the physician, residents can experience shortness of breath which can lead to hypoxia. Staff should conduct frequent rounding to ensure residents receiving supplemental oxygen are receiving the appropriate oxygen.<br><br>During a review of the facility's policy and procedure titled, Oxygen Administration: Policy and Procedure, with review date of 3/12/2025, the policy and procedure indicated oxygen will be administered to residents as needed per attending physician's order. The date, time, and initials should be noted on oxygen equipment when it is initially used and when changed.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of the facility's policy and procedure titled, Oxygen Administration, with review date 1/3/2025, the policy and procedure indicated oxygen therapy is administered by way of an oxygen mask, nasal cannula, and/or nasal catheter.<br><br>2.b. During a review of Resident 87's Admission Record, the Admission Record indicated the facility admitted the resident on 2/1/2025 with diagnoses including chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing).<br><br>During a review of Resident 87's Minimum Data Set (MDS- a standardized assessment and screening tool) dated 3/3/2025, the MDS indicated Resident 87's cognition (refers to conscious mental activities including thinking, reasoning, understanding, learning, and remembering) was intact. The MDS also indicated Resident 87 required setup or clean up assistance with eating, required partial/moderate assistance with oral hygiene, and was dependent on toileting hygiene and was dependent on staff with oral hygiene, toileting hygiene, and personal hygiene.<br><br>During a review of Resident 87's Order summary report, the Order Summary Report indicated an order dated 2/25/2025 to change nasal canula/mask every night shift every Sunday.<br><br>During a review of Resident 87's Order Summary Report indicated the following order dated 2/25/2025:<br><br>-Change oxygen every night shift every Sunday<br><br>During a review of Resident 87's care plan for oxygen, revised on 3/14/2025. The care plan indicated Resident 87 is receiving oxygen therapy. The care plan indicated an intervention to change oxygen tubing weekly or as needed.<br><br>During an observation on 4/25/2025 at 8:14 p.m., in Resident 87's room, observed Resident 87 in bed. Observed an oxygen concentrator at bedside and Resident 87's nasal canula was connected to the oxygen concentrator. Resident 87's oxygen tubing and oxygen bag was dated 4/17/2025.<br><br>During a concurrent observation and interview on 4/25/2025 at 8:18 p.m., with the Infection Preventionist (IP) in Resident 87's room, the IP stated that Resident 87's oxygen bag and tubing was dated 4/17/2025. The IP stated that the oxygen tubing should be changed every 7 days, and the resident's tubing should have been changed, on 4/24/2025.<br><br>During an interview on 4/27/2025 at 1:35 p.m. with the Assistant Director of Nursing (ADON) the ADON stated that the oxygen tubing should be replaced every week and as needed. The ADON stated that central supply staff is responsible for replacing oxygen tubing and placing dates on the oxygen tubing bag and oxygen tubing when changed. The ADON stated that it is important to change residents' oxygen tubing weekly to prevent bacterial growth.<br><br>During a review of the facility's policy and procedure titled, Oxygen Administration: Policy and Procedure, with review date of 3/12/2025, the policy and procedure indicated oxygen will be administered to residents as needed per attending physician's order. The date, time, and initials should be noted on oxygen equipment when it is initially used and when changed. |

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| | 055142 | A. Building<br>B. Wing | 04/27/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Magnolia Gardens Convalescent Hospital | 17922 San Fernando Mission Rd<br>Granada Hills, CA 91344 |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate dialysis care/services for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44309<br><br>Based on observation, interview, and record review, the facility failed to implement the physician's order for fluid restriction (limiting the amount of liquid a person consumes daily, often prescribed to manage kidney disease) limited to no water pitcher at bedside for one of two sampled residents (Resident 33) reviewed under dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) care area.<br><br>This deficient practice had the potential to place Resident 33 at risk for fluid overload (a condition where you have too much fluid volume in your body) which can result in health complications.<br><br>Findings:<br><br>During a review of Resident 33's Admission Record (face sheet), the admission record indicated that the facility originally admitted the resident on 12/4/2024 and readmitted on [DATE] with diagnoses including type two (2) diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), dependence on renal dialysis, and end stage renal disease (ESRD-irreversible kidney failure).<br><br>During a review of Resident 33's Minimum Data Set (MDS - a resident assessment tool) dated 3/12/2025, the MDS indicated that 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 (decisions consistent/reasonable). The MDS indicated that Resident 33 required staff substantial/maximal assistance (helper does more than half the effort) for toileting hygiene, upper body dressing, showering/bathing, and putting on/taking off footwear. The MDS further indicated that Resident 33 was undergoing hemodialysis while a resident in the facility.<br><br>During a review of Resident 33's physician Order Summary Report (physician orders) dated 1/28/2025, the Order Summary report indicated to place Resident 33 on fluid restriction and not place any water pitcher at his bedside.<br><br>During a review of Resident 33's physician Order Summary Report (physician orders) dated 3/22/2025, the Order Summary Report indicated that Resident 33 required hemodialysis every Tuesday, Thursday, and Saturday at 4:45 p.m.<br><br>During an observation on 4/27/2025 at 10:28 a.m., inside Resident 33 `s room, a full pitcher of water, a full glass of water and another half full glass of water were observed on the resident`s side table. Resident 33 stated that he is on fluid restriction because of his hemodialysis treatments, and that he only drinks water when he takes his medications in the mornings.<br><br>(continued on next page) |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a concurrent observation and interview on 4/27/2025 at 10:30 a.m. with Licensed Vocational Nurse 2 (LVN 2) inside Resident 33 `s room, LVN 2 stated that there was a full pitcher of water, a full glass of water and another glass, half full of water on the resident`s side table. LVN 2 stated Resident 33 is undergoing hemodialysis, and his physician ordered to place no water pitcher at his bedside. LVN 2 stated the staff failed to follow Resident 33`s physician order regarding fluid restrictions. LVN 2 stated that the potential outcome of not following the order for fluid restriction is that Resident 33 may experience a fluid overload.<br><br>During an interview on 4/27/2025 at 6:16 p.m., with Director of Nursing (DON), the DON stated that staff are required to implement physician orders for the resident`s fluid restriction. The DON stated Resident 33 requires hemodialysis three times a week, and it is necessary to not place a water pitcher at his bedside as ordered by his physician to prevent fluid overload and edema.<br><br>During a review of the facility`s Policy and Procedures (P&P) titled No Water Pitcher at bedside-Less restrictive Fluid Restriction, last reviewed on 3/12/2025, the P&P indicated that fluid restriction that is limited to no water at the bedside will be utilized when less-restrictive fluid restrictions are allowed by the attending physician, thus improving the quality of life for the resident. Obtain order from attending physician for fluid restriction limited to no water pitcher at bedside. The procedure simply limits the fluid to no water carafe at the bedside. |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure medication error rates are not 5 percent or greater.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44309<br><br>Based on observation, interview and record review, the facility failed to ensure that its medication error rate was less than five (5) percent. Nine medication errors out of 28 opportunities contributed to an overall medication error rate of 32.14 percent (%) affecting one of five randomly selected residents (Resident 44) observed for medication administration.<br><br>The medication errors were as follows:<br><br>Resident 44 received anastrazole (a medication used to treat breast cancer), bupropion (a medication used to treat depression [a mood disorder that causes a persistent feeling of sadness and loss of interest]), carvedilol (a medication used to high blood pressure), furosemide (a medication used to treat buildup of fluid in the body), sertraline (a medication used to treat depression), Vitamin C (a type of vitamin), thiamine (a type of vitamin), multivitamin with mineral, and magnesium oxide ( a type of supplement) at times different than ordered by the physician.<br><br>These failures had the potential for Resident 44 to experience adverse effects (unwanted, uncomfortable, or dangerous effects that a medication may have) from the medications and the potential to result in poor health outcomes.<br><br>Findings:<br><br>During a review of Resident 44's Admission Record (face sheet), the AdmissionRrecord indicated that the facility originally admitted the resident on 1/15/2023, and readmitted on [DATE] with diagnoses including difficulty walking, depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), dysphagia (difficulty swallowing), and history of falling.<br><br>During a review of Resident 44's Minimum Data Set (MDS- a resident assessment tool) dated 4/8/2025, the MDS indicated that the resident`s cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was moderately impaired (decisions poor, cues/supervision required). The MDS indicated that Resident 44 required staff partial/moderate assistance (helper does less than half the effort) for oral hygiene, toileting hygiene, showering/bathing, upper and lower body dressing, personal hygiene, and putting off footwear.<br><br>During a review of Resident 44's physician's Order Summary Report (physician orders), the Order Summary report indicated that Resident 44 was prescribed:<br><br>1. Carvedilol oral tablet, 3.125 milligrams (mg-a unit of measure of mass), one tablet by mouth one time a day for hypertension (HTN-high blood pressure) starting 4/2/2025.<br><br>2. Anastrazole oral tablet one (1) mg by mouth one time a day for breast cancer starting 4/2/2025.<br><br>3. Bupropion HCL oral tablet, 75 mg, one tablet by mouth two times a day for depression starting 4/13/2025.<br><br>4. Furosemide oral tablet 40 mg, one tablet by mouth in the morning for edema starting 4/4/2025.<br><br>(continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 5. Magnesium Oxide oral tablet 400 mg, one tablet by mouth two times a day for supplement starting 4/9/2025.<br><br>6. Sertraline HCL oral tablet 50 mg, one tablet by mouth one time a day for depression starting 4/13/2025.<br><br>7. Multivitamin with minerals, one tablet by mouth one time a day for supplement, starting 4/3/2025.<br><br>8. Thiamine HCL oral tablet 100 mg, one tablet by mouth one time a day for supplement starting 4/2/2025.<br><br>9. Vitamin C tablet 500 mg, one tablet by mouth one time a day for wound healing starting 4/3/2025.<br><br>During a review of Resident 44's Medication Administration Record (MAR- a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for 4/1/2025-4/26/2025, the MAR indicated that Resident 44 was prescribed:<br><br>1. Carvedilol oral tablet, 3.125 milligrams (mg-a unit of measure of mass), one tablet by mouth one time a day for hypertension (HTN-high blood pressure) to be administered at 9:00 a.m.<br><br>2. Anastrazole oral tablet one (1) mg, one tablet by mouth one time a day for breast cancer to be administered at 9:00 a.m.<br><br>3. Bupropion HCL oral tablet, one (1) mg, one tablet by mouth two times a day for depression to be administered at 9:00 a.m. and 5:00 p.m.<br><br>4. Furosemide oral tablet 40 mg, one tablet by mouth in the morning for edema to be administered at 9:00 a.m.<br><br>5. Magnesium Oxide oral tablet 400 mg, one tablet by mouth two times a day for supplement to be administered at 9:00 a.m. and 5:00 p.m.<br><br>6. Sertraline HCL oral tablet 50 mg, one tablet by mouth one time a day for depression to be administered at 9:00 a.m.<br><br>7. Multivitamin with minerals, one tablet by mouth one time a day for supplement to be administered at 9:00 a.m.<br><br>8. Thiamine HCL oral tablet 100 mg, one tablet by mouth one time a day for supplement to be administered at 9:00 a.m.<br><br>9. Vitamin C tablet 500 mg, one tablet by mouth one time a day for wound healing to be administered at 9:00 a.m.<br><br>(continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an observation of the medication administration on 4/26/2025 at 11:24 a.m., with Licensed Vocational Nurse 1 (LVN 1), LVN 1 was observed preparing Resident 44`s medications. LVN 1 stated that she is going to administer Resident 44`s morning medications which were scheduled to be administered at 9:00 a.m. LVN 1 stated that she was busy with other residents, and unable to administer anastrazole, bupropion, carvedilol, furosemide, sertraline, vitamin C, thiamine, multivitamin with mineral, and magnesium oxide at 9:00 a.m. LVN 1 stated there is an hour window to administer the residents medication. However, she (LVN 1) exceeded the one-hour window, and all nine medications will be administered late. LVN 1 stated that administering medications later than the prescribed time is considered a medication error.<br><br>During an interview on 4/26/2025 at 11:54 a.m., with the Director of Nursing (DON), the DON stated that LVN 2 contacted Resident 44`s physician and received an ok to administer all 9 medications to the resident later than the prescribed time. The DON stated that licensed nurses are required to administer all medications in accordance with the time frame ordered by the physician. The DON stated that medications are administered within one hour of their prescribed time. The DON stated administering medication outside their prescribed time frame is considered a medication error and the potential outcome is that residents may not receive the benefits and therapeutic effects of the medication.<br><br>During a review of the facility's Policy and Procedure (P&P) titled, Administering Medications, last reviewed on 3/12/2025, the P&P indicated that medications are administered in a safe and timely manner, and as prescribed. The DON supervises and directs all personnel who administer medications and/or have related functions. Medications are administered in accordance with prescriber orders, including any required time frame. Medication administration times are determined by resident need and benefit, not staff convenience. Factors that are considered include enhancing optimal therapeutic effect of the medication, preventing potential medication or food interactions and honoring resident choices and preferences. Medications are administered within one hour of their prescribed time, unless otherwise specified. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44309<br><br>Based on observation, interview, and record review, the facility failed to ensure:<br><br>1. Drugs and biologicals were stored in accordance with accepted professional principals when an expired first aid kit (a portable collection of supplies and equipment designed to provide immediate medical assistance for minor injuries and emergencies) was not removed and disposed of from the only Medication Storage Room inspected during the investigation of medication storage and labeling.<br><br>This deficient practice had the potential for the use of less effective medications or supplies which may not produce the expected results.<br><br>2. Medication cart was locked while the medication cart was left unattended for one of two sampled medication carts (Covid Unit Cart)<br><br>This deficient practice had the potential for unsafe nursing practices and unauthorized entry to the medication cart, which could result in a negative impact to the health, and well-being of residents and increases the risk of contamination.<br><br>Findings:<br><br>1. During a medication storage room inspection and observation, on 4/26/2025 at 11:19 a.m., and a concurrent interview with Registered Nurse 1 (RN 1), an expired first aid kit was observed stored on the shelf. The first aid kit expiration date was 9/3/2024. RN 1 confirmed that the observed first aid kit expired on 9/3/2024. RN 1 stated that licensed staff are required to immediately remove all expired items from the medication storage room. RN 1 stated that the potential outcome of using expired medical supplies is reduced effectiveness of the medications and supplies whiuch could lead to inadequate treatment.<br><br>During an interview on 4/27/2025 at 6:15 p.m., with Director of Nursing (DON), the DON stated licensed nurses are required to inspect the medication storage room during every shift and remove the expired medications and supplies and replace them. The DON stated there was an expired first aid kit present inside the medication storage room. The DON stated the potential outcome of not disposing expired medication and supplies from the medication storage room is the administration and use of less effective medication or supply which may not produce the expected result.<br><br>During a review of the facility`s Policy and Procedure (P&P) titled Medication Storage in The Facility, last reviewed 3/12/2025, the P&P indicated that medications and biologicals are stored safely, securely, and properly, following manufacturer`s recommendations or those of the supplier. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy if a current order exists. Medication storage area and kept clean, well-lit and free of clutter and extreme temperatures. Medication storage conditions are monitored on a routine basis and corrective actions are taken if problems are identified.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 39550<br><br>2. During an observation on 4/25/2025 at 7:39 p.m., observed Medication Cart A parked between room [ROOM NUMBER] and room [ROOM NUMBER], unlocked, and unattended. Observed facility staff walking by the unlocked medication cart.<br><br>During an interview on 4/25/2025 at 7:41 p.m., with Licensed Vocational Nurse 3 (LVN 3), LVN 3 stated that she left Medication Cart A unlocked to go to the physician's lounge to grab a binder. LVN 3 stated that she did not forget to lock the medication cart and that LVN 3 didn't lock it because LVN 3 was coming back. LVN 3stated that the medication cart should always be locked for safety and so unauthorized staff and residents do not open the cart and access medications.<br><br>During an interview on 4/27/2025 at 1:42 p.m., with the Assistant Director of Nursing (ADON), the ADON stated that medications carts should always be kept locked when the nurses are away from the medication cart for safety.<br><br>During a review of the facility's policy and procedure titled, Medication Storage in the Facility, reviewed 3/12/2025, the policy indicated medications and biologicals are stored safely, securely and properly following manufacturers recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized. Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access. |

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| F 0813<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Have a policy regarding use and storage of foods brought to residents by family and other visitors.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38469<br><br>Based on observation, interview, and record review, the facility failed to ensure leftover food brought to residents by family and other visitors were labeled with resident identifier and use by date for two of two (Resident 50 and 82) sampled residents.<br><br>This deficient practice had the potential to result in foodborne illness (also called food poisoning, illness caused by eating contaminated food) among the residents.<br><br>Findings:<br><br>a. During a review of Resident 50's Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE], with diagnoses including muscle chronic kidney disease (a progressive and long-term decline in kidney function) and hypertension (high blood pressure).<br><br>During a review of Resident 50`s Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 2/19/2025, the MDS indicated the resident`s cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was intact. The MDS also indicated that the resident was independent with performing activities of daily living (ADLs - activities related to personal care).<br><br>During an observation and concurrent interview on 04/26/25 07:45 a.m., with Resident 50, inside Resident 50's room, observed two containers on the resident`s overbed table-one containing cooked plantains and the other one containing squid. Resident 50 stated her family member brought the food yesterday (4/25/2025). The containers were not labeled with use by date and resident identifier.<br><br>During a concurrent observation and interview on 4/26/2025 at 08:05 a.m., with Registered Nurse 1 (RN 1), reviewed the facility's policy on food brought by family or visitors. RN 1 stated that residents are allowed to consume food brought by family or visitors as long as it`s consistent with the diet order. RN 1 stated that when a visitor or family member brings food to the resident, the facility staff will ensure that any leftover food are placed in the refrigerator and labeled with the resident`s name and use by date. RN 1 stated that left-over food should be refrigerated to prevent spoilage and reduce the risk of food borne illness. RN 1 stated Resident 50's left over food in the containers were not labeled with use by date and the resident's name.<br><br>During a review of the facility`s policy and procedure (PP) titled Food Brought by Family/Visitors, last reviewed on March 12, 2025, the PP indicated that food brought to the facility by visitors and family is permitted. Facility staff will strive to balance a resident choice and a homelike environment with the nutritional and safety needs of the residents .food brought by family/visitors that is left with the resident to consume later is labeled and stored in a manner that is clearly distinguishable from facility-prepared food .the nursing staff will discard perishable foods on or before the use by date .<br><br>b. During a review of Resident 82's Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE], with diagnoses including muscle chronic kidney disease (a progressive and long-term decline in kidney function) and hypertension (high blood pressure).<br><br>(continued on next page) |

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| F 0813<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of Resident 82`s Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 1/15/2025, the MDS indicated the resident`s cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was intact. The MDS also indicated that the resident required assistance with performing activities of daily living (ADLs - activities related to personal care).<br><br>During an observation and interview on 04/26/25 at 08:38 a.m., with Resident 82 inside Resident 82's room, observed on the overbed table a box of pizza containing one slice of pizza. Resident 82 stated that a friend brought the pizza yesterday (4/25/2025).<br><br>During a concurrent interview and record review on 4/26/2025 at 8:42 a.m., with Registered Nurse 1 (RN 1), reviewed facility's policy on food brought by family or visitors from home. RN1 stated that any left-over food from outside will be refrigerated and labeled with the resident name and use by date. RN 1 stated that if food is left at the bedside longer than 2 hours, the food can become spoiled and contaminated, leading to foodborne illnesses. RN 1 stated the left over pizza should have been refrigerated and labeled with use by date and the resident's name.<br><br>During a review of the facility`s policy and procedure (PP) titled Food Brought by Family/Visitors, last reviewed on March 12, 2025, the PP indicated that food brought to the facility by visitors and family is permitted. Facility staff will strive to balance a resident choice and a homelike environment with the nutritional and safety needs of the residents .food brought by family/visitors that is left with the resident to consume later is labeled and stored in a manner that is clearly distinguishable from facility-prepared food .the nursing staff will discard perishable foods on or before the use by date . |

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| | 055142 | A. Building<br>B. Wing | 04/27/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Magnolia Gardens Convalescent Hospital | 17922 San Fernando Mission Rd<br>Granada Hills, CA 91344 |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47883<br><br>Based on observation, interview, and record review, the facility failed to maintain infection control practices by failing to:<br><br>1. Ensure Treatment Nurse 1 (TN 1) removed their isolation gown (type of personal protective equipment [PPE- specialized clothing or equipment worn by an employee for protection against infectious materials] used in healthcare settings to protect healthcare personnel from the spread of infection or illness, particularly from contact with blood and body fluids) prior to leaving a resident's room who was on enhanced barrier precautions (EBP -a set of infection control practices that use PPE to reduce the spread of multidrug-resistant organisms [MDROs -microorganisms that are resistant to multiple classes of antibiotics and antifungals] in nursing homes) for one of 13 sampled residents (Resident 86).<br><br>2. Ensure a trashcan was provided to doff (take off) PPE inside a resident's room who was under droplet isolation (used to prevent the spread of pathogens that are passed through respiratory secretions) for one of 28 sampled residents (Resident 7).<br><br>These deficient practices had the potential to increase the risk of spreading infection to other residents.<br><br>3. Ensure a resident's nasal cannula (NC- a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) oxygen tubing was not touching the floor for one of three sampled residents (Resident 56).<br><br>This deficient practice had the potential to result in contamination of the resident's care equipment and risk of transmission of bacteria that can lead to infection.<br><br>4. Ensure a resident's urinal (a container used to collect urine) was labeled with the resident's identifier for two of two sampled residents (Residents 14 and 82).<br><br>This deficient practice had the potential to cause cross contamination if the urinal bottle is accidentally switched between residents.<br><br>5. Ensure staff wore full PPE when entering a room on transmission-based precaution (TBP-specific infection control practices used in healthcare settings to prevent the spread of infections that are transmitted through contact, airborne, or droplet routes) where residents were identified as exposed to coronavirus disease -2019 (COVID-19, a highly contagious viral infection that can trigger respiratory tract infection) for one out of seven rooms on TBP.<br><br>This deficient practice had the potential to cause cross contamination and increase the risk of spreading infection to 30 out of 98 residents who were not on TBP.<br><br>Findings:<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 1. During a review of Resident 86's Admission Record, the Admission Record indicated the facility admitted the resident on 1/19/2025 and readmitted the resident 2/25/2025 with diagnoses that included gangrene (the death of body tissue, typically due to a lack of blood flow), pressure ulcer (injury to the skin and underlying tissue resulting from prolonged pressure) of sacral region (bottom of the spine), stage four (a full thickness tissue loss with exposed bone and tendon), and diabetes type two (2) (a chronic condition that affects the way the body processes blood glucose [sugar]).<br><br>During a review of Resident 86's Minimum Data Set (MDS, a resident assessment tool), dated 3/3/2025, the MDS indicated Resident 86 had severe impaired cognition (mental abilities, including remembering things, making decisions, concentrating, or learning). The MDS indicated Resident 86 was dependent (helper does all the effort) on staff for toileting hygiene, shower, dressing, and bed mobility.<br><br>During a review of Resident 86's physician orders, the physician orders indicated an order for EBP due to: sacrococcyx (pertaining to both the sacrum [triangular bone located in the lower back] and coccyx [tailbone]) pressure sore, dated 3/26/2025.<br><br>During a concurrent observation and interview on 4/27/2025 at 12:12 p.m., with Treatment Nurse 1 (TN 1), observed TN 1 providing wound care to Resident 86. TN 1 removed gloves, washed hands, and exited Resident 86's room while still wearing an isolation gown. When asked why TN 1 was still wearing the isolation gown after exiting Resident 86's room on EBP precautions, TN 1 stated TN 1 should have removed the isolation gown before exiting the room. TN 1 stated it is important to follow EBP guidelines to prevent the spread of infection.<br><br>During an interview on 4/27/2025 at 1:50 p.m., with the Infection Preventionist (IP), the IP stated when staff are providing care for residents who are on EBP, the practice is to remove the isolation gown before leaving a resident's room. The IP stated TN 1 should have removed the gown before exiting Resident 86's room. The IP stated this was important to prevent the spread of infection.<br><br>During an interview on 4/27/2025 at 5:33 p.m., with the Director of Nursing (DON), the DON stated when staff are providing care for residents who are on EBP, the practice is to remove the isolation gown before leaving a resident's room. The DON stated TN 1 should have removed the gown before exiting Resident 86's room. The DON stated this was important to prevent the spread of infection.<br><br>During a review of the facility's policy titled, Infection Prevention and Control Program, with review date of 3/12/2025, the policy indicated the facility an infection prevention and control program has been established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>2. During a review of Resident 7's Admission Record, the Admission Record indicated the facility admitted the resident on 10/15/2007 and readmitted the resident on 1/22/2024 with diagnoses that included heart failure (when heart muscle cannot pump enough blood to meet the body's needs), chronic obstructive pulmonary disease (a group of diseases that cause airflow blockage and breathing-related problems), and major depression (a mood disorder that causes a persistent feeling of sadness and loss of interest).<br><br>During a review of Resident 7's MDS dated [DATE], the MDS indicated Resident 7 had intact cognition. The MDS indicated Resident 7 was dependent (helper does all the effort) on staff for toileting hygiene and shower, and required moderate assistance with dressing and bed mobility.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of Resident 7's physician orders, the physician's orders indicated an order for droplet precautions due to COVID-19 exposure, dated 4/20/2025.<br><br>During an observation on 4/25/2025 at 8:02 p.m., observed Resident 7's room with signage that indicated Resident 7 was on droplet isolation due to exposure to COVID-19.<br><br>During an observation on 4/25/2025 at 8:10 p.m., inside Resident 7's room, the surveyor was inside the resident's room wearing PPE and was attempting to doff and exit the room. However, there was no trashcan inside Resident 7's room to discard the PPE.<br><br>During a concurrent observation and interview on 4/25/2025 at 8:12 p.m., the Director of Social Service (DSS) observed the surveyor inside Resident 7's room wearing an isolation gown and gloves and unable to doff because there was no trashcan available. The DSS stated that there is a sign for airborne/droplet precaution at Resident 7's door, and a closed lid trash can is required to be present inside the room for staff to be able to doff their PPE.<br><br>During an interview on 4/27/2025 at 1:50 p.m., with the IP, the IP stated when staff are providing care for residents who are on airborne/droplet isolation, the practice is to remove the isolation gown before leaving a resident's room. The IP stated the potential outcome of not providing a trashcan inside Resident 7's room under airborne/droplet isolation is the possibility of the staff exiting the room while having their isolation gown and gloves on and spreading infection to other staff members and residents. The IP stated this was important to prevent the spread of infection.<br><br>During an interview on 4/27/2025 at 5:33 p.m., with the DON, the DON stated the potential outcome of not providing a trashcan inside Resident 7's room under airborne/droplet isolation is the possibility of the staff exiting the room while having their isolation gown and gloves on and spreading infection to other staff members and residents. The DON stated this was important to prevent the spread of infection.<br><br>During a review of the facility's policy and procedure titled, Infection Prevention and Control Program, revised 3/12/2025, the policy indicated an infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infection.<br><br>44309<br><br>3. During a review of Resident 56's Admission Record, the Admission Record indicated that the facility admitted the resident on 11/22/2024 with diagnoses including Parkinsonism (an umbrella term that refers to brain conditions that cause slowed movements, rigidity [stiffness], and tremors [involuntary shaking or moving]), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and hypertension (high blood pressure [the force of the blood pushing on the blood vessel walls is too high]).<br><br>During a review of Resident 56's MDS dated [DATE], the MDS indicated the resident's cognitive skills for daily decision making was intact. The MDS indicated that Resident 56 required staff partial/moderate assistance (helper does less than half the effort) for lower body dressing. The MDS further indicated that Resident 56 was receiving oxygen therapy while a resident in the facility.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of Resident 56's Order Summary Report dated 3/14/2025, the Order Summary Report indicated an order to administer oxygen at two (2) liters per minute (LPM- unit of measurement for oxygen) via nasal cannula as needed for shortness of breath (SOB).<br><br>During a concurrent observation and interview on 4/26/2025 at 12:37 p.m., with Certified Nursing Assistant 2 (CNA 2), inside Resident 56's room, Resident 56 was observed laying on his bed not using oxygen. Resident 56's nasal cannula oxygen tubing was observed on the floor. CNA 2 stated that Resident 56's nasal cannula oxygen tubing was on the floor. CNA 2 stated the nasal cannula oxygen tubing is contaminated and could potentially introduce bacteria to Resident 56 which can lead to infection. CNA 2 immediately discarded Resident 56's nasal cannula oxygen tubing.<br><br>During an interview on 4/27/2025 at 6:11 p.m., with the DON, the DON stated that residents' nasal cannula oxygen tubing should not touch the floor to prevent contamination and can lead to infection. The DON stated oxygen tubing that is not used by a resident, should be placed in a clean bag to prevent infection.<br><br>During a review of the Centers for Disease Control and Prevention (CDC, national public health agency) source material titled, Guidelines for Environmental Infection Control in Health-Care Facilities, updated 7/2019, the document indicated floors can become rapidly contaminated from airborne microorganisms and those transferred from shoes, equipment wheels, and body substances.<br><br>38469<br><br>4.a. During a review of Resident 14's Admission Record, the Admission Record indicated the resident was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life) and overactive bladder (a problem with bladder function that causes the sudden need to urinate).<br><br>During a review of Resident 14's MDS, dated [DATE], the MDS indicated the resident`s cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was intact. The MDS also indicated that the resident required supervision with performing activities of daily living (ADLs - activities related to personal care).<br><br>During an observation and interview on 4/26/2025 at 7:59 a.m., inside Resident 14's room, observed a plastic urinal bottle with no label hanging in Resident 14`s bed side rails. Resident 14 stated he uses a urinal, and staff will empty it when they are in the room.<br><br>During a concurrent observation and interview on 4/26/25 at 8:38 a.m., with Registered Nurse 1 (RN1), inside Resident 14's room, RN 1 stated that urinal is provided to residents who can use it. RN 1 stated Resident 14's urinal should have been labeled with the resident's initials and room and bed number to prevent the urinal from being used by another resident. RN 1 stated that if the urinal was accidentally used by another resident, it could result in cross contamination and spread of infection.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of the facility`s policy and procedure (PP) titled Giving and Removing Urinal, last reviewed on 3/12/2025, the PP indicated an objective to provide resident with a container for urine and label urinal as indicated .<br><br>4.b. During a review of Resident 82's Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE], with diagnoses including muscle chronic kidney disease (a progressive and long-term decline in kidney function) and urinary tract infection (UTI- an illness in any part of the urinary tract, the system of organs that makes urine).<br><br>During a review of Resident 82`s Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 1/15/2025, the MDS indicated the resident`s cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was intact. The MDS also indicated that the resident required assistance with performing activities of daily living (ADLs - activities related to personal care).<br><br>During an observation and interview on 4/26/2025 at 7:59 a.m., inside Resident 82's room, observed a plastic urinal bottle with no label on top of Resident 82`s bedside table. Resident 82 stated he uses urinal, and staff will empty it when they are in the room.<br><br>During an observation and interview on 4/26/25 at 8:38 a.m., with Registered Nurse 1 (RN 1) RN 1 stated that urinal is provided to the residents who can use it. RN 1 verified that Resident 82's urinal was no labeled with the resident's initial, room and bed number. RN 1 stated Resident 82's urinal should have been labeled with the resident's initials, room and bed number to prevent the urinal from being used by another resident. RN 1 stated that if the urinal was accidentally used by another resident, it could result in cross contamination and spread of infection.<br><br>During a review of the facility`s policy and procedure (PP) titled Giving and Removing Urinal, last reviewed on 3/12/2025, the PP indicated an objective to provide resident with a container for urine and label urinal as indicated .<br><br>5. During an observation on 4/26/25 at 8:57 a.m., observed Certified Nurse Assistant 1 (CNA 1) enter room [ROOM NUMBER] (RM 1- with four residents) with a sign outside the room indicating respiratory precautions and requiring staff to wear PPE (includes gown, gloves, face shields, goggles, facemasks, respirators, and other equipment to protect front-line workers from injury, infection, or illness), without wearing a gown.<br><br>During an interview on 4/26/25 at 9:12 a.m., with the Infection Preventionist Nurse (IPN), the IPN stated that the residents in RM 1 were placed on respiratory droplet precautions following exposure to COVID-19. The IPN stated that everyone who enters the room must wear full PPE including gown to prevent the risk of spreading the infection to other residents and staff.<br><br>During an interview on 4/26/25 at 3:40 p.m., with CNA 1, CNA 1 stated she should have worn a gown when she entered the room on respiratory precautions to protect herself and other residents from getting and spreading the infection.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of the facility's policy and procedure (PP) titled, Isolation- Transmission-Based Precautions [TBP], last reviewed on 3/12/2025, the PP indicated, Transmission-based precautions are initiated when a resident develop signs and symptoms of a transmissible infection; arrives in the facility with symptoms of an infection; or has a laboratory confirmed infection; and is at risk of transmitting the infection to other resident . TBP may include contact precautions, droplet precautions, or airborne precautions .when TBP are implemented, the infection preventionist or designee clearly identifies the type of precautions, the anticipated duration, and the personal protective equipment (PPE) that must be used . |

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| F 0912<br><br>Level of Harm - Potential for minimal harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47883<br><br>Based on observation, interview, and record review, the facility failed to provide at least 80 square (sq.) feet (ft.) per resident for 26 of 40 multiple resident rooms (room [ROOM NUMBER], 103, 105, 106, 107, 108, 109, 110, 111, 112, 114, 115, 116,117,118,119,120123,126,133,136,137,138,139,140,141)<br><br>This deficient practice had the potential to result in inadequate space to provide safe nursing care and privacy for the residents.<br><br>Findings:<br><br>During the recertification survey from 4/25/2025 to 4/27/2025 the residents residing in the rooms with an application for room variance were observed with sufficient amount of space for residents to move freely inside the rooms. There was adequate room for the operation and use of wheelchairs, walkers, or canes. The room variance did not affect the care and services provided by nursing staff for the residents.<br><br>The Administrator submitted an application for the Room Variance Waiver, dated 4/25/2025, for 26 residents' rooms. The room waiver request indicated the following:<br><br>Room No. Square Footage Bed Capacity Sq Ft per Resident<br><br>102 156 2 78<br><br>103 156 2 78<br><br>105 156 2 78<br><br>106 156 2 78<br><br>107 156 2 78<br><br>108 156 2 78<br><br>109 316 4 79<br><br>110 156 2 78<br><br>111 156 2 78<br><br>112 156 2 78<br><br>114 156 2 78<br><br>(continued on next page) |

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| F 0912<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | 115 288 4 72<br><br>116 156 4 78<br><br>117 156 4 78<br><br>118 156 4 78<br><br>119 157 2 78.50<br><br>120 312 4 78<br><br>123 311 3 77.75<br><br>126 226 3 75.33<br><br>133 313 4 78.25<br><br>136 313 4 78.25<br><br>137 313 4 78.25<br><br>138 313 4 78.25<br><br>139 313 4 78.25<br><br>140 155 2 77.50<br><br>141 158 2 79<br><br>The minimum requirement for a 2-bed room should be at least 160 sq. ft. The minimum requirement for 4 -bed room should be at least 360 sq. ft.<br><br>During a review of the room waiver letter dated 1/12/2025, the letter indicated, The rooms are in accordance with the special needs of the resident and would not have an adverse effect on the resident health and safety, or impede the ability of any resident in the rooms to attain his or her highest practicable well-being. Each room has adequate space for each patient with his/her own closet space, over bed table and nightstand. Cubicle curtains are hung at each bedside, giving each patient privacy when pulled closed. The rooms are also equipped with a call light for each patient. There is adequate space for moving around in the rooms for both ambulatory and non-ambulatory patients and adequate space for wheelchair accessibility and medication carts to provide care.<br><br>During a resident council group interview on 4/26/2026 at 10:28 a.m. residents stated they do not have any problem physically getting around their room. The residents stated their nurses were able to provide them with good care and privacy.<br><br>(continued on next page) |

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| F 0912<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | During multiple room observations conducted in Rooms 101, 103, 105, 110, 112, 115, 117, 119 and 141 from 4/25/2025 to 4/27/2025, between the hours of 7:30 a.m. - 9 p.m., it was observed the that nursing staff had adequate space to provide care to the residents, and that each resident was provided privacy curtains for privacy; and the rooms had two modes of egress, one with direct access to the corridors and another leading to the outside of the building.<br><br>During an interview on 4/27/2025 at 12:12 p.m., with Resident 86, the resident verbalized the room afforded him adequate space to accommodate their needs and staff were able to provide care safely and without restrictions.<br><br>During a review of the facility's policy and procedure titled, Bedrooms, last reviewed 3/12/2025, the policy and procedure indicated :All residents are provided with clean, comfortable and safe bedrooms that meet federal and state requirements . Bedrooms measure at least measure at least 80 square feet of space per resident in double resident bedrooms, and at least 100 square feet of space in a single resident room. |