STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055163	A. Building B. Wing	05/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montecito Heights Healthcare & Wellness Centre, LP	4585 N. Figueroa St. Los Angeles, CA 90065

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview and record review, the facility failed to provide a Notice of Medicare Non-Coverage (NOMNC, a notice that is provided to beneficiaries that indicates when their Medicare covered services are ending) to one of three sampled residents (Resident 129). This failure had the potential to result for Resident 129 not to be informed of her coverage end date and not being able to exercise her right to file an appeal of her discharge from the facility. Findings: During a review of Resident 129's admission Record, the admission Record indicated the facility admitted the resident on 8/16/2024 with diagnoses that included type 2 diabetes (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), hypertension (high blood pressure), and anxiety disorder (a mental health condition with feeling of worry, anxiety, or fear interfering with one's daily activities). During a review of Resident 129's Minimum Data Set (MDS, a resident assessment tool) dated 11/10/2024, the MDS indicated the resident was cognitively intact (had the ability to think, understand, and reason). The MDS indicated Resident 129 required set up or clean up assistance with eating, oral hygiene, toileting hygiene, showering/bathing self, upper/lower body dressing, putting on/taking off footwear, and personal hygiene. During a review of Resident 129's Skilled Nursing Facility (SNF) Beneficiary Notification Review form, the Beneficiary Notification Review form indicated the resident's last covered day for Medicare Part A skilled services was on 11/9/2024. The Beneficiary Notification Review form indicated the facility initiated the discharge from Medicare part A Services when benefit days were not exhausted. The Beneficiary Notification Review form indicated Resident 129 was not provided with a NOMNC because the resident left the facility to go home. (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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/25/2025 at 10:31 AM, with the Business Office Manager (BOM), Resident 129's SNF Beneficiary Notification Review form was reviewed. The BOM stated Resident 129 should have been provided with a NOMNC because the resident's discharge was initiated by the facility. The BOM stated a NOMNC should be provided to the resident, so the resident would be aware the resident had the option to appeal the discharge if the resident felt she was not ready to be discharged . The BOM stated there was a potential for the resident to not know she (the resident) had the option to appeal the discharge if the resident was not given a NOMNC. During an interview on 5/25/2025 at 3:14 PM with the Director of Nursing (DON), the DON stated Resident 129 was discharged on 11/10/2024. The DON stated Resident 129's discharge was planned. The DON stated Resident 129 should have received a NOMNC because the resident's discharge was planned. The DON stated a NOMNC notified the residents of their last covered day and the option to appeal the discharge if they are not ready. The DON stated there was a potential for the residents (in general) not to have the option and ability to appeal the discharge if the residents (in general) were not given a NOMNC. During a review of the facility's Policy and Procedure (P&P) titled Medicare Denial Process dated 3/10/2025, the P&P indicated Purpose: To properly determine and inform Medicare beneficiaries of coverage decisions in accordance with Medicare guidelines for Medicare Part A and Part B coverage. Policy: Medicare beneficiaries will be properly notified when it is determined that they do not meet the requirements for covered skilled services under the Medicare Program . Notice of Medicare Non-Coverage (NOMNC/Generic Notice/CMS-10123): The beneficiary or representative will sign and date the applicable Generic Notic acknowledging that is was received. If the facility is unable to personally deliver the Generic Notice to a person legally acting on behalf of the beneficiary, then the facility must contact the representative via telephone and advise the representative when the beneficiary's services are no longer covered. During a review of the Centers for Medicare and Medicaid Services (CMS) undated document titled Form Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS -10123, the documented indicated A Medicare provider or health plan (Medicare Advantage plans and cost plans, collectively referred to as plans) must deliver a completed copy of this notice to beneficiaries/enrollees receiving covered skilled nursing, home health, comprehensive outpatient rehabilitation facility, and hospice services. The NOMNC must be delivered at least two calendar days before Medicare covered services end or the second to last day of service if care is not being provided daily.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed ensure the Minimum Data Set (MDS, a resident assessment tool) was accurately performed for two of six sampled residents (Resident 67 and Resident 48) by failing to: 1.Ensure the MDS assessment for restraints (any physical, chemical, or mechanical device or method used to limit a patient's movement or restrict their freedom of movement, typically to prevent harm to themselves or others) was accurately performed for Resident 67. 2.Ensure the MDS assessment for bowel and bladder was accurately documented for Resident 48. This failure had the potential to result in inadequate care for Resident 67 and Resident 48. Findings: 1.During a review of Resident 67's admission Record, the admission Record indicated the facility admitted the resident on 3/13/2025 with diagnoses that included dementia (a progressive state of decline in mental abilities), difficulty in walking, and muscle weakness. During a review of Resident 67's MDS dated [DATE], the MDS indicated the resident had moderately impaired cognition (some impairment in the ability to think, understand, and reason). The MDS indicated that a trunk (the upper part of the body that includes the back and abdomen) restraint was used less than daily for Resident 67. During an observation on 5/23/2025 at 7:42 PM, in Resident 67's room, the resident was observed sitting on the side of her bed watching TV. Resident 67's was observed without restraints. During an interview on 5/24/2025 at 12:53 PM with Certified Nursing Assistant (CNA) 2, CNA 2 stated that she was taking care of Resident 67. CNA 2 stated Resident 67 did not have restraints. During an interview on 5/25/2025 at 1:06 PM with Licensed Vocational Nurse (LVN) 1, LVN 1 stated she (LVN1) was taking care of Resident 67. LVN 1 stated Resident 67 never had restraints. LVN 1 stated the facility did not use restraints. During a concurrent interview and record review on 5/24/2025 at 2:50 PM, with the MDS Coordinator (MDSC), Resident 67's MDS dated [DATE] was reviewed. The MDSC stated the MDS indicated Resident 67 used trunk restraints daily. The MDSC stated Resident 67's MDS assessment for restraints was not accurate. The MDSC stated Resident 67 did not have restraints. The MDSC stated that the MDS assessments should be accurate because they paint a picture of the resident's needs and the services that are provided to them. The MDSC stated that if the MDS assessment was not accurate there was a potential for the resident not to get the care Resident 67 needed. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/25/2025 at 3:11 PM, with the Director of Nursing (DON), Resident 67's MDS assessment dated [DATE] was reviewed. The DON stated the MDS for Resident 67 had an inaccurate assessment of trunk restraints. The DON stated Resident 67 did not have restraints. The DON stated the MDS assessments should always be accurate. The DON stated that an inaccurate MDS assessment had the potential to lead to inadequate care for the resident. During a review of the facility's Policy and Procedure (P&P) titled RAI Process dated 3/10/2025, the P&P indicated Purpose: To provide resident-assessments that accurately depict and identify resident-specific issues and objectives as required, while meeting state and federal guidelines and data submission requirements. The facility will utilize the Resident Assessment Instrument (RAI) process as the basis for the accurate assessment of each resident's functional capacity and health status, as outlined in the CMS RAI MDS 3.0 Manual. 2.During a review of Resident 48's admission Record, the admission Record indicated the facility admitted Resident 48 on 3/28/2025 with diagnoses including resistance to multiple antimicrobial drugs (medication that kills microorganisms [can be seen only through a microscope] such as bacteria or mold, or stops them from growing and causing disease), urinary tract infection (UTI- an infection in the bladder/urinary tract), acute kidney failure (a sudden and often reversible loss of kidney (organ that filters blood] function, where the kidneys are no longer able to filter waste products from the blood) and difficulty in walking. During a review of Resident 48's Care Plan Report, dated 3/28/2025, the Care Plan Report indicated Resident 48 was continent (able to verbalize/control bladder and bowel movements) of bowel and bladder and the goal was to keep Resident 48 dry, clean, and comfortable. During a review of Resident 48`s History and Physical (H&P), dated 3/31/2025, the H&P indicated Resident 48 had the capacity to understand and make decisions.  During a review of Resident 48`s MDS, dated [DATE], the MDS indicated Resident 48 could understand others and make herself understood. The MDS indicated Resident 48 was frequently, but not always, incontinent (to lack control) of bladder and bowel. The MDS indicated resident 48 was not currently offered the bowel and bladder program (program to assist the resident in retraining continence). During an interview on 5/24/2025 at 11:24 am with Resident 48, Resident 48 stated she (Resident 48) knew when she (Resident 48) needed to urinate and have a bowel movement. Resident 48 stated she (Resident 48) would wear depends (disposable underwear) and almost never soiled herself. Resident 48 stated she (Resident 48) soiled herself the night 5/23/2025 and stated I couldn't make it and it makes me sad. It's so embarrassing. Resident 48 stated it would be helpful to be reminded on a schedule and assisted to the restroom. During a concurrent interview and record review on 5/24/2025 at 1:25 pm, Resident 48's MDS and Care Plan with the Minimum Data Set Coordinator (MDSC) was reviewed. The MDS stated Resident 48's MDS should have reflected Resident 48's care plan that indicated Resident 48 was continent. The MDSC stated the initial care plan was completed by a Registered Nurse and the Registered should have reviewed the care plan to help determine Resident 48's bowel and bladder status to help prevent UTI's and skin breakdown. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/25/2025 at 3:14 pm Resident 48's MDS and Care Plan Report were reviewed with the Director of Nursing (DON). The DON stated the MDS and care plan information must match, and accuracy of assessments were extremely important because without accuracy, it could lead to a lack of care to a resident. The DON stated Resident 48 had a history of UTI's, was alert and should have been started on a Bowel and Bladder program. During a review of the facility's P&P titled, Bowel and Bladder Training/Toileting Program last reviewed on 3/10/2025, indicated the purpose of the program is to provide for residents who are incontinent of bowel and/or bladder appropriate treatment and services to minimize UTIs and to restore as much bowel and/or bladder function as possible to prevent skin breakdown and irritation, to improve the resident's morale and restore resident dignity and self respect.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop a complete baseline care plan for one of one sampled resident (Resident 23) by failing to address Resident 23's dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney[s] have failed) access site. This failure had the potential for Resident 23 not to receive the appropriate care and treatment. Findings: During a review of Resident 23's admission Record, the admission Record indicated the facility admitted the resident on 3/17/2025, with diagnoses including end stage renal disease (ESRD, irreversible kidney failure), hypertension (HTN, high blood pressure), and acquired absence of left leg below knee and lack of coordination. During a review of Resident 23`s History and Physical (H&P) dated 3/17/2025, the H&P indicated the resident had the capacity to understand and make decisions.  During a review of Resident 23's physician Order Summary Report dated 3/18/2025, the Order Summary Report indicated to monitor Resident 23`s left femoral artery (the main artery in the left thigh, supplying blood to the structures in the leg) permcath site (a special catheter used for short-term dialysis treatment) for redness, tenderness, bleeding, and drainage during every shift. During a review of Resident 23's Minimum Data Set (MDS, a resident assessment tool) dated 3/24/2025, the MDS indicated the resident`s cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was intact (decisions consistent/reasonable). The MDS indicated Resident 23 required staff partial/moderate assistance (helper does less than half the effort) for eating, oral hygiene, toileting hygiene, and personal hygiene. The MDS indicated Resident 23 would undergo dialysis. During a concurrent interview and record review on 5/24/2025 at 1:38 PM with Registered Nurse 1 (RN 1), Resident 23`s baseline care plan and physician orders were reviewed. RN1 stated Resident 23 was admitted to the facility on [DATE] with a left femoral permcath and a left and right upper arm arteriovenous fistula (AVF, a connection that is made between an artery and a vein for dialysis access). RN 1 stated Resident 23`s current access for dialysis was Resident 23's left femoral permcath. RN 1 stated Resident 23`s baseline care plan initiated on 3/17/2025, did not indicate the resident had a left femoral permcath. RN 1 stated residents` (in general) baseline care plans must be completed thoroughly including all the necessary information regarding the residents` care. RN 1 stated the potential outcome of not thoroughly completing a resident`s baseline care plan (in general) was the inability to meet the resident`s immediate care needs and the lack of care. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/25/2025 at 2:12 PM, with the Director of Nursing (DON), the DON stated a resident`s baseline care plan (in general) was required to be completed within 48 hours of the resident`s admission to the facility. The DON stated that upon admission, licensed staff are required to develop a complete and thorough baseline care plan for each resident and to address all necessary information to properly care for the residents. The DON stated Resident 23`s baseline care plan was not completed thoroughly because the baseline care plan did not indicate anything about the resident`s left femoral dialysis access site. The DON stated the potential outcome was the inability to meet the resident`s immediate care needs for the dialysis access site and the inability to deliver necessary services to the resident.  During review of the facility`s Policy and Procedure (P&P) titled Person-Centered Care Planning, last reviewed on 3/10/2025, the P&P indicated that the baseline care plan must include the minimum healthcare information necessary to properly care for each resident immediately upon their admission. It should address resident-specific health and safety concerns to prevent decline or injury, and would identify needs for supervision, behavioral interventions, and assistance with activities of daily living, as necessary. The baseline care plan would be developed and implemented, using the necessary combination of problem specific care plans to promote continuity of care and communication among facility staff, increase resident safety and safeguard against adverse events within 48 hours of the resident`s admission.

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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. Based on interview and record review, the facility failed to develop an individualized person-centered care plan (a plan of care that summarizes a resident's health conditions, specific care and services facility staff need to provide a resident to promote healing and prevent a worsening of a condition, and current treatments) to meet the resident's needs for two of six sampled residents (Resident 64 and Resident 38) by failing to: 1.Ensure to create an appropriate care plan for Resident 64's incontinence (the involuntary leakage of bodily fluids, specifically urine or stool). 2. Ensure to create a care plan to address Resident 38's oxygen use. This failures had the potential to result in Resident 64 and Resident 38 not to have their needs met. Findings: 1.During a review of Resident 64's admission Record, the admission Record indicated the facility admitted the resident on 9/9/2024 with diagnoses that included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (mild or partial weakness or loss of strength on one side of the body), difficulty in walking, muscle weakness, transient ischemic attack (TIA, a temporary disruption of blood flow to the brain) and the need for assistance with personal care. During a review of Resident 64's Minimum Data Set (MDS, a resident assessment tool) dated 3/12/2025, the MDS indicated the resident had severe cognitive impairment (impairment in the ability to think, understand, and reason). The MDS indicated the resident was frequently incontinent of bowel and urine. During a review of Resident 64's care plan dated 3/25/2025, the care plan indicated the resident was incontinent of bowel and bladder. The care plan indicated a goal for Resident 64 to be dry, clean, and comfortable. The care plan indicated an intervention to administer medications as ordered and document the medications effectiveness. The care plan indicated there were no other interventions listed. During a concurrent interview and record review on 5/25/2025 at 12:46 PM, with the MDS Coordinator (MDSC), Resident 64's care plan for incontinence dated 3/25/2025 was reviewed. The MDSC stated the only intervention on Resident 64's care plan for incontinence was to administer medications as ordered and document the medications effectiveness. The MDSC stated Resident 64's care plan for incontinence was not sufficient. The MDSC stated other interventions for Resident 64's care plan for incontinence could include assisting the resident when going to the bathroom and changing soiled incontinence briefs as needed. The MDSC stated the care plan should be sufficient and have appropriate interventions to ensure the resident reached his goals. The MDSC stated the care plan should be resident centered and should indicate the care that was provided to the resident. The MDSC stated that there was a potential for Resident 64 to not reach his goals and could develop a UTI because the care plan was not created appropriately. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/25/2025 at 3:16 PM, with the Director of Nursing (DON), Resident 64's incontinence care plan dated 3/25/2025 was reviewed. The DON stated Resident 64 only had one intervention on his care plan for incontinence. The DON stated Resident's 64's care plan for incontinence was not sufficient. The DON stated there should have been more interventions that addressed the care that was provided to Resident 64 for incontinence. The DON stated that because the care plan was not sufficient there was potential for Resident 64 to not have his needs completely met. During a review of the facility's Policy & Procedure (P&P) titled P-NP04 Person-Centered Care Planning dated 3/10/2025, the P&P indicated The facility must develop and implement a comprehensive person-centered care plan for each resident consistent with the 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 comprehensive assessment. The comprehensive care plan must describe the following: The services that are to be furnished to attain to maintain the resident's highest practical, physical, mental, and psychosocial well-being. 2.During review of Resident 38`s admission Record, the admission Record indicated the facility admitted the resident on 5/6/2025 with diagnoses including cough, dementia (a progressive state of decline in mental abilities), and type two diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 38's Order Summary Report (physician order) dated 5/9/2025, the Order Summary Report indicated to administer oxygen at two (2) liters per minute via nasal canula (NC, a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) as needed for shortness of breath (SOB) to keep the resident`s oxygen saturation (a measurement of how much oxygen your blood is carrying compared to its maximum capacity-for healthy adults, normal oxygen saturation is between 95% and 100%) above 92%. During a review of Resident 38's Minimum Data Set (MDS, a resident assessment tool) dated 5/13/2025, the MDS indicated the resident`s cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated Resident 38 required staff substantial/maximal assistance (helper does more than half effort) for eating, oral hygiene, upper body dressing, and personal hygiene. During a review of Resident 38's care plans, the care plans (in general) did not indicate a comprehensive care plan to address Resident 38`s oxygen use.  During a concurrent interview and record review on 5/25/2025 at 12:49 PM, with the MDS Coordinator (MDSC), Resident 38`s physician orders and care plans were reviewed. The MDSC stated Resident 38 used oxygen. The MDSC stated licensed nurses (in general) did not develop a comprehensive care plan with person-centered interventions for the resident`s oxygen use. The MDSC stated that it was required to develop a person-centered care plan with goal and interventions to monitor Resident 38`s oxygen use. The MDSC stated the potential outcome of not developing a care plan for a resident who used oxygen (in general) was the lack of care and the inability to implement the specific services and monitoring that a resident required.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to follow the physician's order for one of four sampled residents (Resident 36) who was at risk for developing pressure injuries/sores (PI, injuries to the skin and underlying tissue resulting from prolonged pressure on the skin) by failing to: 1. Ensure to provide Resident 36 with bilateral (both) heel protectors (a device used to prevent and treat heel pressure sores) while Resident 36 was in bed. This failure placed Resident 36 at risk for developing PIs. Findings: During a review of Resident 36's admission Record, the admission Record indicated the facility admitted Resident 36 on 1/8/2025 and readmitted Resident 36 on 4/6/2025 with diagnoses including Diabetes Mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity) and paraplegia (loss of movement and/or sensation, to some degree, of the legs). During a review of Resident 36's risk for skin break/ulcer formation care plan initiated 1/8/2025, the care plan indicated the resident was at risk for pressure ulcer development related to impaired mobility, incontinence, and poor nutrition. The care plan indicated the interventions included to provide pressure redistributing devices and assess for effectiveness and bilateral heel protectors while the resident was in bed. During a review of Resident 36's Order Summary Report (physician orders) dated 2/25/2025, the Order Summary Report indicated an order for bilateral heel for protectors while Resident 36 was in bed. During a review of Resident 36's Minimum Data Set (MDS, a resident assessment tool) dated 4/13/2025, the MDS indicated Resident 36 had moderately impaired cognition (ability to think, understand, and reason). The MDS indicated Resident 36 required total assistance with one-person physical assist for transfer, bed mobility, dressing, toilet use, and personal hygiene. During a review of Resident 36's Braden Scale (pressure ulcer risk predictor tool) dated 5/4/2025, indicated Resident 36 was at moderate risk to develop a pressure ulcer. During a concurrent observation and interview at Resident 36's bedside on 5/24/2025 at 1:09 PM, with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated Resident 36 was not wearing bilateral heel protectors while in bed. LVN 2 stated Resident 36's heels were placed on a pillow. LVN 2 stated Resident 36's heels were to be floated off a pillow to protect them (heels) from developing a pressure sore. LVN 2 stated Resident 36 had a physician order for bilateral heel protectors while in bed. LVN 2 stated Resident 36 could develop a pressure injury as a possible outcome for not having bilateral heel protectors. (continued on next page)

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Montecito Heights Healthcare & Wellness Centre, LP	4585 N. Figueroa St. Los Angeles, CA 90065

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/25/2025 at 3:27 PM, the Director of Nursing (DON), the DON stated Resident 36 had an order for bilateral heel protectors. The DON stated Resident 36 should have bilateral heel protectors on while in bed and the lack of bilateral heel protectors could lead to skin breakdown. During a review of the facility's policy and procedure titled, Pressure Injury Prevention, reviewed 3/10/2025, indicated, [staff are to] implement interventions identified in the plan of care which may include, but are not limited to the following: a. Pressure redistributing devices for bed and chair b. Repetitioned turning c. Heel and elbow protectors . e. Off loading pressure from heels

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to follow the physician orders for one of four sampled residents (Residents 36) by failing to provide Resident 36 with bilateral (both) padded siderails (are adjustable metal or rigid plastic bars that attach to the bed) for safety. This failure had the potential to place Resident 36 at risk for injury. Findings: During a review of Resident 36's admission Record, the admission Record indicated the facility admitted Resident 36 on 1/8/2025 and readmitted the resident on 4/6/2025 with diagnoses including diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity) and paraplegia (loss of movement and/or sensation, to some degree, of the legs). During a review of Resident 36's seizure disorder (a sudden, uncontrolled electrical disturbance in the brain) care plan, initiated 1/8/2025, the care plan indicated the resident had a seizure disorder. The care plan interventions included not to leave the resident alone during a seizure and to protect the resident from injury. During a review of Resident 36's Order Summary Report (physician orders) dated 4/6/2025, the Order Summary Report indicated for Resident 36 to have bilateral padded side rails for seizure precautions. During a review of Resident 36's History and Physical dated 4/8/2025, the History and Physical indicated the assessment and plan for the resident's seizure disorder was to monitor for breakthrough activity and to continue with anticonvulsants as prescribed. During a review of Resident 36's Minimum Data Set (MDS, a resident assessment tool) dated 4/13/2025, the MDS indicated Resident 36 had moderately impaired cognition (ability to think, understand, and reason). The MDS indicated Resident 36 required total assistance with one-person physical assist for transfer, bed mobility, dressing, toilet use, and personal hygiene. During an observation on 5/23/2025, at 7:22 PM, Resident 36 was observed lying in bed, watching television. Resident 36's bedrails did not have any padding as a precaution for seizure. During a concurrent observation and interview at Resident 36's bedside on 5/24/2025 at 1:09 PM, Licensed Vocational Nurse 2 (LVN 2) stated Resident 36 did not have bilateral side rail pads. LVN 2 stated Resident 36 had an order for bilateral side rail padding. LVN 2 stated the use of the side rails padding was to protect Resident 36 from injury if the resident had a seizure. During an interview on 5/25/2025 at 3:27 PM, the Director of Nursing (DON), the DON stated Resident 36 has diagnoses for seizure and it was required to pad and cover the resident's side rails to protect the resident from injury caused by a seizure. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure P&P titled, Seizure, with a review date of 3/10/2025, the P&P indicated the purpose of the policy was to ensure the safety of the residents during a seizure activity. The P&P also indicated seizure precautions may include: A. Medications as ordered by the physician; B. Labs as ordered by the physician; C. Adjusting the resident's bed to the lowest setting; and/or D. Padding the side rails, as applicable.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, and record review, the facility failed to ensure two of two sampled residents (Resident 48 and Resident 278) received appropriate urinary and bowel care services by failing to: 1.Ensure Resident 48 who was continent (able to verbalize/control bladder and bowel movements) on admission, received services and assistance to maintain continence. 2. Ensure Resident 278's urinary catheter (a hollow tube inserted into the bladder to drain or collect urine) did not have a dependent loop (restricts urine flow from the bladder and can lead to improper bladder emptying), and urine did not backflow to the urine drainage port. These failures had the potential to negatively affect Resident 48 and Resident 278 from receiving the proper care necessary to prevent urinary tract infection (UTI, an infection in any part of the urinary system), and skin breakdown. Findings: 1.During a review of Resident 48's admission Record, the admission Record indicated the facility admitted Resident 48 on 3/28/2025 with diagnoses including resistance to multiple antimicrobial drugs (medication that kills microorganisms [can be seen only through a microscope] such as bacteria or mold, or stops them from growing and causing disease), UTI, acute kidney failure (a sudden and often reversible loss of kidney (organ that filters blood] function, where the kidneys are no longer able to filter waste products from the blood) and difficulty in walking. During a review of Resident 48`s History and Physical (H&P) dated 3/21/2025, the H&P indicated Resident 48 had the capacity to understand and make decisions. During a review of Resident 48's Care Plan Report, dated 3/28/2025, the Care Plan Report indicated Resident 48 was continent of bowel and bladder and the goal was to keep Resident 48 dry, clean, and comfortable. During a review of Resident 48`s Minimum Data Set (MDS, a resident assessment tool) dated 4/4/2025, the MDS indicated the Resident 48 could understand others and make herself understood. The MDS indicated Resident 48 was frequently, but not always, incontinent (to lack control) of bladder and bowel. The MDS indicated resident 48 was not currently offered the bowel and bladder program (program to assist the resident in retraining continence). During an interview on 5/24/2025 at 11:24 am with Resident 48, Resident 48 stated she (Resident 48) knew when she (Resident 48) needed to urinate and have a bowel movement. Resident 48 stated she (Resident 48) would wear depends (disposable underwear) and almost never soiled herself. Resident 48 stated she (Resident 48) soiled herself the night 5/23/2025 and stated I couldn't make it and it makes me sad. It's so embarrassing. Resident 48 stated it would be helpful to be reminded on a schedule and assisted to the restroom. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/24/2025 at 1:25 pm, Resident 48's MDS and Care Plan with the Minimum Data Set Coordinator (MDSC) was reviewed. The MDS stated Resident 48's MDS should have reflected Resident 48's care plan that indicated Resident 48 was continent. The MDSC stated the initial care plan was completed by a Registered Nurse and the Registered should have reviewed the care plan to help determine Resident 48's bowel and bladder status to help prevent UTI's and skin breakdown. During a concurrent interview and record review on 5/25/2025 at 3:14 pm of Resident 48's MDS and care plan with the Director of Nursing (DON), the DON stated the MDS and care plan information must match, and accuracy of assessment's were extremely important because without accuracy, it could lead to a lack of care to a resident. The DON stated Resident 48 had a history of UTI's, was alert and should have been started on a Bowel and Bladder program. During a review of the facility's P&P titled, Bowel and Bladder Training/Toileting Program last reviewed on 3/10/2025, indicated the purpose of the program is to provide for residents who are incontinent of bowel and/or bladder appropriate treatment and services to minimize UTIs and to restore as much bowel and/or bladder function as possible to prevent skin breakdown and irritation, to improve the resident's morale and restore resident dignity and self-respect. 2. During a review of Resident 278's admission Record, the admission Record indicated the facility admitted Resident 278 on 5/17/2025 with diagnoses including displaced avulsion fracture (a type of bone break where a small piece of bone is pulled away from the main bone, and the broken pieces are not aligned) of left ilium (the largest and uppermost part of the hip bone), difficulty in walking, muscle weakness, and obstructive (blockage) and reflux (flow back) uropathy (a blockage in the urinary tract, causing a buildup of urine and difficulty urinating). During a review of Resident 278`s History and Physical (H&P) dated 3/21/2025, the H&P indicated Resident 48 had the capacity to understand and make decisions. During a review of Resident 278's Care Plan Report dated 5/17/2025, the Care Plan Report indicated Resident 278 had an indwelling catheter and the nursing intervention was to position the catheter bag and tubing below the level of the bladder. During a review of Resident 278's Order Summary Report dated 5/19/2025, the Order Summary Report indicated an order for an indwelling catheter (a tubing inserted through the urethra and into the bladder to drain urine) for obstructive uropathy. During an observation on 5/23/2025 at 7:02 pm in Resident 278's room, Resident 278 was lying in bed with a urinary catheter bag hanging on the right side of the resident's bedframe. The urinary catheter tubing hung below the middle-right side of the bed and had a large, dependent loop. The looped portion of the urinary catheter tubing contained yellow liquid with a small amount of sediment (particles that may be indicative of an infection) that back flowed all the way to the urine drainage port. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview 5/33/2025 at 7:05 pm in Resident 278's room with Registered Nurse 2 (RN 2), RN 2 stated Resident 278's urinary catheter tubing was looped and contained yellow liquid with white sediment that back flowed all the way to the urine drainage port. RN 2 stated the urinary catheter tubing should be straight in order drain the urine into the urinary catheter bag. RN 2 stated if the urine was not draining properly Resident 278 could possibly get an infection because the urine might backflow into his body. During an interview 5/25/2025 at 3:22 pm with the DON, the DON stated staff (in general) should always ensure the urinary catheter tubing remained straight and not coiled to prevent UTIs. The DON stated Resident 278 had a history of obstruction and it was necessary to not let the urine back flow. During a review of the facility's P&P titled, Catheter, Care Of, last reviewed on 3/10/2025, indicated the purpose of the P&P was to prevent UTIs and keep the collection bag below the level of the bladder to prevent back-flow.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. During a review of Resident 10's admission Record, the admission Record indicated the facility originally admitted Resident 10 to the facility on [DATE] and readmitted the resident on 4/7/2024 with diagnoses including chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing), heart failure (condition in which the heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen), and shortness of breath. During a review of Resident 10's Order Summary Report (physician orders), dated 3/9/2022, the Order Summary Report indicated the physician ordered for Resident 10 to receive the oxygen at four liters per minute (lpm) as needed for COPD. During a review of Resident 10's Oxygen Therapy care plan, initiated 3/9/2022, the care plan indicated the resident required oxygen due to a diagnosis of COPD. The care plan indicated the goal was for the resident not to have signs or symptoms of poor oxygen absorption. During a review of Resident 10's MDS dated [DATE], the MDS indicated Resident 10's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions was intact. The MDS indicated Resident 10 required set up assistance on staff for all activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). During a concurrent interview and observation on 5/23/2025 at 7:34 PM at Resident 10's bedside, Resident 10 was observed lying in bed, with oxygen at 4 LPM via a facial mask and the humidifier bottle was about 10% full. Resident 10 stated the oxygen would run continuously. During an observation on 5/24/2025 at 11:23 AM inside Resident 10's room, Resident 10's oxygen administration set up was observed. Resident 10's humidifier bottle was observed empty. During an interview on 5/24/2025 at 12:19 PM, with Resident 10, Resident 10 stated he (Resident 10) used oxygen continuously and he (Resident 10) needed humidification (the process of adding moisture to the air). During a concurrent interview and observation on 5/24/2025 at 12:22 PM inside Resident 10's room, Licensed Vocational Nurse 1 (LVN 1) stated Resident 10's humidifier bottle was empty. LVN 1 stated the humidifier bottle prevented dryness of the nostrils (the outer openings of the nose through which one breathes). LVN 1 stated not humidifying the resident's oxygen could lead to nasal bleeding. During an interview on 5/25/2025 at 3:26 PM, the Director of Nursing (DON) stated a resident's (in general) humidifier bottle needed to be changed prior to the liquid running out. The DON stated nursing staff (in general) should check the humidifier bottle daily to prevent nasal dryness and to make sure the oxygen flow is effective. During a review of the facility's policy and procedure (P&P) titled, Oxygen Therapy, reviewed 3/10/2025, the P&P indicated staff were to administer oxygen per physician's orders. The P&P indicated humidification of oxygen it was not necessary unless more than 4 liters per minute is ordered or the resident requests humidification for the leader flow of 4 liters per minute or below. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to provide respiratory care services for two of four sampled residents (Resident 7 and Resident 10) by failing to: 1.Ensure to label Resident 7's nasal cannula (flexible plastic tubing used to deliver oxygen through nostrils [nose] and the tubing is fitted over the patient's ears) as indicated in the facility's Oxygen Therapy policy and procedure. 2. Ensure to change Resident 10's humidifier bottle (a medical device used to humidify oxygen) when empty. These failures had the potential to place Resident 7 at risk for respiratory infections and for Resident 10 not to receive effective respiratory therapy care. Findings: 1. During a review of Resident 7's admission Record, the admission Record indicated the facility admitted Resident 7 on 3/20/2025 with diagnoses including displaced fracture (the broken pieces of bone have moved out of their normal alignment [straight line], creating a gap or misalignment between the fracture ends) of the olecranon process (boney point known as the elbow) with routine healing (healing without surgery), respiratory failure (a condition where your blood doesn't have enough oxygen) with hypoxia (low levels of oxygen in your body tissues), history of falling, muscle weakness, depression (constant feeling of sadness), unspecified fracture of the sacrum (a large, triangular bone located at the base of the spine connected to the pelvis) with routine healing. During a review of Resident 7's Order Summary Report, dated 3/20/2025, the Order Summary Report indicated for Resident 7 to receive oxygen at two liters per minute (refers to a unit of measurement for fluid flow rate), via nasal cannula. During a review of Resident 7`s History and Physical (H&P) dated 3/21/2025, the H&P indicated Resident 7 had the capacity to understand and make decisions.  During a review of Resident 7`s Minimum Data Set (MDS, a resident assessment tool), dated 3/27/2025, the MDS indicated Resident 7 could understand others and make herself understood and was dependent on facility staff for activities such as toileting, bathing, and dressing. The MDS indicated Resident 7 was on continuous oxygen therapy. During a concurrent observation and interview on 5/23/2025 at 7:42 pm in Resident 7's room with Licensed Vocational Nurse 4 (LVN 4), Resident 7's nasal cannula was not labeled with the date it was last changed. LVN 4 stated the nasal cannula was changed every Sunday on night shift and the nasal cannula needed to be labeled with the date otherwise it was an infection control issue. During an interview on 5/25/2025 at 3:12 pm with the Director of Nursing (DON), the DON stated licensed nurses (in general) needed to change the nasal cannula tubing on Sunday nights on night shift and they needed to label each nasal cannula with the date it was changed. The DON stated labeling nasal cannula with the last date changed to prevent the growth of bacteria in the tubing that could cause respiratory infections. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Oxygen Therapy, last reviewed on 3/10/2025, the P&P indicated the purpose of the P&P was to ensure the safe storage and administration of oxygen in the facility. The P&P further indicated the tubing should be changed no more that every seven days and labeled with the date of the change.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. 2. During a review of Resident 63's admission Record, the admission Record indicated the facility admitted Resident 63 on 8/19/2024 and re-admitted the resident on 4/23/2025 with diagnoses including lumbar region (low back) spinal fusion (a surgical procedure that joins two or more bones that make up your spine together, essentially welding them into one solid bone), low back pain and ESRD (End Stage Renal Disease-irreversible kidney failure). During a review of Resident 63's Pain Medication Therapy Care Plan initiated on 11/28/2024, indicated the resident used oxycodone (a narcotic pain medication) for pain relief. The care plan interventions included to administer oxycodone as ordered, to monitor, and document side effects and effectiveness and to ask the physician to review the medication if side effects persisted. During a review of Resident 63's Minimum Data Set (MDS, a resident assessment tool), dated 4/30/2025, indicated Resident 63 had intact cognition. The MDS indicated Resident 63 required maximal assistance from staff for toileting hygiene, bathing and lower body dressing. The MDS indicated the resident received pain relief medication as needed. During a review of Resident 63's Physician's orders, dated 5/3/2025 indicated the facility was to administer Oxycodone 5 milligrams (mg, a unit of measurement) by mouth every six hours as needed for moderate to horrible pain (5-10/ pain rating scale of zero being no pain and 10 being the worst pain possible). During a review of Resident 63's electronic Medication Administration Record (e-MAR) Administration Notes for May 2025 indicated Resident 10 received: -oxycodone 5mg on 5/7/2025 at 9:55 AM and the resident's pain was re-evaluated at 11:11 AM (more than one hour after administration). -oxycodone 5mg on 5/7/2025 9:39 PM and the resident's pain was re-evaluated at 11:58 PM (more than two hours after administration). -oxycodone 5mg on 5/8/2025 at 9:38 PM and the resident's pain was re-evaluated at follow up at 11:33 PM (more than one hour and a half after administration). -oxycodone 5mg on 5/10/2025 at 6:18 AM and the resident's pain was re-evaluated at 11:08 AM (more than three hours and a half after administration). - oxycodone 5mg on 5/11/2025 9:52 AM and the resident's pain was re-evaluated at 5/11/2025 at 12:53 (more than three hours after administration). -oxycodone 5mg on 5/17/2025 AM at 5:46 AM and the resident's pain was re-evaluated at 11:19 AM and the resident's pain was re-evaluated at (more than five hours after administration). Resident 63 was unable to be interviewed. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review of Resident 63's electronic MAR Administration Notes, on 5/24/2025 at 2:02 PM, with Registered Nurse 1 (RN 1), RN1 stated Resident 63 received oxycodone for pain control on 5/7/2025, 5/8/2025, 5/10/2025, 5/11/2025, 5/13/2025, and on 5/17/2025. RN 1 stated the facility's protocol for each of these doses, Resident 63's pain was reassessed more than an hour after administration. RN 1 stated the nurses (in general) re-evaluated a resident's (in general) pain level within one hour of pain medication administration to verify if the medication was effective. RN 1 stated not following up on the resident' pain level, had the potential for the resident's pain to increase. During an interview and concurrent record review on 5/25/2025 at 3:25 PM, the Director of Nursing (DON) stated nursing staff (in general) were required to assess resident's (in general) pain prior to administering pain medications. The DON stated nursing staff (in general) were required to reassess and evaluate the resident's pain within one hour after administering pain medication to monitor the effectiveness of the medication. The DON stated not reevaluating the resident's pain level could lead to not identifying if the resident's pain was controlled. During a review of the facility's policy and procedure titled Pain Management, with a review date of 3/10/2025 indicated After medications/interventions are implemented, the licensed nurse will re-evaluate the resident's level of pain within one hour. Based on interview and record review, the facility failed to ensure to assess two of two sampled residents (Resident 7 and Resident 63) for pain levels by failing to: 1.Ensure licensed nurses (in general) followed Resident 7's physician orders to assess/monitor Resident 7's pain levels and document prior to administering hydromorphone (a strong medication used for moderate to severe pain, especially when other pain relievers haven't worked). 2. Ensure to reevaluate the pain level for Resident 63 within an hour after the administration of a pain relief medication as indicated in the facility's Pain Management policy and procedure. These failures had the potential for Resident 7 and Resident 63's pain not to be treated effectively and had the potential for Resident 7 to receive too much pain relief medication. Findings: 1. During a review of Resident 7's admission Record, the admission Record indicated the facility admitted Resident 7 on 3/20/2025 with diagnoses including displaced fracture (the broken pieces of bone have moved out of their normal alignment [straight line], creating a gap or misalignment between the fracture ends) of the olecranon process (boney point known as the elbow) with routine healing (healing without surgery), respiratory failure (a condition where your blood doesn't have enough oxygen) with hypoxia (low levels of oxygen in your body tissues), history of falling, muscle weakness, depression (constant feeling of sadness), unspecified fracture of the sacrum (a large, triangular bone located at the base of the spine connected to the pelvis) with routine healing. During a review of Resident 7's Order Summary Report (physician orders) dated 3/20/2025, the Order Summary Report indicated to monitor Resident 7 for pain every shift and document. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 7`s History and Physical (H&P) dated 3/21/2025, the H&P indicated Resident 7 had the capacity to understand and make decisions. During a review of Resident7's Care Plan Report dated 3/25/2025, the Care Plan Report indicated Resident 7 was at risk for acute pain due to fractures and the nursing interventions was for the licensed nurses (in general) to evaluate Resident 7's pain level. During a review of Resident 7`s Minimum Data Set (MDS, a resident assessment tool), dated 3/27/2025, the MDS indicated Resident 7 could understand others and make herself understood and was dependent on facility staff for activities such as toileting, bathing, and dressing. The MDS indicated Resident 7 was taking a high-risk opioid (a class of drug used to reduce moderate to severe pain) medication. During a review of Resident 7's Medication Administration Record (MAR) dated May 2025, the MAR indicated a start date of 4/22/2025 for Resident 7 to receive hydromorphone four milligrams (mg, a unit of measurement) one tablet three times a day for pain management. The MAR indicated to hold the hydromorphone if Resident 7's respiratory rate was less than 12). The MAR indicated the licensed nurses (unidentified) did not assess Resident 7's pain level on 5/4/2025 at 9 am, 5/5/2025 at 1 am, 5/6/2025 at 1 am, 5/7/2025 at 1 am, 5/16/2025 at 1 am, 5/17/2025 at 1 am, 5/21/2025 at 1 am, 5/22/2025 at 1 am, and on 5/23/2025 at 1 am, when they (licensed nurses) administered (not held) the hydromorphone. The MAR indicated the licensed nurses did not document Resident 7's respiratory rate on 5/1/2025 at 1 am and 9am, 5/2/2025 at 1 am and 9 am, and on 5/3/2025 1 am and at 9 am. During a concurrent interview and record review on 5/25/2025 at 11:15am of Resident 7's MAR with Licensed Vocational Nurse 4 (LVN 4), LVN 4 reviewed Resident 7's MAR and stated licensed nurses (in general) must assess for pain and respirations prior to giving the hydromorphone every single time. LVN 4 stated she (LVN4) would assess for pain prior to giving hydromorphone. LVN 4 stated she (LVN4) would look for pain symptoms such a grimacing as well as to ask the resident for pain level first, then count the respirations, administer the pain relief medication if the respirations were above 12. LVN 4 stated hydromorphone was a very strong pain medication that could slow down respirations even further. During a concurrent interview and record review on 5/25/2025 at 3:04 pm of Resident 7's MAR with the Director of Nursing (DON), the DON stated the licensed nurses (unidentified) did not indicate Resident 7's pain level on several days and the licensed nurses needed to check and document the pain level prior to giving any pain medication as a baseline to re-evaluate the pain level for effectiveness. The DON stated it was necessary to record the pain level each time to determine if there was a need to notify the physician to increase or decrease the amount of pain medication ordered. During a review of the facility's policy and procedure (P&P) titled, Pain Management, last reviewed on 3/10/2025 indicated the licensed nurse will complete a pain assessment for resident's identified as having pain. The P&P indicated the licensed nurse will administer pain medication a ordered and after medication is implemented, the licensed nurse will re-evaluate the resident's level of pain within one hour and document the results in the medical record. During a review of the facility's P&P titled, Medication - Administration last reviewed on 3/10/2025, indicated tests and taking of vital signs, upon which administration of medication are conditioned, will be performed as required and the results recorded.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 23) who was on dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney[s] have failed) received dialysis care and treatment by failing to: 1. Ensure to assess Resident 23's dialysis access sites (a way to reach the blood for dialysis). 2. Ensure to assess Resident 23 before and after (pre and post) dialysis treatment on 4/7/2025, 4/14/2025, 4/23/2025, and 4/30/2025. These failures had the potential to result in undetected complications of a dialysis access site and could lead to the delay of necessary care for Resident 23. Findings: During a review of Resident 23's admission Record, the admission Record indicated the facility admitted the resident on 3/17/2025, with diagnoses including end stage renal disease (ESRD, irreversible kidney failure), hypertension (HTN, high blood pressure), and acquired absence of left leg below knee and lack of coordination. During a review of Resident 23`s History and Physical (H&P) dated 3/17/2025, the H&P indicated Resident 23 had the capacity to understand and make decisions.  During a review of Resident 23`s Clinical admission form dated 3/17/2025, the Clinical admission form did not indicate Resident 23 underwent dialysis. During a review of Resident 23`s admission Progress Note dated 3/17/2025, the admission Progress Note indicated the resident had hemodialysis (dialysis) on Mondays, Wednesdays, and Fridays via Resident 23's right upper arm arteriovenous fistula (AVF, a connection that is made between an artery and a vein for dialysis access). During a review of Resident 23's physician Order Summary Report dated 3/18/2025, the Order Summary Report indicated to monitor Resident 23`s left femoral artery (the main artery in the left thigh, supplying blood to the structures in the leg) permcath site (a special catheter used for short-term dialysis treatment) for redness, tenderness, bleeding, and drainage during every shift.  During a review of Resident 23`s care plan (a document that outlines how a patient's health care needs will be met) for hemodialysis initiated on 3/17/2025, the care plan indicated the goal for the resident was not to have any sign and symptoms of complications from dialysis. The care plan interventions were to observe Resident 23`s left femoral artery permcath site for redness, tenderness, to check and change the dressing at the access site daily, to monitor for dry skin and apply lotion as needed and to monitor and document any sign and symptoms of infection to the access site and report to the physician as needed. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 23's Minimum Data Set (MDS, a resident assessment tool) dated 3/24/2025, the MDS indicated the resident`s cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was intact (decisions consistent/reasonable). The MDS indicated Resident 23 required staff partial/moderate assistance (helper does less than half the effort) for eating, oral hygiene, toileting hygiene, and personal hygiene. The MDS indicated Resident 23 underwent dialysis. During a concurrent observation and interview on 5/24/2025 at 12:40 PM, inside Resident 23's room, Resident 23 was observed sitting in her wheelchair next to her bed. Resident 23 stated she (Resident 23) underwent hemodialysis on Mondays, Wednesdays, and Fridays, and her dialysis access site was the permcath on her left thigh and not the AV fistulas on both of her arms. During a concurrent interview and record review on 5/24/2025 at 1:45 PM, with Registered Nurse 1 (RN 1), Resident 23`s physician orders, clinical admission notes and pre-post dialysis assessment notes were reviewed. RN 1 stated Resident 23 underwent hemodialysis, and her access site for treatment was the resident's left femoral artery permcath. RN 1 stated Residents 23`s General Acute Care Hospital 1 (GACH 1) discharge records indicated Resident 23 had a right and left AVFs and left femoral artery permcath access sites. RN 1 stated Resident 23`s clinical admission form was completed incorrectly and it did not indicate Resident 23 underwent hemodialysis. RN1 stated Resident 23`s admission Progress Note dated 3/17/2025, indicated Resident 23 had hemodialysis treatments on Mondays, Wednesdays, and Fridays via her right upper arm AVF. RN 1 stated the admission progress note did not indicate Resident 23`s left femoral permcath dialysis access site currently being used for hemodialysis treatments. RN 1 stated licensed staff (in general) were required to assess the residents (in general) thoroughly upon admission and complete the admission assessment forms accurately. RN 1 stated the potential outcome of inaccurate admission assessment forms was the lack of care and the inability to deliver necessary services to the resident. RN 1 stated Resident 23`s pre and post dialysis assessment forms dated 4/30/2025, 4/23/2025, 4/14/2025 and 4/7/2025 were not completed thoroughly and did not indicate any assessments for the dialysis access site post hemodialysis treatment. RN 1 stated licensed nurses (in general) were required to thoroughly complete the resident`s pre and post dialysis assessments forms prior to dialysis and after the treatment. RN 1 stated the potential outcome of not assessing a resident`s dialysis access site post dialysis is bleeding at the site and the inability to timely detect any complications. During an interview on 5/25/2025 at 3:00 PM, with the Director of Nursing (DON), the DON stated Resident 23`s clinical admission form and admission shift progress notes were completed incorrectly. The DON stated the potential outcome of inaccurate admission assessment forms was the lack of care and the inability to deliver necessary services to the resident. The DON stated licensed staff (unidentified) did not complete Resident 23`s pre and post dialysis assessment forms on 4/30/2025, 4/23/2025, 4/14/2025 and 4/7/2025 thoroughly. The DON stated licensed staff were required to assess residents` dialysis access site after their treatment and complete the pre and post dialysis assessments accurately prior to dialysis and after the treatment. The DON stated the potential outcome of not thoroughly completing the pre and post dialysis assessment forms is the lack of care and monitoring for the residents. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility`s Policy and Procedures (P&P) titled Dialysis Management, last reviewed on 3/10/2025, the P&P indicated the facility must ensure that residents who required dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident`s goals and references. A pre and post dialysis evaluation will be completed by the licensed nurse. Vascular access site care included: Assessing, observing and documenting care of access site daily. Central venous catheter care included: monitor site for redness, vascular access, tenderness, bleeding and drainage. The nursing staff will send a dialysis communication form to the dialysis center every time a resident is scheduled for off-site dialysis. The dialysis provider`s nurse will be responsible for documentation of dialysis treatment and providing the resident`s post dialysis weight.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure to follow safe and sanitary food storage and food preparation practices in the kitchen by failing to: 1.Ensure boxed food items were not stored directly on the floor. 2.Ensure the dispensing scoop was not stored inside the salt container These failures placed the residents of the facility at risk for foodborne illnesses (refers to illness caused by the ingestion of contaminated food or beverages). Findings: During a concurrent interview and observation in the dry storage room on 5/23/2025 at 6:42 PM with [NAME] 1 (CK 1), a scoop was observed stored directly in a clear storage container of salt and the following food items were observed stacked directly on the floor: a. One clear storage container of rice. b. One box of non-dairy creamer packets. c. One clear storage container of parsley. d. One box of mayonnaise. e. One clear storage container of salt. During a concurrent interview and observation in the dry storage room on 5/23/2025 at 6:42 PM with CK1, CK1 stated the new dietary supervisor (DS 1) placed the food items on the floor then left for the day. CK1 stated the boxes should be stored at least six inches off the floor to prevent contamination and not to spread infection to the residents. CK 1 stated the scoop should not be stored inside the salt container as it was unsanitary. During an interview on 5/25/2025 at 10:48 AM with DS 1, DS1 stated they (unidentified staff) left the boxes on the floor because DS 1 had cleaned other portions of the dry storage area. DS 1 stated that food items were to be stored six inches off the floor and the scoop should not have been left inside the salt container for infection control purposes. During a review of the facility policy and procedure titled, Food Storage and Handling, dated 6/4/2024, under the section labeled Dry Storage Area indicated Shelving should be mounted at least 6 inches from the floor, preferably on castors for ease of cleaning and 18 inches from the ceiling and foods should be stored off the floor and to store foods off the floor.

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F 0911 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure two of 35 rooms (room [ROOM NUMBER] and room [ROOM NUMBER]) did not accommodate more than four residents. This failure had the potential to result in inadequate usable living space for the residents and working space for the healthcare staff. Findings: During review of the facility's room waiver request letter dated 5/25/2025, the room waiver request letter indicated room [ROOM NUMBER] and room [ROOM NUMBER] did not meet the four bed per room regulation. The letter indicated the rooms had adequate space for each resident. The letter indicated room [ROOM NUMBER] and room [ROOM NUMBER] were in accordance with the special needs of the residents and would not have an adverse effect on the residents' health and safety. The letter indicated room [ROOM NUMBER] and room [ROOM NUMBER]'s measurements were the following: Room number Room size Number of beds 3 609.17 square feet 7 4 422.11 square feet 5 During multiple room observations conducted in room [ROOM NUMBER] and room [ROOM NUMBER] from 5/23/2025 to 5/25/2025, nursing staff (in general) were observed with adequate space to provide care to the residents in room [ROOM NUMBER] and room [ROOM NUMBER]. Each resident in room [ROOM NUMBER] and room [ROOM NUMBER] were observed to have privacy curtains for privacy, working call-lights (a device used by a patient to signal his or her need for assistance), a dresser, and a bedside table. During a concurrent observation and interview on 5/25/2025 at 11:40 AM, in room [ROOM NUMBER], Resident 128 was observed sitting in her wheelchair at the foot of her bed. A dresser and bedside table were observed next to Resident 128's bed. Resident 128 stated she had no concerns about the space in her room. Resident 128 stated she was happy with the space and felt she could move around in her wheelchair easily. Resident 128 stated the nursing staff (unidentified) did not have any issues with the space in her room when giving her care. (continued on next page)

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F 0911 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on 5/25/2025 at 1:02 PM with Certified Nursing Assistant (CNA) 1, CNA 1 stated she (CNA1) was taking care of the residents in room [ROOM NUMBER]. CNA 1 stated she (CNA1) did not have any issues with the space in room [ROOM NUMBER]. CNA 1 stated she (CNA1) there was more than enough space to move and transfer the residents to and from bed. CNA 1 stated there was enough room in room [ROOM NUMBER]. The Department is recommending continuation of the room waiver request.