STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055153	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER: Montebello Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1035 W Beverly Blvd Montebello, CA 90640	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44636 Based on observation, interview and record review, the facility staff failed to ensure one (1) of 22 sampled residents (Resident 18) was cared for in a dignified way by failing to sit and be at eye level while feeding Resident 18 on 4/22/2024. This failure had the potential to negatively affect Resident 18's dignity and self-worth. Findings: A review of Resident 18's Admission Record, indicated Resident 18 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including, but not limited to Parkinson's disease (a condition that causes nerve damage in the brain that affects, speech and movement) and dementia (the loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities). A review of Resident 18's Physician's Orders, dated 3/30/2023, indicated the resident should receive a regular dysphagia (difficulty swallowing foods or liquids) puree (a smooth, creamy substance) texture, thick liquids- nectar consistency (a liquid slightly thicker than water) double portions as ordered. A review of Resident 18's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 3/21/2024, indicated Resident 18 was severely impaired with cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. Resident 18 was dependent (helper does all of the effort. Resident does none of the effort to complete the activity or the assistance of 2 or more helpers is requires for the resident to complete the activity) on staff to help with feeding. During a concurrent observation and interview on 4/22/2024 at 12:27 PM with Certified Nursing Assistant 1 (CNA1) and Infection Preventionist Nurse (IPN) in Resident 18's room, CNA 1 was standing and leaning in front of Resident 18, while feeding the resident in a wheelchair. IPN stated it is important to sit while feeding the resident to make sure nothing is being pushed down the resident's mouth and to be at eye level. During an interview on 4/25/2024 at 8:22 AM with Restorative Nursing Assistant (RNA), RNA stated staff should sit down while feeding the resident to provide dignity. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055153	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/25/2024

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Montebello Care Center	1035 W Beverly Blvd Montebello, CA 90640

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/25/2024 at 10:52 AM with the Director of Nursing (DON), the DON stated the resident should be fed at eye level to show respect and dignity. A review of the facility's Policy and Procedure titled, Quality of Life-Dignity, revised in February 2020, 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, feeling of self-worth and self-esteem. and Residents are treated with dignity and respect at all times.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42223 Based on observation, interview, and record review, the facility failed to ensure the call light was within reach for two of 22 sample residents (Resident 94 and 24). This deficient practice had the potential for a delay in necessary care and services for Resident 94 and 24. Findings: 1. A review of Resident 94's Admission Record indicated resident was admitted on [DATE] with the following diagnosis of hemiplegia (paralysis on one side of the body) affecting the right dominant side and muscle weakness. A review of Resident 94's History and Physical (H&P), dated 3/9/2024, indicated resident does not have the capacity to understand and make decisions. A review of Resident 94's Minimum Data Set (MDS), dated [DATE], indicated resident is moderately impaired in cognitive skills (ability to understand and make decision) for daily decision making. The MDS also indicated resident required substantial/maximal assistance (helper does more than half the effort. Helper lifts or hold trunk or limbs and provides more than half the effort) with eating, oral hygiene, and personal hygiene. Resident 94's is dependent (helper does all of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) with toileting hygiene, shower/bath self, upper body dressing, lower body dressing and putting on/taking off footwear. A review of Resident 94's Occupational Therapy (OT) Evaluation, dated 3/6/2024, indicated resident's right elbow/ forearm can flex up to 45 degrees, right shoulder flex 0 degrees, and right wrist flex 0 degrees. OT evaluation also indicated resident's right upper extremity strength is impaired. During an observation on 4/22/2024 at 11:40 AM, Resident 94 was observed with a call light placed on the bed beside of the resident's right shoulder. During an interview on 4/24/2024 at 8:14 AM, Director of Staff Development (DSD) stated resident is unable to move her right arm since admission. During an interview on 4/24/2024 at 8:27 AM, Physical Therapy (PT) stated Resident 94's right elbow can only move 45 degrees actively (the space in which you move a part of your body by using your muscles). During an interview on 4/24/2024 at 8:39 AM, DSD stated the call light is not within Resident 94's reach and it is too high for the resident to reach. DSD also stated it is not okay because the resident is unable to use the call light to call facility staff in case of an emergency. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/29/2024 at 10:45 AM, the Director of Nursing (DON) stated it is not okay for the call light to not be within Resident 94's reach because the facility needs to make sure the resident's needs are promptly met or if the resident were to have an emergency. A review of the facility's Policy and Procedure titled Answering the Call Light, revised 9/2022, indicated to ensure that the call light is accessible to the resident when in bed, from the toilet, form the shower or bathing facility and from the floor. 48143 Findings: 1.b. A review of Resident 24's Admission Record indicated Resident 24 was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included history of fall, history of transient ischemic attack (a temporary disruption in the blood supply to part of the brain), generalized muscle weakness, and other lack of coordination. During a review of Resident 24's Minimum Data Set (MDS- a comprehensive assessment and screening tool) dated 2/20/2024, the MDS indicated Resident 24 was unable to follow commands, and required maximum assistance with the toilet, personal hygiene, change of position and transfer. A review of Resident 24's care plan titled At risk for falls, injury related due to fall related to impaired safety judgment, impaired gait and mobility weakness dated 10/25/2021, revised on 02/20/2024, indicated Resident 24 required assist with transfer and mobility as needed (PRN) and Resident 24 also required monitoring of fall. The care plan indicated interventions included Certified Nurse Assistant (CNA) to remind resident to use call light when attempting to ambulate or transfer, CNA will make sure Resident 24's call light is placed within reach while in bed or proximity to the bed. During a concurrent interview and observation on 4/22/2024 at 8:00 AM, in the Resident 24's room, Resident 24 was observed resting in bed and tried to get up to her right-side of the bed and she was asking for help and there was no CNA present. During the observation, Resident 24's call light device was out of the resident's reach and was placed on the floor near the middle of the headboard closed to the wall. Resident 24 stated she was not able to find her call light device. Resident 24 stated she needed help to get up from her bed. During an interview on 4/22/2024 at 08:03 AM with CNA 6 (assigned to Resident 24 on 4/22/2024 during the 7 AM to 3 PM), CNA6 stated the call light should have been placed on Resident 24's bed close to the resident for easy reach, so that the resident is able to get service in a timely manner. CNA 6 also stated this way, Resident 24 can be prevented from having another fall. During an interview on 4/22/2024 at 10:31 AM with Licensed Vocational Nurse (LVN) 8, LVN 8 stated the call light should have been on Resident 24's bed close to the resident for easy reach. LVN 8 stated it is important to ensure the call light was withing the resident's reach so that Resident 24 can get service in a timely manner and can prevent resident from another fall incident. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure titled Answering the call light revised September 2022, indicated each resident is provided with a means to call staff directly for assistance from his/her bed and the purpose of the call system is to ensure timely responses to the resident's requests and needs. The policy also indicated, ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower, bathing facility and from the floor.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42223 Based on observation, interview, and record review, the facility failed to ensure one of five (5) sampled Residents (Resident 107) was given information to formulate an advance directive (written statement of a resident's wishes regarding medical treatment, often including a living will, made to ensure those wishes are carried out should the resident be unable to communicate them to the doctor). This deficient practice had the potential to cause conflict in carrying out the Resident 107's wishes for medical treatment and health care decisions. Findings: A review of Resident 107 Admission Record indicated resident was admitted on [DATE] with the following diagnoses of arthritis (joint inflammation) and sciatica (pain, weakness, numbness, or tingling in the leg). A review of Resident 107's History and Physical (H&P), dated 4/5/2024, indicated resident has the capacity to understand and make decisions. A review of Resident 107's Minimum Data Set (MDS, a standardized care screening and assessment tool), dated 4/8/2024, indicated resident had an intact cognitive (ability to understand and make decision) skills for daily decision making. MDS also indicated Resident 107 required set up or clean up assistance (helper sets up or cleans up; resident completes the activity. Helper assists only prior to or following the activity) with eating, oral hygiene, toileting hygiene and personal hygiene. Resident 107 required substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with shower/bathe self and upper body dressing. During a record review on 4/23/2024 at 12:07 PM, there was no advance directive noted in the chart. Resident 107's Physician Orders for Life Sustaining Treatment (POLST, form is a written medical order form a physician that give people more control over their own care by specifying the types of medical treatment they want during serious illness) was noted with advance directive box unchecked. During a concurrent interview and record review of Resident 107 POLST on 4/24/2024 at 11:41 AM, Administrator (ADM) and Assistant Administrator (AADM) stated the Social Services Director (SSD) was not supposed to put a check mark on the No Advance Directive box on Section D. ADM also stated SSD needs to confirm if the resident has an advance directive or not before adding the check mark; and if not, the SSD should provide the resident an option to formulate an advance directive. ADM also stated it should be done at the time of admission. ADM stated there was no documented evidence that the resident was given an option to formulate an advance directive. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Policy and Procedure titled, Advanced Directive, dated 3/23/2022, indicated at the time of admission, admission staff or designee will inquire about the existence of an Advance Directive. Policy also indicated the facility will honor resident's Advance Directive and will provide information but if no Advance Directive exist then the facility provides the resident with an opportunity to complete one.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44636 Based on interview and record review, the facility failed to notify the resident's physician/ medical doctor (MD) when there was a delay in discharging one (1) of 22 sampled residents (Resident 108) to home from 3/8/2024 to 3/9/2024. This deficient practice had the potential to result in an unsafe discharge. Findings: A review of Resident 108's Admission Record indicated Resident 108 was admitted to the facility on [DATE], with diagnoses of generalized osteoarthritis (the cartilage within a joint begin to break down and the underlying bone begins to change causing reduced function and disability), syncope (fainting) and collapse, and history of falling. A review of the Resident 108's Physician Order Summary Report, dated 2/29/2024, indicated Resident 108's last covered day (LCD, the last day insurance company pays for in full or in part) on 3/7/2024 and discharge home on 3/8/2024. A review of Resident 108's Minimum Data Set (MDS, a comprehensive standardized assessment and screening tool), dated 3/1/2024, indicated Resident 108's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making were intact. The MDS indicated Resident 108 required partial/moderate assistance (helper does less than half the effort) with shower/bathe, lower body dressing, chair/bed-chair transfer, toilet transfer, and walking ten feet. A review of Resident 108's Change of Condition (COC, tool used by health care professionals when communicating about critical changes in a resident's status), dated 3/7/2024, indicated Resident 108 was found in kneeling position next to foot of bed on right side. Resident 108 stated she tried to go to the restroom by herself and lost footing. A review of Resident 108's Nursing Notes, dated 3/8/2024, indicated to discharge Resident 108 home on 3/9/2024, Saturday. A review of Resident 108's Nursing Notes, dated 3/9/2024, indicated Resident 108 was discharged home. A review of Resident 108's Physician Progress Notes (PPN), dated 3/9/2024, indicated the Medical Doctor (MD) came to see Resident 108 but was Resident 108 was discharged today (3/9/2024). MD was not able to see the resident. PPN indicated MD had to check Resident 108's records since MD was notified Resident 108 had a fall on 3/7/2024 at 5:30 AM and was waiting for X-Ray (an imaging study that takes pictures of bones and soft tissues) reports after the fall. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/25/2024 at 3:19 PM with Registered Nurse 1 (RN 1), RN 1 stated when residents' insurance had a last covered day, the doctor would be notified of the LCD, and the doctor would order for the resident to be discharged at a later date. RN 1 stated if a resident was not discharged home on the day of the discharge in accordance with the physician's order, the nurse need to notify the MD. RN 1 stated an order for discharge would be obtained if the resident were to be discharged on a different day. During a concurrent interview and record review of Resident 108's medical records on 4/25/2024 at 3:24 PM with RN 2, RN 2 stated MD ordered for Resident 108 to be discharged on [DATE]. RN 2 stated Resident 108 was not discharged on [DATE]. RN 2 stated Resident 108 was discharged on [DATE], which was not what the MD had ordered. During a concurrent interview and record review of Resident 108's medical records on 4/25/2024 at 3:56 PM with the Director of Nursing (DON), the DON stated Resident 108 was discharged from the facility on 3/9/2024. The DON stated Resident 108 had an order to be discharged on [DATE] which was placed on 2/29/2024. The DON stated the doctor needed to be notified and an order received to discharge Resident 108 on 3/9/2024. The DON stated, according to the COC report, Resident 108 had a fall on 3/7/2024 (two days prior to being discharged) and according to the PPN, it did not seem that MD was aware that Resident 108 was discharged home when the MD came to the facility on [DATE]. A review of the facility's Policy and Procedure titled, Notification of Change in Condition, dated 8/25/2021, indicated physicians are informed of changes in the resident's condition. The facility must immediately consult with the resident's physician and/or Nurse Practitioner (NP) where there is a decision to discharge the resident from the center. When making notification of above, the facility must ensure that all pertinent information is available and provided upon request to the physician and/or NP. A review of the facility's Policy and Procedure titled, Transfer and Discharge, dated 3/23/2022, indicated the Interdisciplinary Team (IDT, group of healthcare professionals from diverse fields who work in a coordinated manner toward a common goal for the resident) and the Attending Physician will determine that the resident may be appropriate for discharge.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0641

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Ensure each resident receives an accurate assessment.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 42223

Based on observation, interview, and record review, the facility failed to ensure the Minimum Data Set (MDS, an assessment and care screening tool) accurately reflected the status of two (2) of 2 sampled residents (Residents 77 and 31) by failing to:

1. Resident 77 did not have an accurate assessment for falls.

2. Resident 31 did not have an accurate assessment for restorative nursing program (a program that helps residents maintain any progress made during therapy treatments, enabling them to achieve their highest practicable level of functioning) received.

This deficient practice had the potential for the facility to not develop and implement an individualized care plan, which could negatively affect Resident 77 and 31's overall well-being.

Findings:

1. A review of Resident 77's Admission Record, indicated resident was originally admitted on [DATE] with the following diagnoses of muscle weakness and dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities).

A review of Resident 77's History and Physical, dated 10/11/2023, indicated resident does not have the capacity to understand and make decisions.

A review of Resident 77's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 2/8/2024, indicated resident is severely impaired (never/rarely made decisions) with cognitive (mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making. MDS indicated resident required partial/moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with eating, oral hygiene, and personal hygiene. Resident required substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with upper and lower body dressing. Resident 77 was dependent (helper does all of the effort. Resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity) toileting hygiene, shower/bathe self and putting on/taking off footwear.

A review of Resident 77's Interdisciplinary Team (IDT, a group of healthcare professionals from complementary fields who work in tandem to treat a patient) fall, dated 6/12/2023, indicated resident had a fall incident on 6/8/2023.

A review of Resident 77's Progress Notes, dated 7/10/2023, timed at 7:03 PM, indicated resident had a Change of Condition (COC, a sudden clinically deviation from a resident's baseline in physical, cognitive, behavioral, or functional domains) for falls.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent record review of Resident 77's MDS, dated [DATE] and interview with the Director of Nursing (DON) on 4/25/2024 at 12:32 PM, the DON stated the MDS did not and should have accurately reflected Resident 77's fall of two or more falls since reentry on 5/28/2023 in accordance with the MDS. The DON also stated it was important that the MDS was accurate because this can affect the residents plan of care. A review of the facility's Policy and Procedure titled, Resident Assessments, revised 10/2023, indicated information in the MDS assessments will consistently reflect information in the progress notes, plans of care and resident observations/ interviews. 44636 2. Resident 31 did not have an accurate assessment for restorative nursing program (a program that helps residents maintain any progress made during therapy treatments, enabling them to achieve their highest practicable level of functioning) received. These deficient practices have the potential for the facility to not develop and implement an individualized care plan, which could negatively affect Resident 77 and 31's overall wellbeing. Findings: 2. A review of Resident 31's Admission Record indicated Resident 31 was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses of abnormal posture, contracture (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) of the right knee, and contracture of the left knee. A review of Resident 31's MDS, dated [DATE], indicated Resident 31's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making were intact. The MDS indicated Resident 31 was dependent (helper does all the effort) toileting hygiene, shower/bathe self, lower body dressing, putting on/taking off footwear, sit to lying, lying to sitting on bed, chair/bed-to-chair transfer, and tub/shower transfer. The MDS indicated Resident 31 had a functional limitation in range of motion on both lower extremities (LEs - hip, knee, ankle, and foot). The MDS indicated Resident 31 did not receive restorative nursing care. A review of Resident 31's Medication Review Report are as follows: a. Order dated 8/4/2024, Restorative Nurse Aide (RNA) order, passive range of motion (PROM, the range that can be achieved by external means such as another person or a device) on bilateral upper extremities (BUE - both arms from shoulder to hands) every day seven (7) times per week as tolerated. a. Order dated 2/21/2024, RNA PROM exercise on head and neck motion as tolerated five (5) times per week. b. Order dated 8/8/2023, RNA PROM exercise on both LEs as tolerated every date 5 times per week. c. Order dated 8/8/2023, RNA to apply cervical soft collar (a device used to support the neck and spine and limit neck movement) up to four (4) hours as tolerated 5 times per week. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. Order dated 8/8/2023, RNA to perform skin inspection on both LEs before and after orthotic (an artificial support brace for the limbs or spine) use, to report to charge nurse of any change in condition. A review of Resident 31's RNA Record for March and April 2024, indicated as follows: - BUE PROM every day 7 times per week as tolerated. - PROM on bilateral lower extremities (BLE - hips, knees, ankles, and feet) exercises as tolerated 5 times per week. - To apply bilateral LE Ankle Foot Orthosis (AFO, a brace that provides support to the foot and ankle) up to 4 hours as tolerated 5 times per week. - To perform skin inspection on BLE before and after orthotic use. - To perform PROM exercises head/neck as tolerated 5 times per week. - To apply cervical soft collar up to 4 hours as tolerated 5 times per week. A review of Resident 31's Care Plan, dated 8/8/2023, indicated Resident 31 was at risk to decline in lower extremity joint mobility and further develop contracture due to immobility. Staff interventions were to have the RNA apply bilateral LE AFO up to 4 hours or as tolerated every day 5 times per week, and the RNA to perform skin inspection on both LEs before and after orthotic use. A review of Resident 31's Care Plan, revised 1/15/2024, indicated Resident 31 was at risk for decreased ability to perform activities of daily living (ADLs - bathing grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting) related to: impaired balance, limited mobility, Parkinson's (progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movement), hyperlipidemia (a condition in which there are high levels of fat particles in the blood), depression (severe feelings on sadness and hopelessness), and psychosis (a mental disorder characterized by a disconnection from reality). Staff interventions included were for RNA to perform PROM to both LE 5 times per week as tolerated, RNA for PROM to BUE 7 times per week as tolerated, RNA for PROM BUE and BLE, RNA to apply AFO on BLE, RNA to apply AFO to BLE for 4 hours every day 5 times per week, RNA to apply cervical collar up to 4 hours as tolerated 5 times per week, and RNA to perform PROM exercises of head and neck as tolerated 5 times per week. During an observation on 4/22/2024 at 4:41 PM in the dining room, Resident 31 was sitting in her wheelchair with her head tilted to the left side. During an interview on 4/25/2024 at 8:14 AM with Resident 31, Resident 31 stated she received RNA services daily. During a concurrent interview and record review of Resident 31's RNA Record on 4/25/2024 at 8:22 AM with RNA 1, RNA 1 stated Resident 31 received RNA services and did not refuse RNA services. RNA 1 stated RNA services provided to Resident 31 took about 15 to 20 minutes. RNA 1 stated Resident 31 used AFOs on both sides of the LE and the AFOs were left on for 4 hours as tolerated. RNA 1 also stated Resident 31 had a cervical collar ordered for 4 hours as tolerated. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montebello Care Center	1035 W Beverly Blvd Montebello, CA 90640

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review of Resident 31's MDS on 4/25/2024 at 11:52 AM with the MDS Coordinator (MDSC), the MDSC stated she had not completed the Restorative Nursing Program Section for Resident 31 who received RNA services. The MDSC stated the RNA section of the MDS did not and should have reflected the RNA services the resident received. A review of the facility's Policy and Procedure titled, Resident Assessments, revised 10/2023, indicated information in the MDS assessments will consistently reflect information in the progress notes, plans of care and resident observations/interviews. A review of the Centers for Medicare and Medicaid Services' Long-Term Facility Assessment Instrument 3.0 User's Manual, dated 10/2023, indicated to code the time for activities provided by restorative nursing staff for range of motion (passive - movement performed without voluntary muscle contraction), range of motion (active - self movement of a joint by contracting your muscles), and splint or brace assistance.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42223 Based on interview and record review, the facility failed to revise the care plan for (one) 1 of 22 residents (Resident 77) who had multiple falls. This deficient practice has the potential for Resident 77 to have further falls, which could result in harm, hospitalization , and death. Findings: A review of Resident 77's Admission Record, indicated resident was originally admitted on [DATE] and was readmitted on [DATE] with the following diagnoses of muscle weakness and dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities. A review of Resident 77's History and Physical, dated 10/11/2023, indicated resident does not have the capacity to understand and make decisions. A review of Resident 77 Minimum Data Set (MDS; a standardized assessment and care screening tool), dated 2/8/2024, indicated resident is severely impaired (never/rarely made decisions) with cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. MDS indicated resident required partial/moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with eating, oral hygiene, and personal hygiene. Resident required substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with upper and lower body dressing. Resident 77 was dependent (helper does all of the effort. Resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity) toileting hygiene, shower/bathe self and putting on/taking off footwear. A review of Resident 77's Situation, Background, Assessment and Recommendation (SBAR, a structured communication framework that can help teams share information about the condition of the resident) Communication Form, dated 2/8/2023, indicated resident had a fall. A review of Resident 77's Interdisciplinary Team (IDT, a group of healthcare professionals from complementary fields who work in tandem to treat a resident) fall, dated 3/1/2023, indicated resident had a fall incident on 2/28/2023 when resident was trying to get up by himself from his wheelchair. A review of Resident 77's IDT fall, dated 5/22/2023, indicated resident had a fall incident on 5/19/2023 when resident was laying on the floor at the right side of the bed. A review of Resident 77's IDT fall, dated 6/12/2023, indicated resident had a fall incident on 6/8/2023 when resident was laying on the fall mat on the right side of the bed. A review of Resident 77's Progress Notes, dated 7/10/2023 at 7:03 PM, indicated resident had a COC for falls when resident was found on the floor on the left side of the bed. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 77's Progress Notes, dated 8/10/2023 at 4:30 PM, indicated resident had a COC for falls when resident tried to stand up from his wheelchair. A review of Resident 77's Change of Condition (COC, a sudden, clinically important deviation from a resident's baseline in physical, cognitive, behavioral or functional domains), dated 1/13/2024, indicated resident fell from his wheelchair in the hallway. A review of Resident 77's COC, dated 4/18/2024, indicated had a fall when resident slid off the wheelchair in the hallway. During a concurrent interview and record review on 4/24/2024 at 12:49 PM of Resident 77's Care Plan, dated 10/03/2023 with the Director of Nursing (DON), the DON stated the care plan indicated Resident is at risk for falls/injury. Staff interventions included were the following: 1. Assess for changes in medical status, pain status, mental status, and report to Medical Doctor (MD) as indicated 2. Bed in low position 3. Collaborate with family and explore residents' bedtime routine at home. Offer and assist patient with toileting at bedtime. 4. Constantly remind resident to use call light for help and assistance 5. Monitor vital signs including orthostatic blood pressure as needed and report to MD. 6. Physical Therapy evaluation and treatment as indicated, re-evaluation of proper wheelchair positioning 7. Toileting schedule. After meal and bedtime. 8. Utilize bilateral floor mats when resident in bed for safety. The DON stated there was not and should have a structured monitoring/ supervision intervention in the care plan to help prevent further falls. The DON also stated Resident 77 should have monitoring/ supervision at least every 2 hours to prevent further falls. During a concurrent interview and record review on 4/24/2024 at 12:49 PM of Resident 77's Care Plan, dated 4/18/2024 with DON, the DON stated the care plan indicated Resident is at risk for falls/injury. Staff interventions included were the following: 1. Medical Doctor and responsible party were notified 2. Monitor vital signs and report abnormalities to MD. 3. Observe for changes in mental status and significant changes in condition 4. Perform body assessment to assess for any injury (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. Perform initial neurological assessment (an assessment of the nerve cells and motor responses to determine if the nervous system [system that carries messages from to and from the brain] is impaired), then times 72hrs per policy. 6. PT evaluation and treatment as indicated, re-evaluation of proper wheelchair positioning. The DON stated there was not and should have a structured monitoring/ supervision intervention in the care plan to help prevent further falls. The DON also stated Resident 77 should have monitoring/ supervision at least every 2 hours to prevent further falls. During an interview on 4/24/2024 at 1:15 PM, Licensed Vocational Nurse 1 (LVN 1) stated no one was at the nursing station to supervise Resident 77 who was near the area at the time of fall on 1/13/2024 and 4/18/2024. During a concurrent record review of Resident 77's COC, SBAR, and Progress notes dated 2/8/2023, 2/28/2023, 5/19/2023, 6/8/2023, 7/10/2023 and 8/10/2023 and interview with the DON on 4/25/24 at 9:39 AM, the DON stated that all these fall incidents of Resident 77 were as a result of not being supervised. The DON stated Resident 77 should have been supervised to prevent falls. During an interview on 4/25/2024 at 3:30 PM, the DON stated Supervision is being close/next to the resident. The DON stated Structured Monitoring means checking/assessing the resident every 2 hours. During a concurrent record review of Resident 77's Care Plans and interview on 4/25/2024 at 1:58 PM, the DON stated the care plan does not and should have been directed to help prevent further falls. The DON stated Resident 77's care plan dates were changed when the resident fell , but the interventions were not revised. The DON stated the care plan should have been revised and should have been individualized to prevent further falls. During an interview on 4/25/24 at 3:40 PM, Administrator (ADM) stated structured monitoring should be in the policy. A review of the facility's Policy and Procedure titled, Comprehensive Person-Centered Care Plans, revised 3/2022, indicated assessment of residents are ongoing and care plans are revised as information about the residents and the resident's condition change.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42223 Based on observation, interview and record review, the facility failed to clean one of one sampled resident (Resident 36) face and gown after having breakfast. This deficient practice resulted in not meeting the resident ' s needs and had the potential for compromised dignity. Findings: A review of Resident 36 ' s Admission record indicated resident was initially admitted on [DATE] and readmitted on [DATE] with diagnoses including dysphagia (difficulty swallowing) following cerebral infarction (occurs as a result of disrupted blood flow to the brain), hemiplegia (complete paralysis) and hemiparesis (partial weakness) following cerebral infarction affecting the left side of the body, dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities). A review of Resident 36 ' s Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 4/9/2024, indicated Resident 36 had difficulty communicating some words or finishing thoughts but is able if prompted or given time and had severely impaired cognitive skills (ability to think, understand, learn, and remember) for daily decision making. The MDS indicated that resident required set-up or clean-up assistance (helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity) for eating and oral hygiene; substantial/maximal assistance (helper does more than half the effort) for toileting hygiene, bathing, lower body dressing, transfers (moving from one surface to another); partial/moderate assistance (helper does less than half the effort) for personal hygiene and upper body dressing. A review of Resident 36 ' s History and Physical (H&P), dated 4/15/2024, indicated resident has fluctuating capacity to understand and make decisions. A review of Resident 36 ' s Care Plan, titled Resident assistance, date initiated 4/15/2024 by Registered Nurse (RN), indicated resident is dependent for activities of daily living (ADL) care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, and toileting. During an observation on 4/22/2024 at 9:56 AM, Resident 36 is lying in bed asleep and observed with food crumbs on the resident ' s gown and around the resident ' s mouth. In addition, Resident 6 was noted to have drool marks on the left side of the resident ' s mouth, and gown has wet mark at the chest area. During a concurrent interview and record review of resident ' s MDS dated [DATE] on 4/24/2024 at 8:51 AM, with the Director of Staff Development (DSD), DSD stated, MDS indicated Resident 36 need partial to moderate assistance when eating, oral hygiene and personal hygiene. DSD also stated whitish and yellowish stains on the resident ' s gown and face is not okay because it affects the resident ' s dignity, that the CNA should be changing the gown and wiping the face of the resident. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/24/2024 at 10:48 AM with the Director of Nursing (DON), the DON stated it is not okay that the resident has food crumbs on his face and gown, and this was important to maintain the resident ' s dignity. The DON also stated the CNA should have provided hygiene care and changed Resident 36 with a new gown to ensure we are providing the resident ' s needs A review of the facility ' s Policy and Procedures (P&P), titled Activities of Daily Living (ADLs), Supporting, revised 3/2018, the P&P indicated residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out ADLs. The P&P indicated interpretation and implementation included: Residents will be provided with care, treatment, and services to ensure that their ADLs do not diminish unless the circumstances of their clinical condition(s) demonstrate that diminishing ADLs are unavoidable. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene (bathing, dressing, grooming, and oral care). A review of the facility ' s P&P titled, Quality of Life-Dignity, revised February 2020, 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, feeling of self worth and self esteem.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42223 Based on observation, interview, and record review, the facility failed to implement the care plan to insert an indwelling foley catheter (a hollow tube inserted though the urethra [a tube through which urine leaves the body] into the urinary bladder to collect and drain urine) for wound management for one of 22 sampled Residents (Resident 39). This deficient practice had the potential for Resident 39's wound to get worse. Findings: A review of Resident 39's Admission Record indicated resident was admitted on [DATE] with the following diagnoses of pressure ulcer (PU, localized skin and soft tissue injuries that form as a result of prolonged pressure and shear, usually exerted over bony prominences) and muscle weakness. A review of Resident 39's History and Physical (H&P), dated 1/13/2024, indicated resident has the capacity to understand and make decisions. A review of Resident 39's Minimum Data Set (MDS, a standardized care screening and assessment tool), dated 1/11/2024, indicated resident was moderately impaired with cognitive (mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making. MDS also indicated Resident 39 required partial/moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with upper body dressing and putting/on taking off footwear. MDS indicated Resident 39 required substantial/maximal assistance (helper does more than half the effort. Helper lifts or hold trunk or limbs and provides more than half the effort) with shower/bathe self and lower body dressing but was dependent (the ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, including wiping the opening but not managing equipment) with toileting hygiene. A review of Resident 39's Change of Condition (COC, a sudden, clinically important deviation from a resident's baseline in physical, cognitive, behavioral or functional domains), dated 4/14/2024, indicated a skin tear to the penile shaft with slight redness noted. A review of Resident 39's Progress Notes, dated 4/14/2024 at 2:17 PM, indicated per physician, to change Resident 39's condom catheter (collection device that fits like a condom to collect and drain urine) to an indwelling foley catheter for 1 week until skin issue is resolved. A review of Resident 39's Care Plan with focus on, Skin Tear to Penile Shaft, dated 4/14/2024, indicated to discontinue (D/C) condom catheter and place foley catheter for 1 week until skin tear is healed. A review of Resident 39's Wound Assessment form, dated 4/18/2024, indicated open wound at the base of the penis with a length of 1.5 centimeters (cm, unit of measure), width of 4.5 cm and depth of 0.1 cm. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation in Resident 39's room and interview on 4/24/2024 at 9:52 AM, Resident 39 was observed with a penile wound that was pinkish red in color with skin peeling around it. Resident 39's was observed with a condom catheter. During a concurrent record review of Resident 39's care plan on Skin tear to penile shaft, dated 4/14/2024 and interview on 4/24/2024 at 10:21 AM, Treatment Nurse 1 (TN 1) stated Resident 39 still has penile wound and should have a foley catheter until wound heals. TN 1 also stated the care plan was not and should be implemented to prevent resident's wound from getting worse. A review of the facility's policy and procedure titled Comprehensive Person Centered Care Plan, dated 3/2022, indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.

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F 0689

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 42223

Based on observation, interview, and record review, the facility did not provide the necessary care and services for (two) 2 of (three) 3 residents (Residents 77 and 82) who were at risk for falls by failing to:

1. Modify the fall/injury care plan for Resident 77 after episodes of multiple falls. Facility also failed to provide supervision to Resident 77.

2. Ensure Resident 82's floor mat was placed on the floor as indicated on the care plan. This deficient practice had the potential for injury to Resident 82 in an event of a fall.

This deficient practice has the potential for Resident 77 and 82 to have further falls which could result to harm, hospitalization , and/or death.

Findings:

1. A review of Resident 77's Admission Record indicated resident was originally admitted on [DATE] and was readmitted on [DATE] with the following diagnoses of muscle weakness and dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities.

A review of Resident 77's History and Physical, dated 10/11/2023, indicated resident does not have the capacity to understand and make decisions.

A review of Resident 77's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 2/8/2024, indicated resident is severely impaired (never/rarely made decisions) with cognitive (a mental action or process of acquiring knowledge and understanding through thought, experience and senses)

skills for daily decision making. MDS indicated resident required partial/moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with eating, oral hygiene and personal hygiene. Resident required substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with upper and lower body dressing. Resident is was

dependent (helper does all of the effort. Resident does none of the effort to complete the activity or needs the assistance of 2 or more helpers is required for the resident to complete the activity) toileting hygiene, shower/bathe self and putting on/taking off footwear. The MDS indicated Resident 77 had an episode of fall.

A review of Resident 77's Nursing Documentation Evaluation, dated 2/1/2023, indicated resident was at risk for falls with risk factors of poor safety judgement, impaired balance, required assistant for toileting, unsteady gait and taking psychotropic medications (drug taken to exert an effect on the chemical makeup of the brain and nervous system. Medications used to treat mental illnesses).

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 77's Situation, Background, Assessment and Recommendation (SBAR, a structured communication framework that can help teams share information about the condition of the resident) Communication Form, dated 2/8/2023, indicated resident had a fall. A review of Resident 77's Interdisciplinary Team (IDT; a group of healthcare professionals from complementary fields who work in tandem to treat a resident) fall, dated 3/1/2023, indicated resident had a fall incident on 2/28/2023 when resident was trying to get up by himself from his wheelchair. A review of Resident 77's IDT fall, dated 5/22/2023, indicated resident had a fall incident on 5/19/2023 when resident was laying on the floor at the right side of the bed. A review of Resident 77's IDT fall, dated 6/12/2023, indicated resident had a fall incident on 6/8/2023 when resident was laying on the fall mat on the right side of the bed. A review of Resident 77's Progress Notes, dated 7/10/2023 at 7:03 PM, indicated resident had a COC for falls when resident was found on the floor on the left side of the bed. A review of Resident 77's Progress Notes, dated 8/10/2023 at 4:30 PM, indicated resident had a COC for falls when resident tried to stand up from his wheelchair. A review of Resident 77's Change of Condition (COC, a sudden, clinically important deviation from a resident's baseline in physical, cognitive, behavioral or functional domains), dated 1/13/2024, indicated resident fell from his wheelchair in the hallway. A review of Resident 77's COC, dated 4/18/2024, indicated had a fall when resident slid off the wheelchair in the hallway. During an observation on 4/22/2024 at 12:34 PM in Resident 77's room, Resident 77 was observed sitting in a wheelchair with a fall risk band. During a concurrent interview and record review on 4/24/2024 at 12:49 PM of Resident 77's Care Plan, the DON stated there was not and should have a structured monitoring/ supervision intervention in the care plan to help prevent further falls. The DON also stated Resident 77 should have monitoring/ supervision at least every 2 hours to prevent further falls. During an interview on 4/24/2024 at 1:15 PM, Licensed Vocational Nurse 1 (LVN 1) stated no one was at the nursing station to supervise Resident 77 who was near the area at the time of fall on 1/13/2024 and 4/18/2024. LVN1 stated Resident 77 was not supervised and should have been supervised. During a concurrent record review of Resident 77's COC, SBAR, and Progress notes dated 2/8/2023, 2/28/2023, 5/19/2023, 6/8/2023, 7/10/2023 and 8/10/2023 and interview with the DON on 4/25/24 at 9:39 AM, the DON stated that all these fall incidents of Resident 77 were as a result of not being supervised. The DON stated Resident 77 should have been supervised to prevent falls. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055153	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/25/2024
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent record review of Resident 77's Care Plans and interview on 4/25/2024 at 1:58 PM, the DON stated the fall care plans do not and should have been directed to help prevent further falls. The DON stated Resident 77's care plan dates were changed when the resident fell , but the interventions were not revised. The DON stated the care plan should have been revised and should have been individualized to prevent further falls. During an interview on 4/25/2024 at 3:30 PM, the DON stated Supervision is being close/next to the resident. The DON stated Structured Monitoring means checking/assessing the resident every 2 hours. During an interview on 4/25/24 at 3:40 PM, Administrator (ADM) stated structured monitoring should be in the policy. A review of the facility's Policy and Procedure titled, Fall Management, dated 5/26/2021, indicated to communicate patients fall risk status to caregivers, develop individualized plan of care and to review and revise care plan as indicated. A review of the facility's Policy and Procedure titled, Comprehensive Person-Centered Care Plans, revised 3/2022, indicated assessment of residents are ongoing and care plans are revised as information about the residents and the resident's condition change. 44636 2. A review of Resident 82's Admission Record indicated Resident 82 was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses of lack of coordination, abnormalities of gait (a manner of walking or moving on foot) and mobility, history of falling, and dementia (progressive brain disorder that slowly destroys memory and thinking skills). A review of Resident 82's Minimum Data Set (MDS- a standardized assessment and care planning tool), dated 3/11/2024, indicated Resident 82's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making were moderately impaired. The MDS indicated Resident 82 required substantial/maximal assistance (helper does more than half the effort) for shower/bathe self, lower body dressing, sit to stand, chair/bed-to-chair transfer, and tub/shower transfer. There were no incidents of fall as indicated on the MDS. A review of Resident 82's Nursing Documentation Evaluation, dated 12/10/2023, indicated Resident 82's fall risk factors included a history of falls in the last six (6) months, disorientated/confused, poor safety judgement impaired balance, and an unsteady gait. A review of Resident 82's Care Plan, dated 4/1/2024, indicated Resident 82 was found on the floor near his bed in a side lying position. Staff interventions included were to anticipate the resident's needs, keep the environment clutter free, and place a fall mat on the left side of the bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 82's Care Plan, revised on 4/1/2024, indicated Resident 82 was at risk for fall/injury with risk factors of muscle weakness, impaired mobility, impaired vision, poor safety judgement/awareness, narcotic pain medication, cardiac medication, aspirin medication, and medical diagnosis of dementia, hypertension (chronic elevated blood pressure), and anemia (lowered ability of blood to carry oxygen resulting in feeling tired and shortness of breath). Staff interventions included were to assess for changes, in medical status, pain status, mental status and report to medical doctor as indicated, bed in low position, and a fall mat to the left side of the bed. A review of a facility form titled, Interdisciplinary (IDT, involving two or more academic, scientific, or artistic disciplines) Fall, dated 4/2/2024, indicated Resident 82 was observed in left side position next to his bed with an abrasion to the left shoulder. Resident 82's risk factors included poor safety judgement/awareness, impaired cognition, impaired balance, impaired functional mobility, and lack of coordination. Interventions recommended by the Interdisciplinary Team (IDT, group of healthcare professionals from diverse fields who work in a coordinated manner toward a common goal for the resident) were to apply initial treatment to the abrasion on the left shoulder, utilize a fall mat to the left side of the bed when in bed, and provide a regular mattress for the resident. During an observation on 4/22/2024 at 10:09 AM in Resident 82's room, Resident 82 was lying on his back in bed. Resident 82's body was angled diagonally in bed with his right boot (a medical device worn during treatment and recovery of a variety of foot injuries) touching the wall on the right side of the bed. Resident 82's head was partially off on the left side of the bed mattress between the head of the bed and the grab bar. There was no fall mat on the left side of Resident 82's bed. Resident 82's fall mat was folded and was placed leaning onto the privacy curtain which was touching and against the bottom part of Resident 82's roommate bed. During a concurrent observation and interview on 4/22/2024 at 10:13 AM with Licensed Vocational Nurse 4 (LVN 4), LVN 4 stated Resident 82 was resting on his back, angled in bed, and his head was partially on the bed and the rest of his head was partially off the bed. LVN 4 stated Resident 82 tended to move around a lot and was at risk for fall. LVN 4 stated he needed to get another staff to reposition the resident. LVN 4 stated Resident 82's fall mat was not properly placed on the floor. LVN 4 stated the mat was folded up and placed against the curtain. LVN 4 stated the fall mat was to prevent injury in the event Resident 82 had a fall. During an interview on 4/25/2024 at 9:36 AM with LVN 2, LVN 2 stated Resident 82 was at risk for falls. LVN 2 stated Resident 82 recently had a fall on 4/1/2024 and had a history of falling. LVN 2 stated since Resident 82 was found lying on the floor laying on his life side the IDT implemented the use of a floor mat on the left side. LVN 2 stated the fall mat should be placed on the left side of Resident 82's bed in case he fell . LVN 2 stated Resident 82 liked to move around a lot which placed him at risk for falls.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44636 Based on observation, interview, and record review, the facility failed to provide necessary respiratory care services for one (1) of 1 sampled resident (Resident 17) for respiratory care area by failing to ensure Resident 17's nasal cannula (NC, device used to deliver supplemental oxygen placed directly on a resident's nostril) tubing was changed weekly per facility's policy. This deficient practice had the potential for Resident 17 to develop a respiratory infection. Findings: A review of Resident 17's Admission Record indicated Resident 17 was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses of pleural effusion (fluid buildup in the space between the lung and the chest wall), hypertensive heart (heart problems caused by high blood pressure) and chronic kidney disease (gradual loss of kidney damage where kidneys cannot filter the blood the way they should) with heart failure (a lifelong condition in which the heart muscle cannot pump enough blood to meet the body's needs for blood and oxygen) and with end stage renal disease (the final, permanent stage of chronic kidney disease where kidney has declined and can no longer function on their own), and hypoxemia (an abnormally low concentration of oxygen in the blood). A review of Resident 17's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 3/6/2024, indicated Resident 17's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making were severely impaired. The MDS indicated Resident 17 required supervision or touch assistance for toileting hygiene, shower/bathe self, lower body dressing and chair/bed-to-chair transfer. The MDS also indicated Resident 17 received oxygen therapy. A review of Resident 17's Physician's order, dated 1/30/2024, indicated oxygen at two (2) to four (4) liters per minute (LPM, volume of oxygen supplied over a period of time) via nasal cannula as needed to keep oxygen saturation (SpO2, measures how much oxygen is carried by the hemoglobin [Hgb, a protein in red blood cells that carries oxygen to the body's organs and tissues and transports carbon dioxide from the resident's organs and tissues back to the lungs] in the blood or how well a resident is breathing) equal to or greater than 92% as needed. A review Resident 17's Oxygen Saturation Summary indicated Resident 17 received oxygen via nasal cannula on the following dates: - 3/27/2024, 3/28/2024, 3/29/2024, 3/30/2024, 3/31/2024, 4/1/2024, 4/2/2024, 4/3/2024, 4/6/2024, 4/7/2024, 4/8/2024, 4/9/2024, 4/12/2024, 4/13/2024, 4/14/2024, 4/15/2024, 4/18/2024, 4/19/2024, 4/20/2024, 4/21/2024, 4/23/2024. During an observation on 4/22/2024 at 9:40 AM in Resident 17's room, Resident 17 was sitting in her wheelchair and not receiving oxygen therapy. The back of Resident 17's wheelchair had a nasal cannula tube attached to the oxygen tank. The nasal cannula tubing was not dated. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 4/23/2024 at 4:18 PM with Resident 17 in her room, Resident 17 was sitting on her wheelchair. Resident 17 stated she had used her nasal cannula to receive oxygen earlier today. The nasal cannula tubing connected to the oxygen tank was not dated. The end of the nasal cannula tubing containing the prongs were placed inside of a clear bag. The bag containing the nasal cannula was dated 3/27/2024 (27 days prior to observation date 4/23/2024). During a concurrent observation and interview on 4/23/2024 at 4:21 PM with Licensed Vocational Nurse 3 (LVN 3), LVN 3 stated oxygen tubing was supposed to be labeled with the first date the oxygen tubing was used. LVN 3 stated there was no date on Resident 17's oxygen tubing. LVN 3 stated the bag containing Resident 17's tubing was dated on 3/27/2024. LVN 3 stated the oxygen tubing should be labeled upon using and changed regularly for infection control. LVN 3 stated if the oxygen tubing was not changed regularly, the tubing could harbor bacteria because of the moisture and cause an infection. During an interview on 4/24/2024 at 5:25 PM with the Infection Prevention Nurse (IPN), the IPN stated the oxygen tubing should be labeled to know when the tubing was last changed. The IPN stated the oxygen tubing should be changed once a week. The IPN stated if the oxygen tubing being used by the resident was undated, it could already be old and dirty. The IPN stated the bacteria from the tubing could expose the resident to an infection. During an interview on 4/25/2024 at 10:52 AM with the Director of Nursing (DON), the DON stated the oxygen tubing should be dated to ensure the oxygen tubing was being replaced weekly. The DON stated the use of an oxygen tubing longer than a week could create cross contamination and put the resident at risk for an infection. During a follow up interview on 4/25/2024 at 6:28 PM with the DON, the DON stated the facility did not have a policy which indicated to date the oxygen tubing to ensure it was changed every seven (7) days. The DON stated there should be a policy for dating the oxygen tubing since it was the best standard of practice to change the oxygen tubing every 7 days. A review of the facility's undated Policy and Procedure titled, Changing of Nasal Cannula/Oxygen Tubing, indicated it is the policy of the facility to change the nasal cannula and oxygen tubing weekly and as needed if the nasal cannula is visibly soiled or damaged. Setup bags are dated and placed with each nasal cannula to prevent the nasal cannula from touching the floor when not being used.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. 46087 Based on observation, interview and record review, the facility failed to ensure staffing information (list of total number of staff and the actual hours worked by the staff) was posted and placed in a visible and prominent place on 4/22/2024. As a result, the total number of staff was not readily accessible to residents and visitors. Findings: During an observation, on 4/22/2024 at 7:45 AM, no visible daily staffing information posting was found at the facility lobby. During a concurrent observation of the nursing posting on the wall near the lobby and interview with Director of Staff Development (DSD), on 4/24/2024 at 11:15 AM, DSD stated On 4/22/2024, 4/23/2024 and 4/24/2024, she did not post the number of licensed nurses (Registered Nurse [RN] and Licensed Vocational Nurse [LVN]) and the number of unlicensed nursing personnel (Certified Nurse Assistants [CNA]) directly responsible for resident care. DSD stated she cannot recall the exact date when she stopped posting the number of Directly responsible for resident care (means that individuals are responsible for residents' total care or some aspect of the residents' care including, but not limited to, assisting with activities of daily living [ADLs], giving medications, supervising care given by CNAs, and performing nursing assessments to admit residents or notify physicians of changes of condition). During an interview, on 4/24/2024 at 11:30 AM with the Director of Nursing (DON), she stated that she did not know that the facility was not posting the shift staffing information that consist of the census, the total number of RN, LVN and CNA's working each shift. The DON added this posting should be easily seen and read by residents, visitors, and staff and that it is important to post the staffing information so residents and visitors would know that the facility is staffed with the required number of nurses to deliver care to the residents in accordance with the regulations. A review of the facility's policy and procedure titled Posting Direct Care Daily Staffing Numbers, revised August 2022, policy indicated facility will post on a daily basis for each shift nurse staffing data, including the number of nursing personnel responsible for providing direct care to residents.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46087 Based on observation, interview, and record review, the facility failed to provide pharmaceutical services to meet the needs of two (2) of seven (7) sampled residents (Resident 16 and 48) as indicated on the facility policy by: a. During a Medication Pass observation, Licensed Vocational Nurse 7 (LVN 7) failed to administer Resident 16's medications within 60 minutes of scheduled time of 9 AM on 4/24/2024. This deficient practice had the potential for Resident 16's health and well-being to be negatively impacted due to unintended consequences, such as decreased effectiveness of the medications and adverse reactions (an unwanted effect caused by the administration of a drug) from the medications. b. During a Medication Pass observation, LVN 7 failed to check Resident 48's blood glucose (blood sugar, main sugar found in the blood) and administer insulin (medicine to lower the level of glucose [type of sugar] in the body) before lunch meal on 4/24/2024. This deficient practice had the potential for Resident 48's diabetes not to be effectively managed which could result place the resident at risk for hypoglycemia (low blood sugar), hospitalization , and death. Findings: a. A review of Resident 16's Admission Record indicated Resident 16 was originally admitted on [DATE] and readmitted on [DATE], with diagnoses that included asthma (a condition in which a resident's airways become narrow which makes it difficult to breathe), dysphagia (difficulty swallowing), and hypertension (high blood pressure). A review of Resident 16's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 2/20/2024, indicated Resident 16 had moderately impaired (decisions poor; cues/supervision required) cognitive skills (mental action or process of acquiring knowledge and understanding through thought and the senses) for daily decision making. The MDS indicated Resident 16 required supervision with eating. MDS indicated Resident 16 required partial/moderate assistance (helper does more than half the effort) with oral hygiene and personal hygiene. It also indicated that Resident 16 required substantial assistance (helper does more than effort) with toileting hygiene and upper body dressing. Resident 16 was dependent with shower, lower body dressing and putting on/taking off footwear. A review of Resident 48's Physician's order, dated 3/27/2024, indicated the following orders: Advair Diskus (used to prevent asthma attacks) 250 micrograms (mcg, unit of measurement), one (1) inhalation every 12 hours for Asthma, ordered on 3/18/2024. Ascorbic Acid tablet 500 milligrams (mg, unit of measurement), 1 tablet by mouth once a day, ordered on 3/18/2024. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Colace (stool softener) capsule 100 mg, 2 (two) capsules by mouth, 2 times a day for constipation (a problem with passing stool), ordered on 3/18/2024. Enoxaparin sodium solution (blood thinner) injection (act of administering a liquid, especially a drug, into a person's body using a needle and a syringe), inject 30 mg subcutaneously (beneath, or under, all the layers of the skin) once a day to prevent blood clotting, ordered on 3/18/2024. Irbesartan (medication to treat high blood pressure) 150 mg tablet, 1 tablet by mouth once a day for hypertension, ordered on 3/23/2024. Isosorbide Mononitrate (used to prevent angina [chest pain]) extended release 30 mg, 1 tablet by mouth once a day for hypertension, ordered on 3/23/2024. Lactulose solution (used to treat constipation) 10 grams (gm, unit of measurement)/15 milliliters (ml, unit of measurement), 10 gm by mouth once a day for constipation, hold if loose stool, ordered on 3/18/2024. Lorazepam (used to treat anxiety [a feeling of fear, dread, and uneasiness]) oral tablet 1 mg, 1 tablet by mouth 2 times a day for anxiety manifested by physical restlessness and inability to relax, ordered on 3/23/2024. Ferrous sulfate (an iron supplement used to treat or prevent low blood levels of iron) 325 mg, 1 tablet by mouth once a day for supplement. During a concurrent record review of Resident 16's physician's orders and observation of the medication administration for Resident 16 on 4/24/2024, at 10:30 AM, Assistant Director of Nursing (ADON) and LVN 7 were preparing Resident 16's medications. The ADON and LVN 7 stated that the following medications were Resident 16's scheduled medications for 9 AM: Advair Diskus Ascorbic Acid tablet 500 mg, 1 tablet Enoxaparin sodium solution injection Irbesartan 150 mg tablet, 1 tablet Isosorbide Mononitrate extended release 30 mg, 1 tablet Lactulose solution 10 gm/15 ml Lorazepam oral tablet 1 mg, 1 tablet Ferrous sulfate tablet 325 mg, 1 tablet Colace capsule 100 mg, 2 (two) capsules (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with LVN 7 at 4/24/2024 at 10:45 AM, LVN 7 verified that she administered Resident 16's 9 AM medication late because she gave them after 10 AM. She stated that medications can be administered one hour before or after the scheduled time. LVN 7 stated, If medications were not administered on time, for example blood pressure medications, it can affect the blood pressure of the residents which can cause a change in the residents' condition. b. A review of Resident 48's Admission Record indicated Resident 48 was originally admitted on [DATE] with diagnoses that included type 2 diabetes (abnormal blood sugar), muscle weakness, and dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning). A review of Resident 48's MDS, dated [DATE], indicated Resident 48 had severely impaired cognitive skills (mental action or process of acquiring knowledge and understanding through thought and the senses) for daily decision making and required supervision with eating and personal hygiene. The MDS indicated, Resident 48 required partial/moderate assistance (helper does more than half the effort) with oral hygiene, upper body dressing. It also indicated that Resident 48 required substantial assistance (helper does more than effort) with toileting hygiene and shower and was dependent with lower body dressing and lower body dressing. A review of Resident 48's Physician's order, dated 3/27/2024, indicated an order on 3/26/2024 to administer insulin Lispro (a fast-acting insulin used to control high blood sugar) per sliding scale (the increasing administration of the pre?meal insulin dose based on the blood sugar level before the meal), subcutaneously (SQ, method of giving a medication in the fatty layer of tissue just under the skin) before meals and at bedtime for diabetes. The MRR indicated sliding scale as follows: For blood sugar less than 70 milligram per deciliter (mg/dL, unit of measurement), follow hypoglycemia protocol and call Doctor. For blood sugar of 0 mg/dL to 199 mg/dL, give 0 units of insulin. 200 mg/dL to 249 mg/dL = give 1 unit of insulin 250 mg/dL to 299 mg/dL = give 2 units of insulin 300 mg/dL to 349 mg/dL = give three (3) units of insulin 350 mg/dL to 399 mg/dL = give four (4) units of insulin 400 mg/dL to 449 mg/dL = give five (5) units of insulin 450 mg/dL to 999 mg/dL = give six (6) units of insulin and call the doctor During an interview on 4/24/2024 at 12:03 PM, ADON stated Resident 48 was due for blood sugar check and insulin administration per sliding scale at 11:30 AM. During a concurrent observation in the dining room and interview with LVN 7 on 4/24/2024 at 12:05 PM, LVN 7 stated, Resident 48 had already started eating and had consumed a small portion of his lunch plate. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and medication pass observation on 4/24/2024 at 12:07 PM, ADON and LVN 7 checked Resident 48's blood sugar. Resident 48's blood sugar result was 245 mg/dL. The ADON stated per the physician's order, Resident 48 should receive 1 unit of insulin Lispro. The ADON added that Resident 48's blood sugar result of 245 was not reliable since it was checked after Resident 48 had already eaten. During an interview on 4/24/2024 at 5 PM with LVN 3, she stated, prior to giving insulin, licensed nurse should have checked Resident 48's blood sugar to see if resident would need to be administered insulin Lispro in accordance with the physician's order. LVN 3 added, checking the blood sugar level and administering the ordered insulin was important to prevent resident from developing hyperglycemia after eating. During an interview on 4/25/2024 at 11:35 AM, the ADON stated that it was important to administer medication as ordered to get the full benefit of the medication and to prevent complications of inconsistent timing of medication administration. The ADON stated, Resident 48's blood sugar check and insulin order were to control the resident's blood sugar, and if it was not given timely, Resident 48 can develop uncontrolled high blood sugar and can cause complications such as death. A review of facility's Policy and Procedure titled, Administering Medications, revised in April 2019, indicated medications are administered in a safe and timely manner, and as prescribed. Medications are administered in accordance with prescriber orders, including any required time frame. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders).

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F 0759

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Ensure medication error rates are not 5 percent or greater.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 46087

Based on observation, interview, and record review, the facility failed to ensure that its medication error rate was less than five (5) percent (%). 10 medication errors out of 33 total opportunities for error, to yield an overall medication error rate of 30.3 % for two (2) of seven (7) residents observed for medication administration (Residents 16 and 48). The medication errors were as follows:

1. During a Medication Pass observation, Licensed Vocational Nurse 7 (LVN 7) failed to administer Resident 16's medications within 60 minutes of scheduled time of 9 AM on 4/24/2024.

2. During a Medication Pass observation, LVN 7 failed to check Resident 48's blood glucose (blood sugar, main sugar found in the blood) and administer insulin (medicine to lower the level of glucose [type of sugar] in the body) before lunch meal on 4/24/2024.

These deficient practices had the potential to result in Resident 16 and 48 to experience medication adverse effects (unwanted, uncomfortable, or dangerous effects that a medication may have) and the potential to result in Residents health and well-being to be negatively impacted.

Findings:

1. A review of Resident 16's Admission Record indicated Resident 16 was originally admitted on [DATE] and readmitted on [DATE], with diagnoses that included asthma (a condition in which a resident's airways become narrow which makes it difficult to breathe), dysphagia (difficulty swallowing), and hypertension (high blood pressure).

A review of Resident 16's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 2/20/2024, indicated Resident 16 had moderately impaired (decisions poor; cues/supervision required) cognitive skills (mental action or process of acquiring knowledge and understanding through thought and the senses) for daily decision making. The MDS indicated Resident 16 required supervision with eating. MDS indicated Resident 16 required partial/moderate assistance (helper does more than half the effort) with oral hygiene and personal hygiene. It also indicated that Resident 16 required substantial assistance (helper does more than effort) with toileting hygiene and upper body dressing. Resident 16 was dependent with shower, lower body dressing and putting on/taking off footwear.

A review of Resident 48's Physician's order, dated 3/27/2024, indicated the following orders:

Advair Diskus (used to prevent asthma attacks) 250 micrograms (mcg, unit of measurement), one (1) inhalation every 12 hours for Asthma, ordered on 3/18/2024.

Ascorbic Acid tablet 500 milligrams (mg, unit of measurement), 1 tablet by mouth once a day, ordered on 3/18/2024.

Colace (stool softener) capsule 100 mg, 2 (two) capsules by mouth, 2 times a day for constipation (a problem with passing stool), ordered on 3/18/2024.

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NAME OF PROVIDER OR SUPPLIER Montebello Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1035 W Beverly Blvd Montebello, CA 90640	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Enoxaparin sodium solution (blood thinner) injection (act of administering a liquid, especially a drug, into a person's body using a needle and a syringe), inject 30 mg subcutaneously (beneath, or under, all the layers of the skin) once a day to prevent blood clotting, ordered on 3/18/2024. Irbesartan (medication to treat high blood pressure) 150 mg tablet, 1 tablet by mouth once a day for hypertension, ordered on 3/23/2024. Isosorbide Mononitrate (used to prevent angina [chest pain]) extended release 30 mg, 1 tablet by mouth once a day for hypertension, ordered on 3/23/2024. Lactulose solution (used to treat constipation) 10 grams (gm, unit of measurement)/15 milliliters (ml, unit of measurement), 10 gm by mouth once a day for constipation, hold if loose stool, ordered on 3/18/2024. Lorazepam (used to treat anxiety [a feeling of fear, dread, and uneasiness]) oral tablet 1 mg, 1 tablet by mouth 2 times a day for anxiety manifested by physical restlessness and inability to relax, ordered on 3/23/2024. Ferrous sulfate (an iron supplement used to treat or prevent low blood levels of iron) 325 mg, 1 tablet by mouth once a day for supplement. During a concurrent record review of Resident 16's physician's orders and observation of the medication administration for Resident 16 on 4/24/2024, at 10:30 AM with Assistant Director of Nursing (ADON), LVN 7 was observed administering Resident 16's medications. The ADON and LVN 7 stated that the following medications were Resident 16's scheduled medications for 9 AM: Advair Diskus Ascorbic Acid tablet 500 mg, 1 tablet Enoxaparin sodium solution injection Irbesartan 150 mg tablet, 1 tablet Isosorbide Mononitrate extended release 30 mg, 1 tablet Lactulose solution 10 gm/15 ml Lorazepam oral tablet 1 mg, 1 tablet Ferrous sulfate tablet 325 mg, 1 tablet Colace capsule 100 mg, 2 (two) capsules (continued on next page)

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F 0759

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

During an interview with LVN 7 at 4/24/2024 at 10:45 AM, LVN 7 verified that she administered Resident 16's 9 AM medication late because she gave them after 10 AM. She stated that medications can be administered one hour before or after the scheduled time. LVN 7 stated, If medications were not administered on time, for example blood pressure medications, it can affect the blood pressure of the residents which can cause a change in the residents' condition.

2. A review of Resident 48's Admission Record indicated Resident 48 was originally admitted on [DATE] with diagnoses that included type 2 diabetes (abnormal blood sugar), muscle weakness, and dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning).

A review of Resident 48's MDS, dated [DATE], indicated Resident 48 had severely impaired cognitive skills (mental action or process of acquiring knowledge and understanding through thought and the senses) for daily decision making and required supervision with eating and personal hygiene. The MDS indicated, Resident 48 required partial/moderate assistance (helper does more than half the effort) with oral hygiene, upper body dressing. It also indicated that Resident 48 required substantial assistance (helper does more than effort) with toileting hygiene and shower and was dependent with lower body dressing and lower body dressing.

A review of Resident 48's Physician's order, dated 3/27/2024, indicated an order on 3/26/2024 to administer insulin Lispro (a fast-acting insulin used to control high blood sugar) per sliding scale (the increasing administration of the pre?meal insulin dose based on the blood sugar level before the meal), subcutaneously (SQ, method of giving a medication in the fatty layer of tissue just under the skin) before meals and at bedtime for diabetes. The Physician's order indicated sliding scale as follows:

For blood sugar less than 70 milligram per deciliter (mg/dL, unit of measurement), follow hypoglycemia protocol and call Doctor.

For blood sugar of 0 mg/dL to 199 mg/dL, give 0 units of insulin.

200 mg/dL to 249 mg/dL = give 1 unit of insulin

250 mg/dL to 299 mg/dL = give 2 units of insulin

300 mg/dL to 349 mg/dL = give three (3) units of insulin

350 mg/dL to 399 mg/dL = give four (4) units of insulin

400 mg/dL to 449 mg/dL = give five (5) units of insulin

450 mg/dL to 999 mg/dL = give six (6) units of insulin and call the doctor

During an interview on 4/24/2024 at 12:03 PM, ADON stated Resident 48 was due for blood sugar check and insulin administration per sliding scale at 11:30 AM.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation in the dining room and interview with LVN 7 on 4/24/2024 at 12:05 PM, LVN 7 stated, Resident 48 had already started eating and had consumed a small portion of his lunch plate. During a concurrent interview and medication pass observation on 4/24/2024 at 12:07 PM, ADON and LVN 7 checked Resident 48's blood sugar. Resident 48's blood sugar result was 245 mg/dL. The ADON stated per the physician's order, Resident 48 should receive 1 unit of insulin Lispro. The ADON added that Resident 48's blood sugar result of 245 was not reliable since it was checked after Resident 48 had already eaten. During an interview on 4/24/2024 at 5 PM with LVN 3, she stated, prior to giving insulin, licensed nurse should have checked Resident 48's blood sugar to see if resident would need to be administered insulin Lispro in accordance with the physician's order. LVN 3 added, checking the blood sugar level and administering the ordered insulin was important to prevent resident from developing hyperglycemia after eating. During an interview on 4/25/2024 at 11:35 AM, the ADON stated that it was important to administer medication as ordered to get the full benefit of the medication and to prevent complications of inconsistent timing of medication administration. The ADON stated, Resident 48's blood sugar check and insulin order were to control the resident's blood sugar, and if it was not given timely, Resident 48 can develop uncontrolled high blood sugar and can cause complications such as death. A review of the facility's Policy and Procedure titled, Administering Medications, revised in April 2019, indicated medications are administered in a safe and timely manner, and as prescribed. Medications are administered in accordance with prescriber orders, including any required time frame. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). A review of the facility's Policy and Procedure titled, Job Description for Long Term Care Facilities, Licensed Vocational Nurse, revised in May 2022, it indicated duties and responsibilities to administer medications within the scope of practice and according to practitioner orders.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46087 Based on observation, interview and record review the facility failed to ensure for one of seven sampled residents (Residents 48) was free from significant medication error (the observed or identified preparation or administration of medications or biologicals which is not in accordance with the prescriber's order; manufacturer's specifications [not recommendations] regarding the preparation and administration of the medication or biological; or accepted professional standards and principles) by failing to check blood sugar and administer insulin (medicine to lower the level of glucose [type of sugar] in the body) before meals in accordance with the physician's order. On 4/24/2024, Resident 48's blood sugar was checked after the insulin was administered and after the resident already consumed a portion of his lunch meal. This deficient practice had the potential for the resident to experience unwanted side effects of the medication including drowsiness, trouble breathing, hypoglycemia (low blood sugar), mental changes, and jeopardizing Resident 48's health and safety. Findings: A review of Resident 48's Admission Record indicated Resident 48 was originally admitted on [DATE] with diagnoses that included type 2 diabetes (abnormal blood sugar), muscle weakness, and dementia ((long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning). A review of Resident 48's Minimum Data Set (MDS, a standardized assessment and care screening tool) dated 3/29/2024, indicated Resident 48 had severely impaired cognitive skills (mental action or process of acquiring knowledge and understanding through thought and the senses) and required supervision with eating and personal hygiene. The MDS indicated, Resident 48 required partial/moderate assistance (helper does more than half the effort) with oral hygiene, upper body dressing. It also indicated that Resident 48 required substantial assistance (helper does more than effort) with toileting hygiene and shower and was dependent with lower body dressing and lower body dressing. A review of Resident 48's Medication Review Report (MRR), dated 3/27/2024, indicated an order on 3/26/2024 to administer insulin Lispro (a fast-acting insulin used to control high blood sugar) per sliding scale (the increasing administration of the pre?meal insulin dose based on the blood sugar level before the meal), subcutaneously (SQ, method of giving a medication in the fatty layer of tissue just under the skin) before meals and at bedtime for diabetes. The MRR indicated sliding scale: For blood sugar less than 70 milligram per deciliter (mg/dL, unit of measurement), follow hypoglycemia protocol and call Doctor. For blood sugar of 0 mg/dL - 199 mg/dL, give 0 units of insulin. 200 mg/dL to 249 mg/dL = give one unit of insulin 250 mg/dL to 299 mg/dL = give two units of insulin (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	300 mg/dL to 349 mg/dL = give three units of insulin 350 mg/dL to 399 mg/dL = give four units of insulin 400 mg/dL to 449 mg/dL = give five units of insulin 450 mg/dL to 999 mg/dL = give six units of insulin and call the doctor During a medication pass observation on 4/24/2024 at 12:03 PM with Assistant Director of Nursing (ADON) and Licensed Vocational Nurse (LVN) 7, ADON stated Resident 48 is due for blood sugar check and insulin administration per sliding scale due at 11:30 AM. During a concurrent observation of the dining room and interview with LVN 7 on 4/24/2024 at 12:05 PM, LVN 7 stated, Resident 48 already started his lunch meal, and already consumed a small portion of his plate. During a medication pass observation on 4/24/2024 at 12:07 PM with ADON and LVN 7, ADON and LVN 7 checked Resident 48's blood sugar with result of 245 mg/dL ADON stated per the physician's order, Resident 48 should receive 1 unit of insulin Lispro. ADON added, the blood sugar result of 245 mg/dL was not reliable since it was checked after the fact that Resident 48 already ate. During an interview on 4/24/2024 at 5 PM with LVN 3, she stated, prior to giving insulin, licensed nurse should have checked Resident 48's blood sugar to see if resident would need to be administered insulin Lispro in accordance with the physician's order. LVN 3 added, checking blood sugar level, and administering the ordered insulin is important to prevent resident from developing hyperglycemia after eating. During a concurrent interview on 4/25/2024 at11:35 AM with ADON, ADON stated, it was important to administer medication as ordered to get full benefit of the medication and to prevent complications of inconsistent timing of medication administration. ADON stated, Resident 48's blood sugar check and insulin order are to control his blood sugar, and if it was not given timely, Resident 48 can develop uncontrolled high blood sugar and can cause complications such as death. A review of the facility's policy and procedure titled Administering Medications, revised in April 2019, indicated medications are administered in a safe and timely manner, and as prescribed. It also indicated that 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: a. Enhancing optimal therapeutic effect of the medication. b. Preventing potential medication or food interactions.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44636 Based on observation, interview, and record review, the facility failed to label foods in the kitchen with item name, 'use by' date (the last date recommended for the use of the product) and failed to discard expired food as indicated in the facility's policy and procedure. These deficient practices had the potential to result in pathogen (germ) exposure to residents and placed residents at risk for developing foodborne illness (food poisoning) with symptoms including upset stomach, stomach cramps, nausea, vomiting, diarrhea, and fever and can lead to other serious medical complications and hospitalization . Findings: During a concurrent observation in the facility kitchen and interview on [DATE] at 8:02 AM with the Accounts Manager (ACM), the kitchen was observed with food items not labeled to indicate the food item names and use by date. The ACM stated all food items were supposed to be labeled with food item name, use by date, and food must be discarded when expired. ACM stated. the following were found in the kitchen's refrigerators and/or freezer: a. Open bag of fries not labeled with item name, date opened, and used by date. b. Open bag of chicken tenders not labeled with item name, date opened and used by date. c. Clear bag of hash browns not labeled with item name and used by date. d. Two packs of raw meat not labeled with item name and used by date. e. A metal container of beans with used by date of [DATE]. f. A zip lock bag containing deli turkey with used by date of [DATE]. g. An open loaf of bread with no used by date. During the same interview on [DATE] at 8:02 AM with the ACM, ACM stated all expired food items such as the beans and deli turkey should have been thrown away. ACM stated the food items fries, chicken tenders, hashbrowns, raw meat and loaf bread only had the received date. The ACM stated the food items should have been labeled with the item name along with a used by date to know when the food items were going be expired. During a follow up interview on [DATE] at 8:24 AM with the ACM, ACM stated items should be labeled with the expiration date/ used by date to know when food items will expire. ACM stated the importance of having an expiration date of food items was to prevent serving expired food to the residents. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 12:33 PM with the Registered Dietician (RD) Consultant, RD Consultant stated there was no policy for discarding food items. The RD Consultant stated the facility followed Food and Drug Administration (FDA) guidelines for discarding food. A review of the facility's policy and procedure titled. Food Storage: Cold Foods, revised ,d+[DATE], indicated all foods will be stored, wrapped, or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination. A review of the 2022 FDA Food Code U.S. Food and Drug Administration, ,d+[DATE].18 titled, Ready-to-Eat, Time/Temperature Control for Safety Food, Disposition, indicated time/temperature control safety refrigerated foods must be consumed, sold, or discarded by the expiration date. https://www.fda.gov/media/164194/download?attachment

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42223 Based on observation, interview and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices for three out of 22 sampled residents (Resident 18, 41 and 78) by failing to accurately document the administration of antibiotic (medicine to treat infection) and narcotics (drug or controlled substance that affects the mood or behavior and if consumed for nonmedical purposes or not prescribed by the doctor can cause serious harm) count in the narcotic drug record (narcotic count sheet is a document used to document and track the administration of controlled substance to ensure accurate dispensing and administration of medications, as well as to provide a record of how much of a controlled substance has been used and when). This deficient practice had the potential to negatively impact the delivery of services. Findings: 1. A review of Resident 18 Admission Record indicated resident was originally admitted on [DATE] and was readmitted on [DATE] with the following diagnosis of anxiety (feeling of fear, dread, and uneasiness) and dementia (impaired ability to remember, think, or make decisions that interfere with doing everyday activities). A review of Resident 18 Minimum Data Set (MDS; a standardized care screening and assessment tool), dated 3/21/2024, indicated resident severely impaired in cognitive skills for daily decision making. The MDS also indicated resident is dependent (helper does all of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity). A review of Resident 18's Physician Orders, dated 2/24/2023, indicated Ativan/ lorazepam (medication for anxiety) tablet 0.5 milligrams (mg, unit of measure) give 0.25 mg (half tablet) by mouth at bedtime for anxiety as manifested by physical aggression towards staff. A review of Resident 18's Physician Orders, dated 4/24/2024, indicated amoxicillin (medication for infection) oral tablet 500 mg, give 500 mg by mouth two times a day for wound infection for 7 days until finished. During an observation of the Medication Cart A (Med Cart A), interview, and record review of Resident 18's narcotic drug record for amoxicillin undated, on 4/25/2024 at 10:05 AM, the narcotic drug record indicated refill date on 4/24/2024 (date facility received from the facility's pharmacy) with total of 14 tablets. In addition, it indicated last tablet taken out was signed on 4/24/2024 at 4 PM under tablet number 14. Observed Resident 18's amoxicillin bubble pack (packaging in which a product is sealed between a cardboard backing and clear plastic cover), the bubble pack showed 12 tablets left. Assistant Director of Nursing (ADON) stated, the narcotic drug record for Resident 18's amoxicillin was incorrect, it did not indicate the number 13 tablet was taken out from Resident 18's amoxicillin bubble pack and the drug narcotic drug record should indicate the date, time, and signature of the nurse who took out the number 13 tablet and gave it to the resident this morning. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the same observation of the Med Cart A, interview, and record review of Resident 18's narcotic drug record for lorazepam undated, on 4/25/2024 at 10:05 AM, the narcotic drug record indicated refill date on 4/19/2024 with total of 14 tablets of 0.25 mg tablets. In addition, it indicated licensed nurse's signed under tablet #11 (meaning there 10 tablet left) on 4/25/2024 at 8 AM. Observed Resident 18's bubble pack for lorazepam 0.25 mg tablet with 11 tablet (0.25 mg tablets) left. ADON stated, the narcotic drug record for Resident 18's lorazepam was incorrect because it indicated there's 10 tablets left but there were really 11 tablets of lorazepam left in the bubble pack. ADON also stated, the licensed nurse who signed the narcotic drug record under tablet #11 made a mistake by signing under the lorazepam narcotic drug record instead of writing it under Resident 18's narcotic drug record. During an interview the Assistant Director of Nursing (ADON) on 4/25/2024 at 11 AM, the ADON stated he did an investigation of the discrepancy of Resident 18's lorazepam and amoxicillin narcotic drug record and the ADON found out that the licensed nurse (did not identify) who administered the amoxicillin to Resident 18 on 4/25/2024 at 8 AM, mistakenly signed under the lorazepam tablet #11. 2. A review of Resident 41 Admission Record indicated resident is originally admitted on [DATE] and was readmitted on [DATE] with the following diagnosis of chronic pain syndrome and major depression (a group of conditions associated with the elevation or lowering of a person's mood) A review of Resident 41's MDS, dated [DATE], indicated resident had intact cognitive skills for daily decision making. The MDS also indicated resident required partial/moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with toileting hygiene, shower/bathe self, lower body dressing and putting on/taking off footwear. A review of Resident 41's physician orders, dated 4/18/2024, indicated nitrofurantoin mono MCR/macrobid (medication for infection) oral capsule 100 mg, give 1 capsule by mouth two times a day for urinary tract infection (UTI, infection in the urinary tract system) for 7 days. During an observation of Med Cart B, interview, and record review on 4/25/2024 at 10:27 AM, observed Resident 41's medication nitrofurantoin mono MCR 100 mg bubble packet was empty. Licensed Vocational Nurse 5 (LVN 5) stated narcotic drug record for Resident 41's medication indicated there is supposed to be one medication left. LVN 5 stated she gave the nitrofurantoin medication to Resident 41 but she forgot to sign it off in Resident 41's nitrofurantoin mono MCR narcotic drug record. 3. A review of Resident 78 Admission Record indicated resident was originally admitted on [DATE] and was readmitted on [DATE] with the following diagnosis of amputation (loss or removal of a body part such as a finger, toe, hand, foot, arm, or leg) of left lower extremity and muscle weakness. A review of Resident 78's H&P, dated 2/29/2024, indicated resident does not have the capacity to understand and make decisions. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 78's MDS, dated [DATE], indicated resident is moderately impaired in cognitive skills for daily decision making. The MDS also indicated resident requires partial/moderate assistance with toileting hygiene, upper body dressing, lower body dressing and putting on/taking off footwear. The MDS indicates resident required substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with shower/bathe self. A review of Resident 78's physician orders, dated 1/31/2024, indicated morphine sulfate oral tablet (medication for pain) 15 mg, give 1 tablet by mouth every 12 hours for pain management. During an observation, interview, and record review on 4/25/2024 at 10:29 AM on Med Cart B, Observed Resident 78's medication morphine immediate release (IR) 15 mg bubble packet contained 8 tablets. LVN 5 stated narcotic drug record for Resident 78's medication indicated there is nine (9) tablets of morphine IR left in the bubble pack. LVN 5 stated she gave the morphine IR medication to Resident 78 but she forgot to sign it off in Resident 78's morphine IR narcotic drug record. During an interview on 4/25/2024 at 11 AM, Assistant Director of Nursing (ADON) stated it is not okay that the narcotic count record was not signed. During an interview on 4/25/2024 at 4:16 PM, ADON stated if the narcotic count in the narcotic drug records is off, it is not okay because we are not taking into account if there is a missing narcotic medication and if it falls in the wrong hand, it can cause harm to the residents and it is illegal. A review of the facility's policy and procedure titled Controlled Substances, revised November 2022, indicated controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow up.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

Provide and implement an infection prevention and control program.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 42223

Based on observation, interview, and record review, the facility failed to observe infection control measures as indicated on the facility policy when facility staff failed to:

1. Wear Personal Protective Equipment (PPE, protective clothing such as gown, gloves, goggles, mask) when entering an Enhanced Standard Precaution (reducing transmission of organisms through health provider with the use of gown and gloves when caring for the resident) room. This deficient practice has the potential to spread infection to other residents.

2. Ensure the Legionella (a type of bacteria spread through small droplets of water that can cause legionellosis [Legionnaires' Disease, a serious and potentially deadly lung infection]) Water Management Program policy and procedure was fully implemented. This deficient practice had the potential to result in the infection (a process when a microorganism, such as bacteria, fungi, or a virus, enters a person's body and causes harm) and a spread waterborne illness in the facility.

Findings:

1. A review of Resident 39's Admission Record indicated resident was admitted on [DATE] with the following diagnoses of pressure ulcer (PU, localized skin and soft tissue injuries that form as a result of prolonged pressure and shear, usually exerted over bony prominences) and muscle weakness.

A review of Resident 39's History and Physical (H&P), dated 1/13/2024, indicated resident has the capacity to understand and make decisions.

A review of Resident 39's Minimum Data Set (MDS, a standardized care screening and assessment tool), dated 1/11/2024, indicated resident was moderately impaired with cognitive (mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making. MDS also indicated Resident 39 required partial/moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with upper body dressing and putting/on taking off footwear. MDS indicated Resident 39 required substantial/maximal assistance (helper does more than half the effort. Helper lifts or hold trunk or limbs and provides more than half the effort) with shower/bathe self and lower body dressing but was dependent (the ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, including wiping the opening but not managing equipment) with toileting hygiene.MDS indicated resident had a catheter (indwelling catheter, a hollow tube inserted though the urethra [a tube through which urine leaves the body] into the urinary bladder to collect and drain urine).

During a concurrent observation in Resident 39's room and interview on 4/24/2024 at 10:06 AM, Certified Nursing Assistant 1 (CNA 1) was observed with only gloves on while providing care to Resident 39. CNA 1 stated she did not but should have put on a gown to prevent the spread of infection to other residents.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055153	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER Montebello Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1035 W Beverly Blvd Montebello, CA 90640	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 4/24/2024 at 10:52 AM, Infection Preventionist Nurse (IPN) stated, CNAs need to wear gown and gloves while providing close contact care (eating, changing, bathing) in enhanced standard precaution rooms. A review of the facility's Policy and Procedure titled, Infection Prevention and Control Program, revised 10/2018, indicated those with potential direct exposure to blood or body fluids are trained in and required to use appropriate precautions and personal protective equipment. Policy also indicated it is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. 48143 2. During a concurrent interview and record review on 4/25/24 at 9:40 A.M. with the Maintenance Director (MED), the MED stated he never used any toolkit to test the water for water management of Legionella for this facility since 2018. MED stated he did not monitor the cold-water temperature. MED stated he only conducted visual inspection of water heaters and lines and took temperature of hot water from randomly picked residents' rooms. MED stated he entered all the temperatures data to TELS (a building management platform designed for Senior Living with integrated Asset Management, Life Safety, and Maintenance solutions.) MED stated the TELS only recorded inspection data from Monday to Friday and has no data recording for Saturday and Sunday. MED added TELS does not have recording for the heaters and line inspection. MED stated he has no other paperwork to record the monitoring data besides TELS. MED stated hot water monitoring was conducted from Monday to Saturday, but there was no monitoring of hot water temperature, heaters, line inspection on Sundays. MED stated it was important to perform daily water monitor to prevent water contamination. MED added that it was important to test the water to ensure safe and sanitary water to prevent residents from getting sick. During an interview on 4/24/24 at 1:18 P.M. with the Infection Preventionist (IP), the IP stated, I know there is a water management policy in the infection control. IP stated MED knows how to take care of it and the maintenance department is responsible for water management of the infection control program. During a concurrent interview and record review on 4/25/24 at 10:03 A.M. with the Administrator (ADM), the ADM stated the facility did not use any toolkit to test the water. ADM stated the water management monitoring was not performed daily as it was described in the policy. ADM stated any data that was not logged into TELS, was not done. ADM stated it was important for the team to follow instructions to maintain proper water and stop legionella. During an interview on 4/25/24 at 4:35 P.M. with Dietary Manager (DM) and Registered Dietitian (RD), both DM and RD stated the blue water filter system in the kitchen under the sink is to supply drinking water for the whole facility's residents, visitors, and staff. During a review of the facility's Policy and Procedure (P&P) titled, Water Management, Legionella Plan, dated 1/1/2023, indicated the facility promotes proactive steps to establish healthy, infection-free environments for their residents, staff, and visitors. When residents contract Legionnaires' disease, it is often the result of exposure to inadequately managed building water systems, which can be prevented. It also indicated for the Facility to: I. Establish a water management program team. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	II. Describe the building water systems. III. Identify areas where Legionella could grow and spread. IV. Decide control measures and monitoring. V. Establish ways to intervene when control limits are not met. VI. Ensure the program is running as designed and is effective. A review of the Centers for Disease Control and Prevention (CDC) toolkit titled, Developing a Water Management Program to Reduce Legionella Growth & Spread in Buildings, dated 6/24/2021, indicated control measures and limits should be established for each control point. There is a need to monitor to ensure the control measures are performing as designed. Control limits, in which a chemical or physical parameter must be maintained, should include a minimum and a maximum value. Examples of chemical and physical control measures and limits to reduce the risk of Legionella growth: Water quality should be measured throughout the system to ensure that changes that may lead to Legionella growth (such as a drop in chlorine levels) are not occurring. Water heaters should be maintained at appropriate temperatures. Decorative fountains should be kept free of debris and visible biofilm. Disinfectant and other chemical levels in cooling towers and hot tubs should be continuously maintained and regularly monitored. Surfaces with any visible biofilm (i.e., slime) should be cleaned.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44636 Based on observation, interview and record review, the facility failed to ensure one of 22 sampled resident's (Resident 80) call light was within reach. This failure had the potential to result in Resident 80's not receiving assistance when needed from facility staff. Findings: A review of Resident 80's Admission Record indicated Resident 80 was admitted to the facility on [DATE] with the diagnoses including but not limited to hemiplegia (an inability to move one side of body) and hemiparesis (an inability to move the arm, leg and sometimes face on one side of the body) following a cerebral infarction (lack of blood flow resulting in severe damage to some of the brain tissue) affecting left non-dominant side. A review of Resident 80's Minimum Data Set (MDS, a comprehensive assessment and care screening tool), dated 4/06/2024, the MDS indicated Resident 80 had an impairment on one side of upper and lower extremity and required moderate to maximal assistance from staff for activities of daily living (ADLs, toileting hygiene, shower/bathe, upper and lower body dressing, and personal hygiene). During a concurrent observation in Resident 80's room and interview on 4/22/2024 at 9:58 AM, with Resident 80 and Licensed Vocational Nurse 4 (LVN 4), Resident 80 was observed lying in bed and the call light was on the floor, on the left side of the bed. Resident 80 stated he is unable to reach the call light in case he needs assistance from the staff. LVN 4 stated the call light is on the floor and it should be within reach of the resident at all times. During an interview on 4/25/2024 at 10:52 AM with the Director of Nursing (DON), the DON stated the call light should be placed within reach of the resident while in bed for easy access. The DON stated the call light should not be on the floor because the resident may need assistance with toileting, hygiene, repositioning and in case of an emergency. A review of the facility's Policy and Procedure (P&P) titled, Answering the Call Light, dated September 2022, indicated to ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 48143 Based on observation and interview, the facility failed to maintain a safe environment by failing to fix the broken tile around two uncovered sewer drains on the floor, in the hallway, causing the floor to be uneven. This deficient practice had the potential for residents, visitors, and staff to be placed at risk for fall and injury. Findings: During a concurrent observation at the hallway where the rehabilitation room was located and hallway infront of the kitchen and activity/dining room and interview with the Maintenance Director (MED) on 4/25/24 at 8:25 AM, the MED stated there was an uncovered sewer drain, in each area, about four (4) inches in circumference with a broken tile around the hole. MED stated all the sewer drains were supposed to be covered and the broken tile was supposed to be fixed to prevent residents, visitors, and staff from falling. MED stated housekeeping usually checks the floors and the maintenance department is responsible for repairs. MED stated he did not receive any reports for floor repairing. During an interview on 4/25/24 at 8:27 AM, in front of the rehabilitation room, Housekeeping Supervisor (HS) stated Housekeeping cleaned the hallway last night and have reported the two uncovered sewer drains and broken tile to the maintenance department so it can be fixed. HS stated, Somebody might fall due to the two uncovered sewer drains and one broken tile. A review of the facility's Policy and Procedure (P&P) titled, Maintenance Service, Physical Environment, revised on December/2009, indicated the maintenance service shall be provided to all areas of the building, grounds, and equipment. I. The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. 2. Functions of maintenance personnel include, but are not limited to: b. Maintaining the building in good repair and free from hazards. h. maintaining the grounds, sidewalks, parking lots etc., in good order. i. Providing routinely scheduled maintenance service to all areas. J. Others that may become necessary or appropriate.