STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055170	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pico Rivera Healthcare Center	9140 Verner Street Pico Rivera, CA 90660

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49900 Based on observation, interview, and record review, the facility failed to remove the identifiable health information (any information that could be used to identify the individual, such as the full name, date of birth, etc.) on the gastrostomy tube (GT, a surgical opening fitted with a device to allow feedings to be administered directly to the stomach, for people with swallowing problems) feeding bottle before disposing in the trash can for one of eight sampled residents (Resident 23). This deficient practice had the potential to result in unauthorized disclosure of Resident 23's personal information to unauthorized users. Findings: During an observation on 1/6/2025 at 10:36 a.m., in Resident 23's room, Resident 23's GT feeding bottle with the resident's name was observed in the trash can. During an observation on 1/7/2025 at 8:50 a.m., in Resident 23's room, Resident 23's GT feeding bottle with the resident's name was observed in the trash can. During a review of Resident 23's Admission Record, dated 1/8/2025, the admission record indicated Resident 23 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 23's diagnoses included pneumonia (an infection/inflammation in the lungs), sepsis (a life-threatening blood infection), seizure (a sudden, uncontrolled electrical disturbance in the brain which could cause uncontrolled jerking, blank stares, and loss of consciousness), and major depressive disorder (a mood disorder that caused a persistent feeling of sadness and loss of interest). During a review of Resident 23's History and Physical (H&P), dated 12/23/2024, the H&P indicated Resident 23 did not have the capacity to make decisions. During a review of Resident 23's Minimum Data Set (MDS - a resident assessment tool), dated 8/15/2024, the MDS indicated Resident 23's cognitive (the ability to think and process information) skill for daily decision making was severely impaired. The MDS indicated Resident 23 was dependent (helper did all the effort) with oral hygiene, toileting hygiene, shower/ bathe self, and personal hygiene. During a review of Resident 23's Order Summary Report, as of 1/8/2025, the report indicated an order dated 12/22/2024, GT Jevity 1.2 (a high-protein, fiber-fortified nutritional formula that could be used for tube feeding) rate 65 cubic centimeter (cc, a unit of volume) per hour for 20 hours. (continued on next page)

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

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and review of a picture of Resident 23's GT feeding bottle on 1/7/2025 at 12:14 p.m. with Licensed Vocational Nurse (LVN) 1, the picture dated 1/6/2025 at 10:41 a.m. was reviewed. The picture indicated a GT feeding bottle with Resident 23's name disposed of in the trash can in the resident's room. LVN 1 stated the used GT bottle with Resident 23's name should not be in the trash can in the resident's room. LVN 1 stated staff should blacken out Resident 23's name using a sharpie or remove the label before disposing in the trash can because of the Health Insurance Portability and Accountability Act (HIPPA, a United States legislation that provided data privacy and security provisions for safeguarding medical information). LVN 1 stated it was for protecting the resident's privacy and confidentiality. LVN 1 stated the nurses were responsible with ensuring the resident's privacy and confidentiality and there was a risk that information was exposed without the resident's consent. During an interview on 1/8/2025 at 3:49 p.m. with the Director of Staff Development (DSD), the DSD stated nurses needed to make sure there was no resident's information on the GT bottle before disposing in the trash can. The DSD stated the resident's information should be peeled off or use a marker should be used to blacken out the resident's information before disposal for the resident's privacy. The DSD stated the potential risk was that the resident's privacy would be seen by unauthorized personnel, and all staff were responsible to ensure the resident's information was protected. During a review of the facility's Policy and Procedure (P&P) titled Enteral feeding, revised in 3/2023, the P&P indicated When disposing of enteral feeding formula bottle/bag/tubing/syringe, the licensed nurse must ensure the resident's personal information is de-identified. This includes removing or obscuring the resident's name and room number before disposal to maintain privacy and confidentiality.

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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** 47858 Based on observation, interview, and record review, the facility failed to develop and implement a plan of care for a resident that exhibited a behavior of teeth grinding for one out of six sampled residents (Resident 4). This deficient practice had the potential to delay the care or treatment of Resident 4's teeth grinding behavior. Findings: During a review of Resident 4's Admission Record, the Admission Record indicated Resident 4 was originally admitted to the facility on [DATE], and readmitted on [DATE]. Resident 4's diagnoses included gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), cognitive (mental action or process of acquiring knowledge and understanding) communication deficit, dementia (a progressive state of decline in mental abilities), and adult failure to thrive (a progressive decline in an individual's ability to care for themselves due to multiple contributing factors). During a review of Resident 4's Minimum Data Set ([MDS], a resident assessment tool), dated 11/12/2024, the MDS indicated Resident 4's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 4 was entirely dependent on staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a concurrent record review, on 1/7/2024, at 9:44 a.m., with the Infection Prevention Nurse (IPN), all of Resident 4's care plans, dated in 2024 to 2025, were reviewed. There were no care plans addressing Resident 4's behavior of teeth grinding. During an interview, on 1/7/2025, at 9:50 a.m., with Licensed Vocational Nurse (LVN) 2, LVN 2 stated that LVN 2 had known Resident 4 to grind her teeth in the morning time. LVN 2 stated that she noticed Resident 2 started grinding her teeth around Christmas time. LVN 2 stated that it was a behavior that should have been care planned to ensure the Resident 2's care was rendered appropriately. During an interview, on 1/8/2025, at 4:04 p.m., with the Director of Nursing (DON), the DON stated Resident 4 exhibited a change of condition and Resident 4's behavior of teeth grinding should have been care planned. During a review of the facility's Policy and Procedure (P&P), titled, Care Plans, Comprehensive Person-Centered, dated 3/2022, the P&P indicated assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.

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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. 49900 Based on observation, interview, and record review, the facility failed to provide necessary respiratory care and services that were in accordance with the facility's policy for one of eight sampled residents (Resident 239), when the facility did not display No Smoking/ Oxygen in Use signs on the outside of the door of the resident room or in the room where an oxygen concentrator (a medical device that provides oxygen-enriched air to help people breathe) was at the bedside. This deficient practice had the potential to cause fire hazards to all residents, families, visitors, staff, and residents' properties, and result in serious harm and injury. Findings: During an observation on 1/6/2025 at 9:48 a.m., outside of Resident 239's room, there was no No Smoking/ Oxygen in Use sign on the entrance room door. Resident 239 was observed lying on the bed with an oxygen concentrator (a medical device that provides oxygen-enriched air to help people breathe) at the bedside. There was no No Smoking/ Oxygen in Use sign observed in the room. During an observation on 1/7/2025 at 8:32 a.m., outside of Resident 239's room, there was no No Smoking/ Oxygen in Use sign on the entrance room door. Resident 239 was observed lying on the bed with an oxygen concentrator observed at the bedside. There was no No Smoking/ Oxygen in Use sign observed in the room. During a review of Resident 239's Admission Record, the admission record indicated Resident 239 was admitted to facility on 12/18/2024. Resident 239's diagnoses included cirrhosis of the liver (conditions that stopped the liver from working or prevent it from functioning well), generalized muscle weakness, dysphagia (difficulty swallowing), and depression (a constant feeling of sadness and loss of interest). During a review of Resident 239's History and Physical (H&P) dated 12/30/2024, the H&P indicated Resident 239 did not have the capacity to understand and make decisions. During a review of Resident 239's Minimum Data Set (MDS, a resident assessment tool), dated 12/29/2024, the MDS indicated Resident 239's cognitive (the ability to think and process information) skills for daily decision making was severely impaired. The MDS indicated Resident 239 required supervision in eating, partial assistance (helper did less than half the effort) with oral hygiene and personal hygiene, and was dependent (helper did all the effort, resident did none of the effort to complete the activity) for toileting hygiene and showering/ bathing. The MDS indicated Resident 239 used a cane/crutch for mobility. During a review of Resident 239's care plan titled Oxygen, initiated on 12/29/2024, the care plan indicated the goal was for Resident 239 to be free of adverse effects (a harmful or abnormal result) related to use of oxygen daily. (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 Resident 239's Order Summary report, as of 1/8/2025, the summary indicated an order, dated 12/29/2024, to administer oxygen 2-5 liter (L, a unit for measuring the volume of a liquid) per minute for oxygen saturation (a measure of how much oxygen was in blood) less than 90 percent (%) or respiratory comfort as needed. During a concurrent observation and interview on 1/7/2025 at 11:57 p.m. with Licensed Vocational Nurse (LVN) 1, outside Resident 239's room, there was no No Smoking/ Oxygen in Use sign on the room entrance door. Resident 239 was observed lying on the bed with an oxygen concentrator at the bedside. There was no No Smoking/ Oxygen in Use sign observed in the room. LVN 1 stated there should be a No Smoking/ Oxygen in Use sign outside the door when the oxygen concentrator was at the bedside. LVN 1 stated the purpose of a No Smoking/ Oxygen in Use sign was to make sure everyone was aware there was oxygen in the room, and to make sure there was no one smoking. LVN 1 stated it was not safe without the sign and the potential risk was explosion. LVN 1 stated this affected all residents and put the resident at risk for injury. LVN 1 stated it could possibly cause a fire hazard, and the building could become damaged. LVN 1 stated all staff were responsible with ensuring there was a No Smoking/ Oxygen in Use sign outside the resident's door. During a concurrent observation and interview on 1/8/2025 at 3:49 p.m. with the Director of Staff Development (DSD), the DSD stated for safety precautions there should be a No Smoking/ Oxygen in Use sign outside the door if there was an oxygen concentrator at the resident's bedside. The DSD stated whoever installed the oxygen concentrator was responsible in making sure the sign was up. The DSD stated everyone needed to pay attention to ensure there was a No Smoking/ Oxygen in Use sign during room rounds. The DSD stated the purpose of the No Smoking/ Oxygen in Use sign was to alert people during an emergency. During a review of facility policy and procedure (P&P) titled, Oxygen Administration, revised on 10/2010, the P&P indicated No Smoking/ Oxygen in Use sign was necessary for oxygen administration. The P&P indicated staff needed to place an Oxygen in Use sign on the outside of the room entrance door and in a designated place on or over the resident's bed.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48131 Based on observation, interview, and record review, the facility failed to ensure it was free of a medication error rate of five percent (%) or greater, as evidenced by the identification of 6 medication errors out of 28 opportunities for error, to yield a cumulative error rate of 21.43% for one of two of sampled residents (Residents 43). Licensed Vocational Nurse (LVN) 1 administered six oral medications to Resident 43 at one time. Resident 43 had a diagnosis of dysphagia (difficulty swallowing). This deficient practice resulted in Resident 43 not being able to swallow her medications and had the potential to cause aspiration (when a fluid or solid accidentally enters the windpipe and lungs) or a choking hazard for Resident 43. Findings: During a review of Resident 43's Admission Record, dated 1/8/2025, the admission record indicated Resident 43 was initially admitted to the facility on [DATE] and readmitted on [DATE]. The admission record indicated Resident 43 had the following diagnoses which included dysphagia (difficulty swallowing), dementia (a progressive state of decline in mental abilities), and encephalopathy (decreased brain function). During a review of Resident 43's Minimum Data Set (MDS - a resident assessment tool), dated 12/4/2024, the MDS indicated Resident 43's cognition (the ability to think, remember and reason) was severely impaired. The MDS indicated Resident 43 required supervision (helper provides verbal cues and/or touching/steadying as resident completes activity) with eating and maximal assistance (helper does more than half the effort) for oral hygiene, toileting, bathing, and personal hygiene. During a review of Resident 43's History and Physical (H&P), dated 7/22/2024, the H&P indicated Resident 43 did not have the capacity to understand and make decisions. During a review of Resident 43's care plan titled, Patient presents with oral and pharyngeal (throat area) deficits affecting safe and effective swallow, initiated on 7/22/2024 and revised on 1/8/2025, the care plan indicated Resident 43's goal would be to consume a puree (foods that have soft, pudding-like consistency) diet and thin liquids with safe and effective swallowing while maintaining nutritional needs. The care plan interventions included speech therapy, sit resident up right for all oral intake, give smaller bites and sips, double swallows, and chin tuck (moving the chin towards the chest). During a review of Resident 43's Order Summary Report, dated 1/8/2024, the order summary report indicated an active order started on 7/20/2024 May crush medications and mix with applesauce or food. During a review of Resident 43's Order Summary Report, dated 1/8/2024, the order summary report indicated an active order started on 7/20/2024 for Acetaminophen (Tylenol - a medication used to relieve minor aches and pains) 325 milligrams (mg - metric unit of measurement, used for medication dosage and/or amount) oral tablet. Give two tablets by mouth every four hours as needed for mild pain. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 43's Order Summary Report, dated 1/8/2024, the order summary report indicated an active order started on 7/20/2024 for Apixaban (a medication used to prevent blood clots) 5 milligrams (mg, unit of measurement) oral tablet. Give one tablet by mouth two times a day for atrial fibrillation (abnormal heartbeat). During a review of Resident 43's Order Summary Report, dated 1/8/2024, the order summary report indicated an active order started on 7/21/2024 for Aspirin (a medication used to reduce the formation of blood clots), 81 mg oral tablet. Give one tablet by mouth one time a day. During a review of Resident 43's Order Summary Report, dated 1/8/2024, the order summary report indicated an active order started on 7/21/2024 for Losartan Potassium (a medication used to treat high blood pressure) 25 mg oral tablet. Give one tablet by mouth one time a day. During a review of Resident 43's Order Summary Report, dated 1/8/2024, the order summary report indicated an active order started on 7/21/2024 for Namenda (Memantine - a medication used to treat dementia) 5 mg oral tablet. Give one tablet by mouth two times a day. During a review of Resident 43's Order Summary Report, dated 1/8/2024, the order summary report indicated Resident 43 had an active order started on 12/24/2024 for a Renal (related to kidneys) 80 gram (g, unit of measurement), NAS (no added salt) mechanical soft texture, (soft, easily chewable foods that are either pureed, mashed, finely chopped, or ground, designed for individuals who have difficulty swallowing or chewing due to medical conditions like dental issues or swallowing disorders) diet, thin consistency. During a review of Resident 43's Order Summary Report, dated 1/8/2024, the order summary report indicated an active order started on 1/7/2025 for Oyster Shell (a calcium supplement) 500 mg oral tablet. Give one tablet by mouth two times a day. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a medication pass observation on 1/8/2025 at 8:40 a.m., with LVN 1, observed LVN 1 enter Resident 43's room with a medicine cup filled with oral medications. LVN 1 scooped a spoonful of the oral medications from the medicine cup and placed it in front of Resident 43's mouth. LVN 1 stated, It's time to take your medicine, [NAME]. Resident 43 opened her mouth and took the medication from the spoon. LVN 1 offered Resident 43 a sip of water and scooped another spoonful of oral medications from the medicine cup. LVN 1 fed the medication from the spoon to Resident 43 and gave her another sip of water. Resident 43 was squirming in her bed and stated that she needed to go to the restroom. LVN 1 stated, [NAME]! You have to take your medicine. LVN 1 then asked Resident 43 to open her mouth. Resident 43 still had five whole pills on her tongue. LVN 1 stated, Swallow the pills [NAME]! You have to swallow the pills. LVN 1 gave Resident 43 more water and asked Resident 43 to stick out her tongue. The pills were still on the resident 43's tongue. LVN 1 stated again, You have to swallow the pills [NAME]. Swallow [NAME]! LVN 1 continued to give Resident 43 more sips of water to drink and check her tongue. The pills remained on Resident 43's tongue. LVN 1 left the room and went to the med cart to get another cup of water. Resident 43 then stated that she had to use the restroom. LVN 1 stated, I will take you to the restroom as soon as you finish taking your medications. LVN 1 continued to give Resident 1 sips of water and prompted the resident to swallow the pills. After Resident 43 finished a second cup of water, LVN 1 asked Resident 43 to stick out her tongue. The medication was still observed on Resident 43's tongue. Some of the medication had started to dissolve on Resident 43's tongue but had not been swallowed. LVN 1 stated, You have to swallow the medication [NAME]. Resident 43 stated, I did! Resident 43 continued to move around uncomfortably in her bed and stated that she needed to use the restroom again. LVN 1 asked Resident 43 to stick out her tongue again. The pills were still observed on Resident 43's tongue. LVN 1 proceeded to use her gloved hand and scrape the medication from Resident 43's tongue, the back of her throat and sides of her cheeks and placed them back into a medicine cup. LVN 1 then assisted Resident 43 to the restroom. During a concurrent interview and record review on 1/8/2025 at 9:15 a.m., with LVN 1, Resident 43's Medication Administration Record (MAR) for January 2025 and Diagnosis Report was reviewed. LVN 1 stated Resident 43 did get her Aspirin, Apixaban, Losartan, Namenda, and Oyster Shell tablets because she was unable to take them. LVN 1 stated, she also attempted to give Resident 43 Tylenol for pain to her buttocks area. LVN 1 stated she had not known Resident 43 to have difficulty swallowing her medications. LVN 1 reviewed Resident 43's Diagnosis Report. LVN 1 stated, the resident has dysphagia. LVN 1 stated since Resident 43 has a history of dysphagia, she should have given her one medication at a time and given her time to swallow each pill before giving another one. LVN 1 stated Resident 43 could have choked or aspirated because she (LVN 1) gave her (Resident 43) several medications at one time. During an interview on 1/8/2025 at 2:10 p.m., with the facility's Speech Language Pathologist (ST), the ST stated an evaluation was done on Resident 43 and a treatment diagnosis for dysphagia was made. The ST stated she checked Resident 43 during mealtimes to see if there were any deficits in cognition, communication, or swallowing. The ST stated based on her evaluation of Resident 43 she would not recommend giving several medications at one time. The ST stated Resident 43 was at risk of choking or not being able to pass the medications and choking was a life-threatening event. The ST stated it would have been safer for Resident 43 to take one pill at a time. The ST stated if Resident 43 was unable to swallow the first pill, the nurse could have crushed the remaining pills and administered the pills in applesauce. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/9/2025 at 11:12 a.m., with the Director of Nursing (DON), the DON stated the best practice for administering medications to Resident 43 was to assess Resident 43 before giving her the medications. The DON stated Resident 43 had dysphasia and dementia and this could cause behavioral problems that could prevent Resident 43 from swallowing the medication. The DON stated if Resident 43 was not cooperating at the time of the med pass, the nurse (LVN 1) should have come back later when it was safe to give the medication. The DON stated the nurse should have given one medication at a time and waited for Resident 43 to swallow the medication properly before giving more medications. The DON stated the nurse should have also instructed Resident 43 on how to take the medication properly. The DON stated she (DON) did not recommend giving Resident 43 multiple medications at one time because Resident 43 could pocket the medicine, the medication could have gotten stuck in her throat or Resident 43 could have choked. The DON stated she would have to reeducate LVN 1 on how to administer medication to residents like Resident 43 who have dementia because these residents can be unpredictable. During review of the facility's Policy and Procedure (P&P) titled, Administering Medications, revised March 2023, the P&P indicated, Medications are administered in a safe and timely manner, and as prescribed. During a review of the facility's Job Description for LVNs, revised 3/7/2024, the LVN job description indicated the LVN assists in providing a clean, safe, dignified, happy and healthy environment for residents by performing the duties as described below: 1. Medication Pass: a. Prepares and passes medications as indicated. Administer medications according to policy and procedure and observe and document patient's response to pertinent medications. b. Prepares and administers treatment as indicated. Performs resident treatments in accordance with physician orders and evaluates and documents the resident's response to the treatment. c. Administers medication and treatment following regulatory guidelines. d. Provides resident teaching regarding medication as required. 2. Nursing Care: a. Maintains awareness of comfort and safety needs of patient. 3. Competencies: a. Exhibit sound an accurate judgment; makes timely decisions. b. Observe safety and security procedures, reports potentially unsafe conditions.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48131 Based on observation, interview, and record review, the facility failed to ensure one of two sampled resident (Resident 43) was assessed for swallowing ability prior to administering oral medications. This deficient practice resulted in Resident 43 not being able to swallow her medications and had the potential to cause aspiration (when a fluid or solid accidentally enters the windpipe and lungs) or a choking hazard. Findings: During a review of Resident 43's Admission Record, dated 1/8/2025, the admission record indicated Resident 43 was initially admitted to the facility on [DATE] and readmitted on [DATE]. The admission record indicated Resident 43 had the following diagnoses which included dysphagia (difficulty swallowing), dementia (a progressive state of decline in mental abilities), and encephalopathy (decreased brain function). During a review of Resident 43's Minimum Data Set (MDS - a resident assessment tool), dated 12/4/2024, the MDS indicated Resident 43's cognition (the ability to think, remember and reason) was severely impaired. The MDS indicated Resident 43 required supervision (helper provides verbal cues and/or touching/steadying as resident completes activity) with eating and maximal assistance (helper does more than half the effort) with oral hygiene, toileting, bathing, and personal hygiene. During a review of Resident 43's History and Physical (H&P), dated 7/22/2024, the H&P indicated Resident 43 did not have the capacity to understand and make decisions. During a review of Resident 43's care plan titled, Patient presents with oral and pharyngeal (throat area) deficits affecting safe and effective swallow, initiated on 7/22/2024 and revised on 1/8/2025, the care plan indicated Resident 43's goal would be to consume a puree (foods that have soft, pudding-like consistency) diet and thin liquids with safe and effective swallow maintaining nutritional needs. The care plan interventions included speech therapy, to sit Resident 43 up right for all oral intake, give smaller bites and sips, double swallows, and chin tuck (moving the chin close to the chest). During a review of Resident 43's Order Summary Report, dated 1/8/2024, the order summary report indicated an active order started on 7/20/2024 May crush medications and mix with applesauce or food. During a review of Resident 43's Order Summary Report, dated 1/8/2024, the order summary report indicated an active order started on 7/20/2024 for Acetaminophen (Tylenol - a medication used to relieve minor aches and pains) 325 milligrams (mg - metric unit of measurement, used for medication dosage and/or amount) oral tablet. Give two tablets by mouth every four hours as needed for mild pain. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 43's Order Summary Report, dated 1/8/2024, the order summary report indicated an active order started on 7/20/2024 for Apixaban (a medication used to prevent blood clots), 5 mg oral tablet. Give one tablet by mouth two times a day for atrial fibrillation (abnormal heartbeat). During a review of Resident 43's Order Summary Report, dated 1/8/2024, the order summary report indicated an active order started on 7/21/2024 for Aspirin (a medication used to reduce the formation of blood clots), 81 mg oral tablet. Give one tablet by mouth one time a day. During a review of Resident 43's Order Summary Report, dated 1/8/2024, the order summary report indicated an active order started on 7/21/2024 for Losartan Potassium (a medication used to treat high blood pressure) 25 mg oral tablet. Give one tablet by mouth one time a day. During a review of Resident 43's Order Summary Report, dated 1/8/2024, the order summary report indicated an active order started on 7/21/2024 for Namenda (Memantine - a medication used to treat dementia) 5 mg oral tablet. Give one tablet by mouth two times a day. During a review of Resident 43's Order Summary Report, dated 1/8/2024, the order summary report indicated Resident 43 had an active order started on 12/24/2024 for a Renal (related to kidneys) 80 gram (g, unit of measurement), no added salt (NAS) mechanical soft texture, (soft, easily chewable foods that are either pureed, mashed, finely chopped, or ground, designed for individuals who have difficulty swallowing or chewing due to medical conditions like dental issues or swallowing disorders) diet, thin consistency. During a review of Resident 43's Order Summary Report, dated 1/8/2024, the order summary report indicated an active order started on 1/7/2025 for Oyster Shell (a calcium supplement) 500 mg oral tablet. Give one tablet by mouth two times a day. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a medication pass observation on 1/8/2025 at 8:40 a.m., with Licensed Vocational Nurse (LVN 1), observed LVN 1 enter Resident 43's room with a medicine cup filled with oral medications. LVN 1 scooped a spoonful of the oral medications from the medicine cup and placed it in front of Resident 43's mouth. LVN 1 stated, It's time to take your medicine, [NAME]. Resident 43 opened her mouth and took the medication from the spoon. LVN 1 offered Resident 43 a sip of water and scooped another spoonful of oral medications from the medicine cup. LVN 1 fed the medication from the spoon to Resident 43 and gave her another sip of water. Resident 43 was squirming in her bed and stated that she needed to go to the restroom. LVN 1 stated, [NAME]! You have to take your medicine. LVN 1 then asked Resident 43 to open her mouth. Resident 43 still had five whole pills on her tongue. LVN 1 stated, Swallow the pills [NAME]! You have to swallow the pills. LVN 1 gave Resident 43 more water and asked Resident 43 to stick out her tongue. The pills were still observed on Resident 43's tongue. LVN 1 stated again, You have to swallow the pills [NAME]. Swallow [NAME]! LVN 1 continued to give Resident 43 more sips of water to drink and check her tongue. The pills remained on Resident 43's tongue. LVN 1 left the room and went to the med cart to get another cup of water. Resident 43 stated again that she had to use the restroom. LVN 1 stated, I will take you to the restroom as soon as you finish taking your medications. LVN 1 continued to give Resident 43 sips of water and told the resident to swallow the pills. After Resident 43 finished a second cup of water, LVN 1 asked Resident 43 to stick out her tongue. The medication was still on the resident's tongue. Some of the medication started to dissolve on Resident 43's tongue but had not been swallowed. LVN 1 stated, You have to swallow the medication [NAME]. Resident 43 stated, I did! Resident 43 continued to move around uncomfortably in her bed and stated that she needed to use the restroom again. LVN 1 asked Resident 43 to stick out her tongue again. The pills were still on Resident 43's tongue. LVN 1 proceeded to use her gloved hand and scrape the medication from Resident 43's tongue, the back of her throat and sides of her cheeks and placed them back into a medicine cup. LVN 1 then assisted Resident 43 to the restroom. During a concurrent interview and record review on 1/8/2025 at 9:15 a.m., with LVN 1, Resident 43's Medication Administration Record (MAR) for the month of January 2025 and Diagnosis Report was reviewed. LVN 1 stated Resident 43 did get her Aspirin, Apixaban, Losartan, Namenda, and Oyster Shell tablets because she was unable to take them. LVN 1 stated, she also attempted to give Resident 43 Tylenol for pain to her buttocks area. LVN 1 stated she had not known Resident 43 to have difficulty swallowing her medications. LVN 1 reviewed Resident 43's Diagnosis Report. LVN 1 stated, the resident has dysphagia. LVN 1 stated since Resident 43 has a history of dysphagia, she should have given her one medication at a time and given her time to swallow each pill before giving her another one. LVN 1 stated Resident 43 could have choked or aspirated because she gave her several medications at one time. During an interview on 1/8/2025 at 2:10 p.m., with the facility's Speech Language Pathologist (ST), the ST stated an evaluation was done on Resident 43 and a treatment diagnosis for dysphagia was made. The ST stated she checked Resident 43 during mealtimes to see if there were any deficits in cognition, communication, or swallowing. The ST stated based on her evaluation of Resident 43 she would not recommend giving several medications at one time. The ST stated Resident 43 was at risk of choking or not being able to pass the medications and choking is a life-threatening event. The ST stated it would have been safer for Resident 43 to take one pill at a time. The ST stated if Resident 43 was unable to swallow the first pill, the nurse could have crushed the remaining pills and administered the pills in applesauce. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/9/2025 at 11:12 a.m., with the Director of Nursing (DON), the DON stated the best practice for administering medications to Resident 43 was to assess Resident 43 before giving her the medications. The DON stated Resident 43 had dysphasia and dementia and this could cause behavioral problems that could prevent Resident 43 from swallowing the medication. The DON stated if Resident 43 was not cooperating at the time of the med pass, the nurse (LVN 1) should have come back later when it was safe to give the medication. The DON stated the nurse should have given one medication at a time and waited for Resident 43 to swallow the medication properly before giving more medications. The DON stated the nurse should have also instructed Resident 43 on how to take the medication properly. The DON stated she (DON) did not recommend giving Resident 43 multiple medications at one time because Resident 43 could pocket the medicine, the medication could have gotten stuck in her throat or Resident 43 could have choked. During review of the facility's Policy and Procedure (P&P) titled, Administering Medications, revised March 2023, the P&P indicated, Medications are administered in a safe and timely manner, and as prescribed. During a review of the facility's Job Description for LVNs, revised 3/7/2024, the LVN job description indicated the LVN assists in providing a clean, safe, dignified, happy and healthy environment for residents by performing the duties as described below: 1. Medication Pass: a. Prepares and passes medications as indicated. Administer medications according to policy and procedure and observe and document patient's response to pertinent medications. b. Prepares and administers treatment as indicated. Performs resident treatments in accordance with physician orders and evaluates and documents the resident's response to the treatment. c. Administers medication and treatment following regulatory guidelines. oProvides resident teaching regarding medication as required. 2. Nursing Care: a. Monitors condition changes and properly documents and follows-up if necessary. b. Maintains awareness of comfort and safety needs of patient. 3. Competencies: a. Exhibit sound an accurate judgment; makes timely decisions. b. Observe safety and security procedures, reports potentially unsafe conditions.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48131 Based on observation, interview, and record review, the facility failed to honor the food preferences and offer an alternative menu for one of eight sampled residents (Resident 75). This deficient practice had the potential to impact Resident 75's nutritional status and quality of life and result in food dissatisfaction leading to insufficient food intake. Findings: During a review of Resident 75's Admission Record, dated 1/8/2025, the admission record indicated Resident 75 was initially admitted to the facility on [DATE] and readmitted on [DATE]. The admission record indicated Resident 75 had the following diagnoses which included dysphagia (difficulty swallowing), anemia (a condition where the body does not have enough healthy red blood cells), diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), hypertension (HTN- high blood pressure), hyperlipidemia (an abnormally high amount of fat in the blood). During a review of Resident 75's Minimum Data Set (MDS - a resident assessment tool), dated 12/4/2024, the MDS indicated Resident 75 was cognitively intact (the ability to think, remember and reason). The MDS indicated Resident 75 required supervision (helper provides verbal cues and/or touching/steadying as resident completes activity). The MDS indicated Resident 75 required maximal assistance (helper does more than half the effort) for oral hygiene, toileting, bathing, and personal hygiene. During a review of Resident 75's History and Physical (H&P), dated 8/29/2024, the H&P indicated Resident 75 had the capacity to understand and make decisions. During a review of Resident 75's care plan titled, Resident has alteration in nutritional status, initiated on 7/2/2024 and revised on 9/2/2024, the care plan indicated Resident 75's alteration in nutritional status was related to a mechanically altered and therapeutic diet. The care plan interventions included diet as ordered, adhere to food preferences, offer substitute for any meals refused or poor intakes, and respect Resident 75's right to refuse. During a review of Resident 75's Order Summary Report, dated 1/8/2024, the order summary report indicated an active order on 8/28/2024 for a controlled carbohydrates (CCHO, receiving the same amount of carbohydrates a day) no added salt (NAS) diet, dysphagia mechanical soft texture (a specially prepared diet with soft, easily chewed foods for people who have difficulty swallowing), thin consistency. During an interview on 1/6/2025 at 11:08 a.m. with Resident 75, Resident 75 stated she did not like the food at the facility. Resident 75 stated she only ate the fruit and drank the milk. Resident 75 stated the nurses would occasionally offer her an alternative but not for all meals that she did not like. Resident 75 stated she felt like she was getting skinny because she was not eating enough. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the lunch menu on 1/7/2025, the lunch menu indicated Pork with pear sauce, polenta (a paste or dough made from cornmeal), seasoned broccoli, fresh green salad with dressing, and cranberry crunch bar. During an observation on 1/7/2025 at 1 p.m., in Resident 75's room, observed Resident 75 sitting at her bedside eating lunch. Resident 75 had eaten less than 25 percent (%) of her lunch. Resident 75 pointed to the left-over items on her tray and stated, I don't like this! Resident 75 then pointed to her milk, which was untouched and shook her head. During a concurrent observation and interview on 1/7/2025 at 1:10 p.m. with Certified Nursing Assistant (CNA) 1 and Resident 75, Resident 75's lunch tray was observed. Resident 75 informed CNA 1 she did not like her lunch or the milk. CNA 1 pointed to each item remaining on Resident 75's tray and asked if Resident 75 if she wanted any of the items left on the tray. Resident 75 grimaced (facial expression showing dislike) and said the resident did not want to eat any of the remaining items. CNA 1 stated Resident 75 had only eaten about 5% of her meal. CNA 1 stated when a resident did not like their meal or if they had eaten very little of their meal the CNAs were supposed to offer the resident something else to eat and inform the charge nurse. CNA 1 stated she could also offer residents an alternative menu if it was approved by the charge nurse. Resident 75 stated the nurses did not offer Resident 75 anything else to eat nor did they offer an alternative menu. CNA 1 admitted she had not offered Resident 75 something else to eat or an alternative menu. CNA 1 stated if Resident 75 did not like her meal, she may not get enough nutrition and could lose weight. CNA 1 stated she would report to the charge nurse and would make sure to get Resident 75 something else she preferred to eat for lunch. During a concurrent observation and interview on 1/8/2025 at 7:53 a.m., with Resident 75, observed Resident 75 sitting in bed with her breakfast tray. Resident 75 had only eaten a small bowl of yogurt and half a cup of milk. Resident 75 frowned at her food and stated she did not like her breakfast. Resident 75 pointed to her juice and shook her head and stated she did not like the way the juice tasted. Resident 75 stated she was not offered any alternatives for breakfast. During an interview on 1/8/2025 at 12:02 p.m., with Licensed Vocational Nurse (LVN) 3, LVN 3 stated per the facility's policy if resident a did not like their meal or ate less than 50%, the CNA must communicate this to the charge nurse. LVN 3 stated she would then visit the resident to find out if the resident would prefer something else to eat. LVN 3 stated she was not informed Resident 75 did not like her breakfast. During an interview on 1/8/2025 at 4:05 p.m., with the facility's Registered Dietician (RD), the RD stated the kitchen was available for the residents if they did not like their meals. The RD stated there was an alternate menu available to the residents and the residents were more than welcome to request something on the alternative menu list. The RD stated nursing should offer an alternate meal if residents did not like their meals. The RD stated Resident 75's food preferences were important and could be detrimental to the resident's health. The RD stated the facility was Resident 75's home and the resident should be happy with her meals. The RD stated not honoring Resident 75's food preferences could potentially cause weight loss. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/9/2025 at 12:46 p.m. with the Dietary Supervisor (DSS), the DSS stated Resident 75 was on a dysphagia mechanically soft diet. The DSS stated Resident 75 preferred hot cereal, soups, and quesadillas. The DSS stated there was a diet substitute for every meal and Resident 75 should be offered a substitute for every meal if she did not like her food. The DSS stated a diet communication slip should have been sent to the kitchen from the nurses to request a substitute. The DSS stated if she was aware Resident 75 was disliking her food, she would have met with the resident to go over her food preferences, likes and dislikes. The DSS stated she wanted to make sure the residents were enjoying their foods. The DSS stated if Resident 75 was not enjoying her meals it could lead to weight variances overtime. During a review of the facility's policy and procedure (P&P) titled, Food Substitution, revised 2019, the P&P indicated, Residents who do not like the menu item will be given an alternate food of similar nutritive value. The P&P indicated menu alternates would be planned and available for all meals. During a review of the facility's P&P titled, Dignity, revised February 2021, the P&P indicated, The facility culture supports dignity and respect for residents by honoring resident goals, choices, preferences, values and beliefs. The P&P indicated individual needs and preferences of the resident were identified through the assessment process.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47858 Based on observation, interview, and record review, the facility failed ensure proper infection control practices were implemented for two of six sampled residents (Resident 189 and Resident 23) when the facility failed to perform the following: 1. Ensure Resident 189, who had a fever and a productive cough, was placed on isolation precautions (methods used to prevent the spread of germs and infections in healthcare and residential settings), as indicated in the facility's policy. 2. Ensure Resident 23's nasal cannula (NC, a plastic medical device to provide additional oxygen to a person directly into the nostrils) was not touching the floor on 1/6/2025 and 1/7/2025. These deficient practices had the potential to spread infection to other residents and staff within the facility and had the potential to place Resident 23 at risk for an upper airway respiratory infection (infection affecting the sinuses and throat). Findings: 1. During a review of Resident 189's Admission Record, the Admission Record indicated Resident 189 was originally admitted to the facility on [DATE]. Resident 189's diagnoses included displaced fracture (broken bone) of the epicondyle (part of the upper arm bone) of the right humerus (upper arm bone), Parkinsonism (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), and muscle weakness. During a review of Resident 189's History and Physical (H&P), dated 1/5/2025, the H&P indicated Resident 189 was able to make medical decisions, and suffered a fall resulting in a right shoulder dislocation. During a review of Resident 189's care plan titled, Urinary Catheter (a hollow tube inserted into the bladder to drain or collect urine) Care Plan, initiated 6/4/2024, the Care Plan indicated the facility was to monitor Resident 259's urine for color, sediments (matter that settles at the bottom of a liquid), amount, and hematuria (blood in the urine), and order laboratory tests, if indicated. During a review of Resident 189's Situation, Background, Assessment, Recommendation (SBAR -a communication tool used by healthcare workers when there is a change of condition among the residents), dated 1/2/2025, the SBAR indicated Resident 189 exhibited a productive cough (cough that produces mucus or phlegm [thick substance secreted by the mucous membranes)] with light green phlegm and a low-grade fever (body temperature slightly above normal). The SBAR indicated Resident 189 had a temperature of 100.1 Fahrenheit (F, unit of temperature, normal range 97 to 99 degrees F). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 189's Order Summary Report, dated 1/8/2025, the summary report indicated Resident 189 did not have orders for any type of isolation precautions. The summary report also indicated to test Resident 189 for the presence of COVID (a contagious disease caused by the coronavirus), influenza (a highly contagious respiratory infection caused by a virus), or respiratory syncytial virus (RSV- s a contagious virus that infects the respiratory tract) and to perform a sputum culture for his cough (a laboratory test that analyzes a sample of sputum, or phlegm, to identify bacteria or other germs that may be causing a respiratory infection). During a review of all of Resident 189's lab results, dated in 1/2025, there were no results indicating the COVID, influenza, or the RSV exams were performed. During an observation on 1/6/2025, at 12:34 p.m., and 1/7/2025, at 9:00 a.m., Resident 189 was observed not on contact or droplet isolation (type of isolation for residents suspected to be infected with pathogens transmitted by respiratory droplet). During an interview, on 1/7/2025, at 9:44 a.m., with the Infection Prevention Nurse (IPN), the IPN stated Resident 189's results were pending, and Resident 189 should have been placed on contact isolation to minimize the spread of infection to other residents and staff. During a review of the facility's Policy and Procedure (P&P), titled, COVID-19, dated 8/26/2024, the P&P indicated to immediately isolate symptomatic (showing signs of) residents in place and to initiate COVID-19 transmission-based precautions while pending testing results. 49900 2. During an observation on 1/6/2025 at 10:40 a.m., in Resident 23's room, Resident 23 was observed receiving oxygen via NC. The NC was observed touching the floor. During an observation on 1/7/2025 at 8:48 a.m., in Resident 23's room, Resident 23 was observed receiving oxygen via NC. The NC was observed touching the floor. During a review of Resident 23's Admission Record, dated 1/8/2025, the admission record indicated Resident 23 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 23's diagnoses included pneumonia (an infection/inflammation in the lungs), sepsis (a life-threatening blood infection), seizure (a sudden, uncontrolled electrical disturbance in the brain which could cause uncontrolled jerking, blank stares, and loss of consciousness), and major depressive disorder (a mood disorder that caused a persistent feeling of sadness and loss of interest). During a review of Resident 23's H&P, dated 12/23/2024, the H&P indicated Resident 23 did not have the capacity to make decisions. During a review of Resident 23's MDS, dated [DATE], the MDS indicated Resident 23's cognition was severely impaired. The MDS indicated Resident 23 was dependent (helper did all the effort) with oral hygiene, toileting hygiene, shower/ bathe self, and personal hygiene. During a review of Resident 23's Oder Summary Report, dated 1/8/2025, the report indicated an order, dated 12/22/2024, to administer oxygen at 2 liters (a unit for measuring the volume of a liquid or a gas) per minute (L/min) via NC. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 1/7/2025 at 12:04 p.m. with Licensed Vocational Nurse (LVN) 1, in Resident 23's room, Resident 23 was observed receiving oxygen via NC. The NC was touching the floor. LVN 1 stated the NC should not be touching the floor because it put Resident 23 at risk for infection. LVN 1 stated the bacteria could move up to the NC tube, and the resident might develop a respiratory infection. LVN 1 stated everyone who took care of the resident should ensure the NC was not touching the floor. During an interview on 1/8/2025 at 11:57 a.m. with the IPN, the IPN stated the NC was not supposed to be touching the floor because it was the source of bacteria. The IPN stated Resident 23 could develop a respiratory infection, such as pneumonia. The IPN stated Resident 23 might experience coughing, fever, increased confusion, and shortness of breath. The IPN stated all staff were responsible to ensure the NC was not touching the floor. During a review of the facility's P&P titled, Oxygen administration, undated, the P&P indicated oxygen tubing should be used in a manner that prevents it from touching the floor.