STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055161	A. Building B. Wing	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Crest Rehabilitation Center	909 Lucile Ave. Los Angeles, CA 90026

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** 49881 Based on interview and record review, the facility failed to ensure each resident was treated with dignity to promote enhancements of quality of life for one of three sampled residents (Resident 58). For Resident 58 the Physicians Order for Life-Sustaining Treatment (POLST) indicating Do Not Resuscitate (DNR, when the heart stops beating, or a person stops breathing, there are no rescue measures taken, including cardiopulmonary resuscitation [CPR] an emergency lifesaving procedure that is done when someone's breathing or heartbeat has stopped) was not honored. This deficient practice resulted in Resident 58 receiving CPR against his wishes and not in accordance with his documented POLST instructions ([DATE]) for DNR when Resident 58 was found unresponsive on [DATE]. Findings: A review of Resident 58's Admission Record indicated the facility admitted the resident on [DATE] with diagnoses including chronic kidney disease (condition that occurs when the kidneys are damaged and cannot filter blood properly), benign prostatic hyperplasia (condition that occurs when the prostate gland enlarges, which can make it difficult to urinate), osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) A review of Resident 58's History and Physical (H&P) dated [DATE] indicated the resident had fluctuating capacity to understand and make decisions and Resident 58's Family Member(FM 1) was the surrogate decision maker. A review of Resident 58's POLST dated [DATE] indicated if the patient had no pulse and was not breathing, the resident cardiopulmonary resuscitation status was DNR (allow natural death). The POLST was signed by FM 1 on [DATE]. A review of Resident 58's Situation Background Assessment and Response form (SBAR) dated [DATE] at 4:35 AM, indicated a charge nurse (unidentified staff) went to the resident room to answer a call light and found Resident 58 with coffee ground emesis, was noted to be unresponsive, and immediate CPR was initiated. The form indicated 911 was called at 4:11 AM, 911 took over and was unable to resuscitate Resident 58. The SBAR form indicated FM 1 was called at 5:30 AM and made aware of the situation. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 58's Record of Death dated [DATE] at 4:35 AM, indicated Resident 58's principal cause of death was cardiopulmonary arrest and malignant neoplasm of the bladder. During an interview with Registered Nurse 1 (RN 1) on [DATE] at 11:31 AM, the RN 1 stated Resident 58 had a POLST dated [DATE] indicating the resident was DNR, which meant for staff not perform CPR. RN 1 confirmed Resident 58 did not have an order for his code status of DNR. RN 1 stated it was important to have a code status order so the staff were aware if the resident was full code or DNR. RN 1 stated it was important to honor resident and family wishes and not perform CPR as indicated in Resident 58's POLST form. During a phone interview on [DATE] at 11:53 AM, FM 1 stated she signed a paper indicating the resident (Resident 58) did not want compressions. FM 1 stated she had a conversation with Resident 58 (unable to recall date) and he told FM 1 he did not want compressions because he had heard his ribs can break and he did not want to have pain. FM 1 stated after the conversation with Resident 58, she signed a paper and made Resident 58 DNR. FM 1 stated she received a call on [DATE] at about 5:35 AM from a female staff (unable to recall name) from the facility reporting 911 came for Resident 58 and they could not do anything for the resident. The FM 1 stated the female staff did not state if Resident 58 received compressions and she did not ask questions. During an interview with the Director of Nursing (DON) on [DATE] at 12:19 PM, the DON stated DNR meant do not perform compressions when a resident was found unresponsive. The DON stated it was important to honor the POLST and follow the resident and family wishes. The DON stated Resident 58 did not have an order for code status in the resident's electronic health record. The DON stated it was important to have a code status order to ensure the staff know if they should perform CPR or not when a resident becomes unresponsive. A review of the facility's policy and procedure titled, Physician Orders for Life Sustaining Treatment (POLST), revised [DATE], indicated the order to Follow POLST Instructions will be added to the resident's admitting orders for physicians review. A review of the facility's policy and procedure titled, Do Not Resuscitate Order, revised ,d+[DATE], indicated the facility will not use cardiopulmonary resuscitation and related emergency measures to maintain life functions on a resident when there is a Do Not Resuscitate Order in effect. A review of the facility's policy and procedure titled, Dignity, revised ,d+[DATE], indicated the facility culture supports dignity and respect for residents by honoring resident goals, choices, preferences, values, and beliefs. This begins with the initial admission and continues throughout the resident's facility stay.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49836 Based on observation, interview, and record review, the facility failed to develop and implement a person-centered care plan for one of three sampled residents (Resident 16). Resident 16's preferred activity preferences were not included in the Activities care plan. This deficient practice had the potential to prevent Resident 16 from having meaningful activity to promote and enhance the resident's quality of life. Findings: A review of the Admission Record indicated Resident 16 was admitted to the facility on [DATE], with diagnoses including muscle wasting and atrophy (the loss or thinning of muscle tissue that can lead to a decrease in muscle mass and strength), sacral pressure ulcer (lower spine wound), and dependence on oxygen. A review of the Minimum Data Set (MDS, a federally mandated resident assessment tool) completed on 10/15/2024, indicated that while in the facility it was important for Resident 16 to have books, newspapers, and magazines to read. The MDS indicated Resident 16 did not have any cognitive impairment and was totally dependent with bed mobility and transfers. A review of Resident 16's Activities care plan revised on 10/10/2024, indicated the goal was to attend and participate in activities of choice. The interventions included inviting Resident 16 to scheduled activities and ensure that activities were compatible with individual needs and abilities. The care plan did not indicate Resident 16's interests such as reading books, newspapers, or magazines. During a concurrent observation and interview on 11/12/2024 at 12:10 PM, Resident 16 was observed lying in bed reading a magazine. Resident 16 stated she had not been able to leave her room because she was unable to walk and had discomfort sitting in a wheelchair due to her hemorrhoids (swollen and inflamed veins in the rectum and anus that cause discomfort and bleeding) and wound on her lower back. Resident 16 stated that someone came and offered magazines once or twice. During an interview with the Activity Director (AD) on 11/13/2024 at 8:57 AM, the AD stated the facility provided residents with different kinds of recreational activities that suit their preferences. The AD stated Resident 16 had a visit on 11/12/2024 and Resident 16 was given books to read as that was their preference. During a concurrent review of Resident 43's activities care plan, the AD stated Resident 43's care plan should have been updated to reflect the resident's current interests. A review of the facility's policy and procedure titled, Care Plans, Comprehensive Person-Centered, and revised July 2024, indicated to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49881 Based on observation, interview, and record review, the facility failed to assist two sampled residents (Resident 31 and Resident 214), who required assistance from staff with activities of daily living (ADLs - essential and routine activities include eating, dressing, getting into or out of a bed or chair, taking a bath or shower, and using the toilet). Resident 31 did not receive assistance with toileting hygiene on 11/11/2024 from about 10 PM to 11:10 PM. This deficient practice had the potential to lead to skin breakdown and Resident 214 experiencing dry lips, oral tissues, tongue, and teeth that were not brushed or cleansed. Findings: a. A review of Resident 31's Admission Record indicated the facility admitted the resident on 9/24/2024 with diagnoses including paraplegia (loss of movement and/or sensation, to some degree, of the legs), Type II diabetes (a disease that results in high levels of sugar in the blood), and end stage renal disease (irreversible kidney failure). A review of Resident 31's care plan initiated on 9/25/2024, indicated the resident had an Activities of Daily Living (ADLs) self-care performance deficit related to paraplegia, bacteremia, glaucoma, lumbar stenosis, deep vein thrombosis (a condition where a blood clot forms in a deep vein in the body, usually in the lower leg or thigh), and osteoporosis (weak and brittle bones due to lack of calcium and Vitamin D). The interventions indicated Resident 31 was totally dependent on one staff for toilet use and required maximum assistance for one staff for personal hygiene and oral care. A review of Resident 31's Minimum Data Set (MDS - a federally mandated assessment tool), dated 9/30/2024, indicated the resident had moderately impaired cognition, required substantial / maximal assistance with oral and personal hygiene, and was dependent on toileting hygiene. The MDS indicated Resident 31 was always incontinent (unable to control) of urine and bowel. A review of the facility's 3-11 PM Shift Assignments dated 11/11/2024, indicated Certified Nursing Assistant 1 (CNA 1) was Resident 31's assigned CNA. During an interview with Resident 31 on 11/12/2024 at 2:06 PM, Resident 31 stated there was an incident on 11/11/2024 in the 3-11 PM shift. Resident 31 stated she informed her assigned certified nurse assistant (CNA 1) that she would need a diaper (incontinent brief) changed between 10 PM to 10:15 PM. Resident 31 stated she turned her call light at about 10 PM to get a diaper change because she had a bowel movement. Resident 31 stated a male CNA (declined to provide name) answered her call light and told her that he would get the supplies to change her. Resident 31 stated the male CNA did not return and she pressed the call light again at 10:15 PM and her call light remained on until another CNA (CNA 3) from the 11 PM to 7 AM shift changed her diaper at about 11:10 PM. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview with Certified Nursing Assistant 2 (CNA 2) on 11/15/2024 at 8:56 AM, CNA 2 stated he observed Resident 31's call light on 11/11/2024 at about 10:20 PM and he answered the call light. CNA 2 stated Resident 31 reported she needed her incontinent brief changed and he informed the resident he would notify her assigned CNA (CNA 1). CNA 2 stated he informed CNA 1 that Resident 35 needed a diaper change and CNA 1 reported she would check on the resident. CNA 2 stated it was important to change the resident's incontinent brief timely because the resident could develop infection, pressure sore, and it was important for their dignity. During an interview with the Director of Nursing (DON) on 11/15/2024 at 9:37 AM, the DON stated Resident 31 was paraplegic and needed ADL assistance with personal and toileting hygiene. The DON stated it was important staff attend to resident's ADL such as toileting to prevent skin breakdown. During a phone interview with Certified Nursing Assistant 3 (CNA 3) on 11/15/2024 at 10:05 AM, CNA 3 stated on 11/11/2024 she observed Resident 31's call light on at 11:02 PM. CNA 3 stated Resident 31 reported she was wet and needed a diaper change and was not changed by the previous shift (3-11 PM). CNA 3 stated Resident 31 reported that CNA 2 from the previous shift had turned off her call light (unknown time) and did not return to assist the resident. CNA 3 stated she changed Resident 31's incontinent brief and that it was important change the resident's incontinent brief right away because they could develop redness on the skin and get a rash. During a phone interview with Certified Nurse Assistant 1 (CNA 1) on 11/15/2024 at 10:34 AM, CNA 1 stated she had changed Residents 31's incontinent brief at about 9 AM on 11/11/2024. CNA 1 stated she observed Resident 31's call light at about 10:20 PM. CNA 1 stated she was busy and asked CNA 2 to answer the call light. CNA 1 stated CNA 2 answered the call light and reported Resident 31 needed help (did not specify). CNA 1 stated she was busy with other residents and at the end of her shift at 11 PM she did not have time to go to Resident 31's room. CNA 1 stated Resident 31 could not move her legs and needed help with her incontinent brief. CNA 1 stated it was important to assist the resident as it could develop into skin issues. A review of the facility's policy and procedure titled, Activities of Daily Living, revised 7/2024, indicated residents will be provided with care, treatment, and services as appropriate to maintain to improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. 50296 b. A review of Resident 214's admission record indicated the resident was admitted to the facility on [DATE] with a diagnoses including nontraumatic intracerebral hemorrhage (a type of stroke that occurs when a blood clot forms in the brain), hemiparesis (a condition that causes weakness or an inability to move on one side of the body), and dysphagia (difficulty swallowing). A review of Resident 214's MDS dated [DATE], indicated Resident 214 did not have signs or symptoms of cognitive patterns, did not present with symptoms of depressed, hopelessness or feeling down, but presented with feelings of isolation. Resident 214's MDS indicated the resident was dependent for oral hygiene, toileting hygiene, showering, upper and lower body dressing, and personal hygiene. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During concurrent observation and interview on 11/12/24 at 10:09 AM, in Resident 214's room, Resident 214 was laying in the bed, the call light within his reach. Resident 214 was on gastrostomy feeding (g-tube - a method of delivering food and medication directly into the stomach through a feeding tube or button placed in an opening in the abdomen). Resident's 214 g-tube feeding, and flush syringe were labeled with date, time, and who prepped the feeding. During observation, Resident 214's mouth presented with dry lips sticking to his teeth as he talked, teeth appeared to have a thick substance on them. Resident 214 stated the care he received was 'so, so,' and the staff need education in paying attention to detail. During concurrent observation and interview on 11/13/24 at 8:42 AM with Resident 214's in his room, Resident 214 was resting in the bed. Resident 214 presented with dry mouth, lips crusty, and thick yellow substance on the resident's tongue. Resident 214 stated about a week ago was the last time he received oral care. The resident stated his daughter provided his oral care when she visited about a week ago. A review of Resident 214's Oral Hygiene Spreadsheet dated 11/24, indicated check marks under the column substantial/maximal assistance - a helper does more than half the effort. The spreadsheet indicated check marks under column dependent - a helper does all the effort. The spreadsheet indicated many checks under column not applicable. During an interview on 11/13/24 at 8:50 AM, LVN 1 stated the residents received oral care once every shift. LVN 1 stated the process to provide oral care was to use the soft mouth sponge and mouthwash. LVN 1 confirmed she saw Resident 214's mouth. LVN 1 stated if her mouth appeared like Resident 214's mouth she would not feel good. During concurrent interview and record review on 11/13/24 at 9 AM with CNA 4, Resident 214's Oral Hygiene Task Spreadsheet for the month of November 2024 was reviewed. The Oral Hygiene Spreadsheet indicated, Resident 214 received substantial/maximal assistance from a helper during oral care, dependent assistance from a helper during oral care, and non-applicable. CNA 4 stated the residents received oral care once a shift and care was provided with a mouth sponge, mouthwash, and/or a toothbrush. CNA 4 stated the check marks indicated Resident 214 was given maximum assistance (a helper does more than half the effort) during oral care or was totally dependent (helper does all of the effort) during oral care or non-applicable. CNA 4 stated when the check marks indicated non applicable, the oral care was not provided. CNA 4 confirmed there were several dates when the check marks indicated non-applicable. CNA 4 stated Resident 214's oral care was lacking due to it not being provided. CNA 4 indicated if she did not receive oral care, she would feel withdrawn and depressed. During a concurrent interview and record review on 11/13/24 at 12:35 with PM, the Minimum Data Set Nurse (MDSN), the Noncompliance related to Refusal of Oral Care Plan, dated 11/13/24 was reviewed. The Noncompliance related to Refusal of Oral Care Plan indicated the goal would be to inform Resident 214 of the risk and benefits of choices that were made daily. The MDSN stated the reason she applied the Noncompliance Care Plan was due to a progress note on 11/8/24 indicating Resident 214 refused oral care. The Oral Hygiene Task Spreadsheet, for the month of November 20241 was reviewed. The MDSN stated the checkmarks, on the oral care tasks spreadsheet, under the column nonapplicable could indicate the times the resident should receive oral care, but the resident was sleeping. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The MDSN stated she did not know where the CNA's chart the date, time care was provided and the assessment of the resident's mouth. The MDSN stated she went to visit Resident 214 to update the care plan. The MDSN stated she observed Resident 214's oral hygiene and stated that according to what she observed, oral care had not been performed for some time. The MDSN stated that if her oral hygiene appeared like Resident 241's oral hygiene, she would not feel good about it. During a concurrent interview and record review on 11/15/24 at 1:11 PM with the Director of Nursing (DON), the Oral Hygiene Task Spreadsheet for the month of November 2024, the facility's policy and procedure titled, Mouth Care, dated 7/24, and the MDS dated [DATE] were reviewed. The DON reviewed the Oral Hygiene Task Spreadsheet and confirmed the check marks under the column non-applicable indicated the task did not apply or that Resident 214 could perform oral care himself. The DON confirmed, per the MDS, that Resident 214 was dependent for oral care. Therefore, the DON stated the check marks on the spreadsheet indicating non-applicable could not apply to Resident 214, due to the resident's status of dependent for oral care per the MDS. The DON reviewed the P&P which indicated that all assessment date concerning the resident's mouth, the certified nursing assistance should report to the licensed nurse to record in the medical record. The DON stated maybe the certified nurse assistants did not understand the charting, and that they need to be reeducated. The DON stated he visited Resident 214 and observed the status of his mouth care. The DON stated Resident 214 had dry crusty substance on the tongue and dry lips. The DON stated if his oral care was not provided, he would not feel good. During an interview on 11/15/24 at 3 PM with Resident 214 and Family Member, the FM stated Resident 214's mouth looked better today and that she had had to give Resident 214 oral care when she visited due to oral care not being provided. A review of the facility's policy and procedure titled, Mouth Care, dated 7/24, indicated that all assessment data concerning the resident's mouth, the certified nurse assistant must report to the licensed nurse. The facility P&P indicated that the supervisor should be notified if the resident refused.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49836 Based on observation, interview and record review, the facility failed to ensure three of four sampled residents (Resident 9, 32, and 46), who received hemodialysis (a medical procedure to remove fluid and waste products from the body) had an emergency dialysis kit (a collection of supplies that people with kidney disease can use in case of an emergency) at the resident's bedside. This deficient practice had the potential for residents to receive a delayed intervention during accidental bleeding. Findings: a. A review of the Admission Record indicated Resident 46 was admitted to the facility on [DATE], with diagnoses including end stage renal disease (kidneys suddenly become unable to filter waste products from your blood that can develop rapidly over a few hours or a few days) and dependence on renal dialysis (your blood is put through a filter outside your body, cleaned, and then returned to you). A review of Resident 46's dialysis care plan revised on 10/12/2024, indicated for the facility staff to check and change the access site dressing daily and to monitor any signs and symptoms of infection to the access site. The care plan goal indicated Resident 46 would have immediate intervention should any signs and symptoms of complications from dialysis occur. A review of the Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 11/6/2024, indicated Resident 46 received dialysis while a resident in the facility, had no cognitive impairment, and needed maximum assistance with transfers and toileting. A review of the Physician's Orders dated 5/2/2024 indicated to monitor access site (right subclavian shunt- a catheter placed in the subclavian vein to provide access for hemodialysis) every shift for redness, swelling, drainage, and pain and to notify the MD. During an observation on 11/12/2024 at 9:54 AM in Resident 46's room, no emergency kit was noted at the bedside. During a concurrent interview and observation with the Registered Nurse (RN 1) on 11/13/2024 at 9:47 AM, the RN stated all resident's who were on dialysis should have an emergency kit at the bedside. The RN attempted to look for the emergency kit at Resident 46's bedside and was unable to find it. The RN stated that there could be a risk for bleeding and infection if there was no emergency kit available. During an interview with the Director of Nursing (DON) at 11/13/2024 at 11:22 AM, the DON stated that all dialysis residents should always have an emergency kit at bedside. The DON stated that by not having the emergency kit immediately available it can cause a delay in treatment if a resident experiences bleeding. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Center for Clinical Standards and Quality / Safety & Oversight Group dated 8/10/2018, indicated that the nursing home should ensure a reserve of supplies to be available in emergency circumstances. It further indicated that the emergency supply reserve was in excess of the routine supply inventory and generally included at least five (5) days of emergency supplies for each resident. 49881 b. A review of Resident 9's Admission Record indicated the facility admitted the resident on 9/27/2017 with diagnoses including end stage renal disease (irreversible kidney failure), Type II diabetes (a disease that results in high levels of sugar in the blood), and dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidneys have failed). A review of Resident 9's care plan revised on 10/13/2024, indicated the resident had a diagnosis of end stage renal disease with hemodialysis. The care plan intervention indicated to monitor hemodialysis site for signs and symptoms of infection and bleeding. A review of Resident 9's MDS dated [DATE], indicated the resident's cognition was intact and that the resident was on dialysis. A review of the Physician's Order dated 11/13/2024 indicated for Resident 9 to receive monitoring of the access site (right chest permacath- flexible tube that's inserted into a vein in the neck or upper chest for dialysis treatment and right arteriovenous fistula- a connection that's made between an artery and a vein for dialysis access) every shift for redness, swelling, drainage, and pain and to notify the MD. During a concurrent observation and interview on 11/13/2024 at 9:42 AM with Registered Nurse 1 (RN 1) in Resident 9's room, RN 1 stated Resident 9 was on dialysis and did not have an emergency kit at bedside. RN 1 stated it was important Resident 9 had an emergency kit at the bedside in case of an emergency of bleeding from the dialysis which would require immediate intervention. During an interview on 11/13/2024 at 11:21 AM, the DON stated all residents on dialysis should have an emergency dialysis kits at the bedside for an emergency like post bleeding after dialysis. The DON stated it was the standard of care for all dialysis residents to have an emergency kit at bedside. The DON stated the facility did not have a policy for dialysis emergency kit. c. A review of Resident 32's Admission Record indicated the facility admitted the resident on 6/14/2024 with diagnoses including end stage renal disease, Type II diabetes with chronic kidney disease (person has Type II diabetes and their kidneys are damaged over time due to high blood sugar levels), and dependence on renal dialysis. A review of the Physician's Order dated 9/12/2024 indicated Resident 32 to receive monitoring of the access site every shift for redness, swelling, drainage, and pain and to notify the MD. A review of Resident's 32's care plan revised on 10/5/2024, indicated the resident had a diagnosis of end stage renal disease with hemodialysis. The intervention included to monitor access site of right upper extremity arteriovenous fistula for signs and symptoms of infection and bleeding. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 32's MDS dated [DATE], indicated the resident's cognition was moderately impaired and that the resident was on dialysis. During a concurrent observation and interview on 11/13/2024 at 9:38 AM with RN 1 in Resident 32's room, RN 1 stated Resident 32 was on dialysis and did not have an emergency kit at bedside. RN 1 stated it was important Resident 32 had an emergency kit at bedside in case of an emergency like bleeding from the dialysis site that required immediate intervention. A review of Center for Clinical Standards and Quality / Quality, Safety & Oversight Group dated 8/10/2018, indicated that the nursing home should ensure a reserve of supplies to be available in emergency circumstances. It further indicated that the emergency supply reserve is in excess of the routine supply inventory and generally include at least five (5) days of emergency supplies for each resident.

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	055161	A. Building B. Wing	11/15/2024

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50296 Based on interview and record review, the facility failed to ensure residents received a monthly drug regimen review for one sampled resident (Resident 6). Resident 6's psychotropic medications (drugs that affect a person's mental state,Venlafaxine [an antidepressant and nerve pain medication] and Quetiapine [Seroquel], used for bipolar disorder) were not reviewed by the facility pharmacist for three months. This deficient practice caused an increased risk of adverse consequences associated with medication therapy. Findings: A review of Resident 6's admission record indicated the resident was admitted to the facility on [DATE] with diagnoses including major depressive disorder (a serious but treatable mood disorder that impacts how a person feels, thinks, and acts) and bipolar disorder (a mental illness that causes extreme shifts in mood, energy, and activity levels). A review of Resident 6's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 9/24/24, indicated the resident did not present with a deficit in cognitive patterns (no problems with persons ability to think, remember or use judgement), did not present with acute mental status changes, feelings of being depressed or hopeless, or little interest or pleasure in doing things. The MDS indicated Resident 6 sometimes felt isolated. During an observation on 11/12/24 at 11:01 AM, outside of Resident 6's room, the door was closed with an oxygen sign on the outside wall. After knocking and upon entrance, Resident 6 stated she did not want anyone coming in. A review of the Drug Regimen Review (DRR) binder for the months of August, September, and October of 2024, indicated there were no DRRs for Resident 6's psychotropic medications. During a review and concurrent interview with the Director of Nursing (DON) on 11/13/24 at 9:30 AM, after review of the DRR binder, the DON stated the August, September and October DRR for Resident 6's psychotropic medications were missing. The DON called the pharmacist to inquire about the missing DRR and the pharmacist then sent an email with the DRR recommendations for Resident 6. The DON presented a copy of the email from the pharmacist which indicated a recommendation from July 2024 for Resident 6. The DRR did not indicate recommendations for the months of August, September or October. During an interview on 11/14/24 at 11:43 AM, the pharmacist (PharmD) stated he did not necessarily send a list of residents reviewed with no recommendations each month. The PharmD stated regarding Resident 6, It's my responsibility to review every single medication for each resident and the DRR wasn't sent to the facility. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/15/24 at 9:41 AM, with the medical director (MD), the MD stated the PharmD comes on a quarterly basis to present a report in a Quarterly Quality Meeting where the PharmD will give a summary of each resident's medications. The MD stated he did not know how often the pharmacist reviewed each resident's medications. The MD stated, It is my responsibility to make sure to review my patient's medications. During an interview on 11/15/24 at 1:11 PM, the DON stated the PharmD was required to send the DRR for each resident for each month, regardless of recommendation. The DON stated the PharmD should indicate the resident's name on the recommendations list if no changes were required for the residents. The DON stated the resident could have an interaction because the pharmacy did not provide a recommendation. A review of the facility's policy and procedures titled, Medication Regimen Reviews, dated 5/2019, indicated the consultant pharmacist performed a MRR for every resident receiving medication in the facility. The P&P indicated the MRR was performed upon admission and at least monthly or more frequently if indicated.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49881 Based on observation and interview, the facility failed to store food properly in accordance with professional standards of practice when several food items in the kitchen were observed unlabeled and undated. These failures placed the residents at risk for food borne illness or contamination. Findings: a. During the initial kitchen tour with the Dietary Supervisor (DS) on 11/11/2024 8:22 AM, one full pitcher of brown liquid was observed undated and unlabeled in the walk-in refrigerator. During a concurrent interview, the DS stated the pitcher contained apple juice and confirmed the pitcher was unlabeled and undated. The DS stated it was important to label the pitcher of juice because there was a potential for foodborne illness when resident receive food after the used by date. During an observation and concurrent interview with the DS on 11/11/2024 at 8:32 AM in the Dry Storage Room, three packs of bread were observed undated. The DS stated it was important the bread was labeled with a delivery date, so the staff knew when it was delivered. During a follow-up visit and observation in the kitchen with the DS on 11/13/2024 at 12:55 PM, at least 79 cups of juice and milk in the walk-in refrigerator were observed unlabeled and undated. During an interview with the DS on 11/13/2024 at 12:57 PM, the DS stated the cups of orange juice, apple juice, cranberry juice, and milk were unlabeled and undated, The DS stated it was important to label and date the cups of juice and milk because there was a potential for foodborne illness when resident receive food after the used by date. A review of the facility's policy and procedure titled, Food Receiving and Storage, revised 7/2024, indicated refrigerated foods were labeled, dated and monitored so they were used by their use-by date, frozen, or discarded. The policy indicated dry foods that were stored must be labeled and dated (use by date, delivery date).

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 50296 Based on interview and record review, the facility failed to ensure to report the Payroll-Based Journal (PBJ - a method to collect staffing data from nursing facilities) for the 3rd quarter (April 1-June 30). This deficiency resulted in the inaccurate data reporting of direct care staff, providers, and vendors potentially placing the facility at risk of not implementing their policy. Findings: A review of the Certification and Survey Provider Enhanced Reports (CASPER) for the PBJ Staffing Data Report Fiscal Year Quarter 3 2024 (April 1 - June 30) indicated the metric was triggered for Failed to Submit Data for the Quarter. During an interview on 11/15/2024 at 12:28 p.m. with the Administrator (ADM) and payroll (Staff 1), Staff 1 stated she had been employed at the facility since 9/16/2024. The ADM stated there was no gap in between when Staff 1 started, and the last payroll staff exited. Staff 1 stated the PBJ was submitted quarterly and received from the payroll department. The ADM stated the previous payroll staff submitted the PBJ for the 3rd quarter in August 2024, but there were a few days that the Wi-Fi in the office was down in the evening but came back on. The ADM was not sure if there was a problem with the submission. The ADM stated the previous payroll staff remained late at the facility to submit the PBJ. The ADM stated the previous payroll staff failed to add the rehabilitation department to the PBJ report. The ADM stated the facility called Centers for Medicare and Medicaid Services (CMS) to report they failed to submit the rehabilitation department. The ADM stated the facility resubmitted the report with the rehabilitation department included in October. During concurrent interview and record review on 11/15/24 at 2:14 p.m. with the ADM, the CASPER Reports Submit printout was reviewed. The CASPER Reports Submit printout indicated the report was the 1705D Staffing Data Report, with the State: CA, the facility's CCN number, and the Fiscal Quarter: Quarter 3 2024 (April 1 - June 30). The report had no date of submission included in the report. The ADM stated the printout revealed the PBJ was submitted, but the ADM confirmed there was no date confirmed on the submission. The ADM stated she would try to produce the date of submission for the PBJ for the 3rd Quarter. The ADM stated that on the submission website, the date of the submission can be viewed for 24 hours. The ADM could not produce the date of submission. A review of the facility's policy and procedure (P&P) titled, Reporting Direct Care Staffing Information (Payroll-Based Journal), dated 8/2022, indicated the direct care staffing information was reported electronically to CMS through the Payroll-Based Journal system. The P&P indicated a complete and accurate direct care staffing information was reported electronically in a uniform format and the direct care staffing information was submitted on the schedule specified by CMS, but no less frequently than quarterly. The P&P indicated the staffing information must be collected and reported no later than 45 days after the end of the reporting quarter; the 3rd quarter deadline was August 14.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49836 Based on observation, interview, and record review, the facility failed to ensure 14 out of 29 (Rooms 21, 22, 23, 24,25, 26,27,28, 33, 34, 35, 36, 37, and 38) met the required 80 square feet per resident. This deficient practice had the potential to result in inadequate space necessary to provide safe nursing care and privacy for residents. Findings: During an observation on 11/15/2024 at 10:01 AM, the Maintenance Supervisor (MS) measured Rooms 21, 22, 23, 24,25, 26,27,28, 33, 34, 35, 36, 37, and 38. The rooms measured as follows: Room No: Room Sq. Footage: Resident Capacity: Square Ft. Per 21 14'4x 10'7 2 151.69 22 20'1x 14'5 4 289.53 23 14'4x 10'6 2 150.5 24 14'4x 10'7 2 151.69 25 14'4x 10'6 2 150.5 26 14'4x 10'6 2 150.5 27 14'4x 10'6 2 150.5 28 14'4x 10'6 2 151.38 33 14'3x 10'6 2 149.63 34 14'3x 10'5 2 148.44 35 14'3x 10'3 2 146.06 36 14'3x 10'4 2 147.25 37 14'3x 10'3 2 146.06 38 14'3x 10'5 2 148.44 The measurements were compared to the client accommodation analysis dated 11/15/2024 and all measurements indicated in the client accommodation analysis matched the measurements taken on 11/15/2024 at 10:01 AM. (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview with Resident 160 on 11/15/2024 at 8:52 AM in room [ROOM NUMBER], Resident 160 stated that the room was a little tight. Resident 160 stated they requested to be moved to a bigger room about three days ago but did not remember who they informed. Resident 160 stated they had not followed up regarding the room change because they would be discharged as of today. During an interview on 11/15/2024 at 8:58 AM in room [ROOM NUMBER], Resident 17 stated they were in the same room since admission to the facility in July. Resident 17 stated there was no issue with the room size and there was enough room for the staff when providing care. Resident 17 stated when visitors come there was plenty of room and privacy. During an observation and interview with the Licensed Vocational Nurse (LVN 1) on 11/15/2024 at 9:02 AM, LVN 1 was observed passing medications in room [ROOM NUMBER]. LVN 1 stated she was able to perform the tasks in the resident's rooms with no issues and that there was enough space in the rooms. LVN 1 stated that when a resident requested to be moved to a more spacious room, the issue was immediately addressed and the facility tried to move the resident within 24 hours. LVN 1 stated there were no complaints from any residents regarding an issue with their room size. A review of the facility's policy and procedures titled, Bedrooms, revised July 2024, indicated bedrooms were to measure at least 80 square feet of space per resident in double rooms.