STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055181	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Gabriel Conv Center	8035 E Hill Drive Rosemead, CA 91770

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44018 Based on observation, interview, and record review the facility failed to promote the resident's right to receive services in the facility with reasonable accommodation of resident needs and preferences for three of three residents (Resident 88, 7 and 98) by failing to: 1. Accommodate Resident 88's needs by not providing a communication board (a sheet of symbols, pictures or photos that residents will learn to point to, to communicate with those around them) for the resident to effectively communcate her needs. 2. For Resident 98, who spoke and preferred to communicate in his native foreign language was not provided a communication board to be used to communicate with the facility staffs. This failure resulted in violation of the residents rights to communciate their needs, and cause confusion and miscommunication such as Resident 88 not receiving oral care. The deficient practice can also result in a decline in psychosocial being. 3 Ensure Resident 7's call light (a device used by residents to signal his or her needs for assistance) was within reach for one or three sampled residents (Resident 7). This deficient practice had the potential for Resident 7 not able to call the facility staff to ask for help or receive assistance specially during emergency. Findings: 1. A review of Resident 88's admission record indicated resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with history of falling and hypertension (having high blood pressure). A review of Resident 88's Minimum Data Set (MDS - a comprehensive standardized assessment and screening tool), dated 5/14/24, indicated Resident 88 has severe cognitive (mental action or process of acquiring knowledge and understanding for daily decision-making) impairment. The MDS indicated Resident 88 required partial/moderate assistance (helper does less than half the effort) on staff for shower/bath self and required supervision or touching assistance (helper provides verbal cues, touching and/or contact guard assistance) on toilet hygiene, and personal hygiene. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Resident 88's History and Physical Examination (H&P) dated 8/16/23, indicated Resident 88 does not have the capacity to understand and make decisions. During the initial tour on 5/21/24 10:17 AM, Resident 88 was observed in bed. Resident 88 was speaking in a language, not the dominant language in the facility, Resident 88 stated, I am hungry, I want a bowl of rice. Resident 88 repeated the same statement four times. A Certified Nursing Assistant 1 (CNA) was observed responded to Resident 88 in English and stated, You're ok now. During a concurrent interview with Resident 88 and CNA 2 (translated for Resident 88) on 5/21/24 at 10:22 AM, Resident 88 stated she did not have a communication board. Resident 88 stated that she communicated with staff by pointing at the pictures printed on the communication board. During a concurrent interview with CNA 1 on 5/21/24 at 10:23 PM, CNA 1 stated Resident 88 does not speak English and should have a communication board in the drawer that was accessible for resident. CNA 1 stated she could not find the communication board in the drawer. CNA 1 stated she did not know what the Resident 88 said earlier as a result she was not able to provide Resident 88 needs. During an interview with Director of Nursing (DON), on 5/24/24 at 2:12 PM, the DON stated that the facility should provide a communication board for residents whose primary language is not the dominant language in the facility-English or resident will not be able to communicate needs. 47467 2. A review of Resident 98's Admission Record indicated Resident 98 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis that included muscle weakness, abnormalities of gait and mobility, blindness of left eye, dementia (a loss of brain function that affects memory, thinking, language, judgment, or behavior), anemia, and Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks.) A review of Resident 98's MDS, dated [DATE] indicated, Resident 98's cognitive skills for daily decision making was moderately impaired and needed partial/moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) for oral hygiene (the ability to use suitable items to lean teeth) and personal hygiene (the ability to maintain personal hygiene, including combing hair, washing/drying face and hands). A review of Resident 98's Care Plan, revised 2/14/244 indicated Resident 98 was at risk for having needs unmet related to difficulty in communication secondary to language barrier due to resident communicates in a foreign language. To ensure Resident 98 communicates his needs appropriately daily, the facility care plan interventions included the use of communication board as needed. During a concurrent observation and interview on 5/21/24 at 8:53 AM with Resident 98, Resident 98's teeth was observed with red gums and food sticking close to the gum line. Resident 98's bedside table and drawer was observed with no oral care kit. Resident 98 stated, since admission, he had never had any teeth cleaning after meals. Resident 98 stated, he had been always very uncomfortable with the uncleanliness of his teeth. Resident 98 stated, the staff had never offered or assisted him to brush his teeth and never brought any toothbrush or toothpaste to him. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/24/24 at 10:05 AM with CNA 4, CNA 4 stated, Resident 98 had been refusing oral care when she was assigned to him. During an observation on 5/24/24 at 10:10 AM in Resident 98's room, CNA 4 was observed asking Resident 98 in a language that the resident did not understand, if he wanted oral care. Resident 98 was observed shaking his head and said No. CNA 4 stated, Resident 98 had been refusing his oral care by saying No. During an interview on 5/24/24 at 10:11 AM with Resident 98, when asked why he said No, Resident 98 stated, he said No because he did not understand what CNA 4 was saying because it was not in a language that he could understand. During an interview on 5/24/24 at 10:13 AM with CNA 4, CNA 4 stated, Resident 98 had communication barrier and would only understand in his preferred language. CNA 4 stated, she should have asked a staff member to translate instead of speaking to Resident 98 in the language that he did not understand. CNA 4 stated, she usually used a communication board with pictures written in Resident 98's preferred language since admission so that he would understand. During a concurrent observation and interview on 5/24/24 at 10:15 AM in Resident 98's room, CNA 4 was observed demonstrating how she had been communicating with Resident 98 by using a communication board. CNA 4 was observed pointing at a picture, which CNA 4 stated was meant for oral care. Resident 98 stated he did not understand anything because the language written in the communication board was not his preferred language. Resident 98 stated, CNA 4 did not use the correct communication board, so he had been confused, and did not realize that he had been missing his oral care because of saying No, which he meant I don't understand. During an interview on 5/24/24 at 10:26 AM with the DON, the DON stated, CNA 4 supposed to use the right communication board with the correct language. The DON stated failure to make sure the resident understand could lead to not meeting the resident's needs, the resident could be frustrated, angry and could cause a noncompliant with care and a decline in resident's health. 46779 3. During a review of Resident 7's Admission Record indicated the facility originally admitted Resident 7 on 9/12/13 and readmitted on [DATE] with diagnoses that included dementia (a general term to describe a group of symptoms related to loss of memory and judgment) and anemia (a condition in which the body does not have enough healthy red blood cells. Red blood cells provide oxygen to body parts). During a review of Resident 7's Care Plan (CP), indicated the resident was at risk for falls/injury, revised on 7/29/23, the CP indicated the goal was to reduce risk of falls & injury daily, and the interventions included the facility will keep call light within easy reach to get assistance. During a review of Resident 7's MDS, dated [DATE], indicated Resident 7 had severely impaired memory and cognition. Resident 7 was dependent with eating, oral hygiene, toileting hygiene, shower/bathe self, and personal hygiene. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation in Resident 7's room and interview on 5/23/24, at 11:45 AM, with CNA 4, Resident 7 was lying on the bed with head of bed elevated at 30 degrees angle. Resident 7's call light was on the floor on the left side of the bed. CNA 4 stated Resident 7 could not move by herself, and the call light was on the floor out of Resident 7's reach. CNA 4 stated the call light should be within the residents reach at all times so that they could call for assistance when needed and to ensure resident's safety. During an interview on 5/24/24 at 12:35 PM, with the Administrator (ADM), the ADM stated it was important to keep call light within residents' reach, so they could call for assistance for their needs and in case of emergency. The AMD stated call light should be within reach for resident's safety. During a review of the updated facility's policy and procedure titled, Call Lights, indicated Ensure that the call light is within the resident's reach when in his/her room or when on the toilet. A review of the facility's Policy and Procedure titled Accommodation of Needs Related to Communication Deficits, undated, indicated Communication needs will be identified and appropriate interventions including care planning, will be developed in order to accommodate the needs of the resident. The policy also indicated that the communication needs will be assessed as follows: a. Resident identifying - Language spoken. b. Rehabilitation screening - modes of expression, c. Communication section on Social Service Progress Notes. d. Care plan will be developed, updated quarterly and as indicated to reflect accurate, current assessment related to communication needs.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46779 Based on interview and record review, the facility failed to ensure residents' medical records were updated to indicate documentation that advance directives (AD-written statement of a person's wishes regarding medical treatment made to ensure those wishes are carried out should the person be unable to communicate them to a doctor) were discussed and the written information were provided to the residents and/or responsible parties for four of the five sampled residents (Resident 7, 113, 107, and 39). These deficient practices violated the residents' and/or the representatives' right to be fully informed of the option to formulate their advance directives (AD) and had the potential to cause conflict with the residents' wishes regarding health care. 2. the facility failed to ensure that AD and Physician Orders for Life-Sustaining Treatment (POLST-a form that gives seriously-ill patients more control over their end-of-life care) were current and part of Resident 39's clinical records. This deficient practice had the potential for the resident to receive inaccurate care and/or treatment in regard to life-sustaining treatment especially in an event of emergency. Findings, 1. During a review of Resident 7's Admission Record indicated the facility originally admitted Resident 7 on [DATE] and readmitted on [DATE] with diagnoses that included dementia (a general term to describe a group of symptoms related to loss of memory and judgment) and anemia (a condition in which the body does not have enough healthy red blood cells. Red blood cells provide oxygen to body pars). During a review of Resident 7's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated [DATE], indicated Resident 7 had severely impaired memory and cognition (ability to think and reason). Resident 7 was dependent with eating, oral hygiene, toileting hygiene, shower/bathe self, and personal hygiene. During a concurrent interview and record review on [DATE] at 9:40 AM, with Registered Nurse (RN) 2, Resident 7's clinical chart was reviewed, RN 2 stated the Advance Directive Acknowledgement (ADA) form in Resident 7's clinical chart was blank. RN 2 stated Resident 7 ' s ADA form should be signed and kept in the resident's clinical chart to ensure the resident and the responsible party (RP) being informed about their right and making the informed decision regarding her care. During a concurrent interview and record review on [DATE] at 9:52 AM, with RN 2, Resident 7's signed ADA form, dated [DATE], was reviewed. RN 2 stated the facility staff removed the signed ADA form from Resident 7's clinical chart and stored it in the overflow chart which was not immediate accessible to the facility staff to review during the emergency. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During a review of Resident 113's Admission Record indicated the facility admitted Resident 113 on [DATE] with diagnoses that included paraplegia (a condition in which a person can not deliberately control or move the legs) and hyperlipidemia (an elevated level of lipids [fat particles] in the blood). During a review of Resident 113's History and Physical (H&P), dated [DATE], indicated Resident 113 has the capacity to understand and make decisions. During a review of Resident 113's MDS, dated [DATE], indicated Resident 113 had intact memory and cognition (ability to think and reason). Resident 113 required setup or clean-up assistance with eating and oral hygiene, partial/moderate assistance with toileting hygiene, shower/bathe self, and personal hygiene, and was dependent with sit to lying, sit to stand, chair/bed-to-chair transfer and toilet transfer. During a concurrent interview and record review on [DATE] at 9:42 AM, with RN 2, Resident 113's clinical chart was reviewed, RN 2 stated there was no ADA form in Resident 113's clinical chart. RN 2 stated she would not know if Resident 113 and his RP were provided with the information regarding their right to formulate the Advance Directive when the facility admitted the resident. RN 2 stated ADA form should be signed and kept in the resident ' s clinical chart. 4. During a review of Resident 107's Admission Record indicated the facility admitted Resident 107 on [DATE] with diagnoses that included encephalopathy (a disorder of brain function that often impairs consciousness) and hyperlipidemia (an elevated level of lipids [fat particles] in the blood). During a review of Resident 107's H&P, dated [DATE], indicated Resident 107 does not have the capacity to understand and make decisions. During a review of Resident 107's MDS, dated [DATE], indicated Resident 107 had severely impaired memory and cognition (ability to think and reason). Resident 107 was dependent with oral hygiene, toileting hygiene, shower/bathe self, personal hygiene, sit to lying, sit to stand, and tub/shoer transfer. During a concurrent interview and record review on [DATE] at 9:30 AM, with RN 1, Resident 107's clinical chart was reviewed, RN 1 stated there was no ADA form in Resident 107 ' s clinical chart and she did not know if the resident and RP was informed about her right to formulate the AD and the staff would know what the resident and the RP's decision regarding her care during emergency. RN 1 stated when the facility admitted a resident, the licensed nurses and the social workers would provide three forms including the Physician Order for Life-Sustaining Treatment (POLST), the ADA, and the surrogate decision-making form to the resident and RPs. RN 1 stated the contents and the purposes of these three forms were the same. During an interview on [DATE] at 12:34 PM with the Administrator (ADM), the ADM stated residents and their RPs should be informed about their rights to formulate the ADs. The ADM stated the signed ADA form should be kept in the resident's clinical chart and be assessable for review. During a review of the facility's policy and procedure titled, Advance Directives for Care, dated on [DATE], indicated residents and their families are informed regarding advance directive. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	44018 2. A review of Resident 39's Admission Record indicated the resident was initially admitted on [DATE] and readmitted to the facility on [DATE], with diagnosis that included chronic obstructive pulmonary disease (COPD-a group of lung diseases that block airflow and make it difficult to breathe) and type 2 diabetes mellitus (a medication condition characterized by the body ' s inability to regulate blood sugar level). A review of Resident 39's MDS, dated [DATE], indicated Resident cognitive skill (mental action or process of acquiring knowledge and understanding for daily decision-making) was moderately impaired. The MDS indicated Resident 39 was bed bound and required total dependent (helper does all of the effort) on staff for eating, oral hygiene, and toilet hygiene. During an interview and record review with the Registered Nurse (RN) 1, on [DATE] at 1:59 PM, the RN 1 stated that Resident 39 had the AD and POLST, but they were not in the resident's chart at this time. The RN 1 stated the AD and POLST must be put in the resident's clinical chart in order for a nurse to be able to act in accordance with resident ' s will of treatment decision and end of life issues. A review of the Resident 39's H&P, dated [DATE] and interview with Social Service Director (SSD), on [DATE] at 2:03 PM, the H&P's Advance Directive Executed section, a check mark was placed on No, The SSD stated Resident 39's H&P needed to be updated because Resident 39 had AD and POLST. The SSD stated that AD and POLST were not in the resident's chart and should be. The SSD also stated that she was responsible for ensuring resident's POLST and AD's and/or services to obtain POLST and ADs were provided upon admission to the facility. A review of Resident 39's Order Summary Report (a summary of all currently active physician orders), dated [DATE], indicated Resident 39 had an AD with full code (full support which includes cardiopulmonary resuscitation {CPR}, if the patient has no heartbeat and is not breathing) treatment. A review of the facility policy and procedure titled, Advance Directive Care, revised dated [DATE], indicted if the resident elects to sign an advance directive, a copy is placed in the resident ' s medical record. All staff are advised of the document and shown the document at the time of the first visit with the resident.

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F 0636

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 47467

Based on interview and record review, the facility failed to ensure the comprehensive Minimum Data Sets (MDS - a comprehensive standardized assessment and screening tool) were completed within the required time frame for four of four sampled residents (Resident 70, 54, 4, and 100).

This deficient practice had the potential to negatively affect the provision of necessary care and services for Resident 70, 54, 4, and 100.

Findings:

1. During a review of Resident 70's Admission Record indicated the facility admitted Resident 70 with diagnoses that included dementia (a general term to describe a group of symptoms related to loss of memory and judgment) and hyperlipidemia (an elevated level of lipids [fat particles] in the blood).

During a concurrent interview and record review on 5/23/24 at 10:20 AM, with the MDS Nurse (MDSN), Resident 70's MDS-Nursing Home Comprehensive Item set, dated 4/2/24, and the Final Validation Report (a log that the facility submitted to the MDS data base each day), dated 5/16/24, were reviewed. The MDSN stated the target date for Resident 70's annual comprehensive MDS was 4/2/24, but the MDS was completed on 5/8/24, and it was submitted and accepted in the MDS data base on 5/16/24. The MDSN stated the MDS assessment was completed late which was more than 14 days after the assessment reference date (ARD) because he and the MDS Coordinator were too busy with other tasks in the facility. The MDSN stated he should assess the resident and complete the MDS by the target date which was 4/2/24 and submit it within 30 days of completion date. The MDSN stated the facility did not assess Resident 70, completed and submited the resident's annual MDS timely.

2. During a review of Resident 54's Admission Record indicated the facility originally admitted Resident 54 on 2/17/22 and readmitted on [DATE] with diagnoses that hyperlipidemia and anemia (a condition in which the body does not have enough healthy red blood cells. Red blood cells provide oxygen to body parts).

During a concurrent interview and record review on 5/23/24 at 10:30 AM, with the MDSN, Resident 54's MDS-Nursing Home Comprehensive Item set, dated 4/2/24, and the Final Validation Report, dated 5/16/24, were reviewed. The MDSN stated the target date for Resident 54's annual comprehensive MDS was 4/2/24, the completion date of the MDS was 5/10/24 and the submission and the accepting date on the MDS data base was 5/16/24. The MDSN stated the assessment was completed late which was more than 14 days after the ARD. The MDSN stated he and the MDS Coordinator should have assessed the resident and completed the MDS by the target date which was 4/2/24, and submitted the MDS assessment within 30 days of completion date. The MDSN stated the facility did not assess Resident 54, completed and submitted the resident's annual MDS timely.

3. During a review of Resident 4's Admission Record indicated the facility originally admitted Resident 4 on 9/22/14 and readmitted on [DATE] with diagnoses that dementia and anemia

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 5/23/24 at 10:40 AM, with the MDSN, Resident 4's MDS-Nursing Home Comprehensive Item set, dated 4/2/24, and the Final Validation Report, dated 5/16/24, were reviewed. The MDSN stated the target date for Resident 4's annual MDS was 4/2/24, the completion date of the MDS was 5/14/24, and the submission and the accepting date in the MDS data base was 5/16/24. The MDSN stated the assessment was completed late which was more than 14 days after the ARD. The MDSN stated he and the MDS Coordinator should have assessed the resident and completed the MDS by the target date which was 4/2/24 and submitted the MDS within 30 days of completion date. The MDSN stated the facility did not assess Resident 4, completed and submitted the resident's annual MDS timely. 4. During a review of Resident 100's Admission Record indicated the facility originally admitted Resident 100 on 3/30/23 and readmitted on [DATE] with diagnoses that included seizure (a burst of uncontrolled electrical activity between brain cells, causing changes in behavior, movements, feelings and levels of consciousness) and anemia. During a concurrent interview and record review on 5/23/24 at 10:50 AM, with the MDSN, Resident 100's MDS-Nursing Home Comprehensive Item set, dated 4/1/24, and the Final Validation Report, dated 5/16/24, were reviewed. The MDSN stated the target date for Resident 100's annual MDS was 4/1/24, the completion date of the MDS was 5/14/24 (43 days late), and the submission and the acceptance date in the MDS data base was 5/16/24. The MDSN stated the assessment was completed late which was more than 14 days after the ARD. The MDSN stated the facility staff should assess the resident and complete the MDS by the target date which was 4/1/24 and submit it within 30 days of completion date. The MDSN stated the facility did not assess Resident 100, and complete and submit his annual MDS timely. During an interview on 5/23/24 at 11:08 AM, with the MDSN, the MDSN stated MDS was an assessment tool that guided the facility staff to assess residents timely. The MDSN stated the facility staff had to make sure the assessment reflected the most current condition and any change needed to revise for care plan. The MDSN stated the MDSs were late because they were too busy to do other tasks in the facility and did not have time to complete and submit them on time. The MDSN stated the late assessment could result in delayed treatment, which could comprise residents' quality of care and safety, especially those with major condition change. During an interview on 5/23/24 at 12:10 PM, with the Director of Nursing (DON), the DON stated the facility staff would not be able to develop care pan and provide necessary interventions promptly to the residents whose conditions were changing because the assessment was late. The DON stated it was important to assess the residents timely, and complete and submit the MDS timely to ensure consistent and quality of care to the residents. During a review of the Center for Medicare and Medicaid (CMS)'s Resident Assessment Instrument (RAI) Version 3.0 Manual dated October 2023, indicated the annual (comprehensive) MDS must be completed no later than 14 calendar days from the ARD, the care plan must be completed no later than 7 days from the annual MDS completion date, and the annual MDS must be transmitted no later than 14 days from the care plan completion date. The target date was the ARD.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47467 Based on interview and record review, the facility failed to ensure the quarterly Minimum Data Sets (MDS - a comprehensive standardized assessment and screening tool) were completed and submitted to the CMS (Center for Medicare and Medicaid) data base within the required time frame for four out of four sampled residents (Resident 70, 54, 4, and 100). This deficient practice had the potential for the residents not to receive or receive delayed necessary care and treatment, which could comprise residents' quality of care and safety, especially for the residents with major condition change that could result in a decline in Residents 70, 54, 4, and 100 wellbeing. Findings: 1.During a review of Resident 70's Admission Record indicated the facility admitted Resident 70 with diagnoses that included dementia (a general term to describe a group of symptoms related to progressive loss of memory and judgment) and hyperlipidemia (an elevated level of lipids [fat particles] in the blood). During a concurrent interview and record review on 5/23/24 at 10:25 AM, with the MDS Nurse (MDSN), Resident 70's MDS-Nursing Home Quarterly Item set, dated 1/4/24, and the Final Validation Report (a log that the facility submitted to the MDS data base each day), dated 4/3/24, were reviewed. The MDSN stated the target date for Resident 70's quarterly MDS was 1/4/24, but the MDS was completed on 3/28/24, and it was submitted and the accepted in the CMS data base on 4/3/24. The MDSN stated the assessment was completed and submitted late which was more than 14 days after the assessment reference date (ARD). The MDSN stated he and the MDS Coordinator should assess the resident and complete the MDS by the target date which was 1/4/24 and submit it within 30 days of completion date. The MDSN stated the facility did not assess Resident 70, and complete or submitted the ressident's quarterly MDS timely. 2. During a review of Resident 54's Admission Record indicated the facility originally admitted Resident 54 on 2/17/22 and readmitted on [DATE] with diagnoses that hyperlipidemia and anemia (a condition in which the body does not have enough healthy red blood cells. Red blood cells provide oxygen to body parts). During a concurrent interview and record review on 5/23/24 at 10:35 AM, with the MDSN, Resident 54's MDS-Nursing Home Quarterly Item set, dated 1/4/24, and the Final Validation Report, dated 4/3/24, were reviewed. The MDSN stated the target date for Resident 54 ' s quarterly MDS was 1/4/24, the MDS was completed on 3/29/24, and it was submitted and accepted on 4/3/24. The MDSN stated the MDS assessment was completed late which was more than 14 days after the ARD. The MDSN stated he and the MDS Coordinator should assess the resident and complete the MDS by the target date which was 4/2/24 and submit it within 30 days of completion date. The MDSN stated the facility did not assess Resident 54, and completed or submitted Resident 54's quarterly MDS timely. 3. During a review of Resident 4's Admission Record indicated the facility originally admitted Resident 4 on 9/22/14 and readmitted on [DATE] with diagnoses that dementia and anemia. (continued on next page)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 5/23/24 at 10:45 AM, with the MDSN, Resident 4's MDS-Nursing Home Quarterly Item set, dated 1/11/24, and the Final Validation Report, dated 4/3/24, were reviewed. The MDSN stated the target date for Resident 4's Quarterly MDS was 1/11/24, the MDS was completed on 3/29/24, and it was submitted and the accepted on 4/3/24. The MDSN stated the assessment was completed late which was more than 14 days after the ARD. The MDSN stated he and the MDS Coordinator should assess the resident and complete the MDS by the target date which was 1/11/24 and submit it within 30 days of completion date. The MDSN stated the facility did not assess Resident 4, and complete or submit his ' s quarterly MDS timely. 4. During a review of Resident 100's Admission Record indicated the facility originally admitted Resident 100 on 3/30/23 and readmitted on [DATE] with diagnoses that seizure (a burst of uncontrolled electrical activity between brain cells, causing changes in behavior, movements, feelings and levels of consciousness) and anemia. During a concurrent interview and record review on 5/23/24 at 10:55 AM, with the MDSN, Resident 100's MDS-Nursing Home Quarterly Item set, dated 1/2/24, and the Final Validation Report, dated 5/16/24, were reviewed. The MDSN stated the target date for Resident 100 ' s quarterly MDS was 1/2/24, the MDS was completed on 2/19/24, and it was submitted and accepted on 5/16/24. The MDSN stated the assessment was completed late which was more than 14 days after the ARD. The MDSN stated the facility staff should assess the resident and complete the MDS by the target date which was 1/2/24 and submit it within 30 days of completion date. The MDSN stated the facility did not assess Resident 100, and completed or submitted the resident's quarterly MDS timely. During an interview on 5/23/24 at 11:08 AM, with the MDSN, the MDSN stated MDS was an assessment tool that guided the facility staff to assess residents timely. The MDSN stated he and the MDS Coordinator had to make sure the assessment reflected the most current condition and any change needed to revise for care plan. The MDSN stated they were having staffing issue so he and the MDS Coordinator were pulled to preform other tasks in the facility, so they did not have time to complete some residents' assessment and MDS. The MDSN stated the late assessment could result in delayed treatment, which could comprise residents' quality of care and safety, especially those with major condition change. During an interview on 5/23/24 at 12:10 PM, with the Director of Nursing (DON), the DON stated the facility staff would not be able to develop care plan and provide necessary interventions promptly to the residents whose conditions were changing because the assessment was late. The DON stated the facility had a staffing issue over the completion the MDS on time, and the faculty utilized an extra staff to help catching up with MDS completion. The DON stated it was important to assess the residents timely, and complete and submit the MDS timely to ensure consistent and quality of care to the residents. During a review of the Center for Medicare and Medicaid (CMS)'s Resident Assessment Instrument (RAI) Version 3.0 Manual dated October 2023, indicated the quarterly MDS must be completed no later than 14 calendar days from the ARD and transmitted no later than 14 days from the MDS completion date. The target date was the ARD.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44018 Based on observation, interview, and record review, facility failed to meet professional standards of quality (care and services are provided according to accepted standards of clinical practice) for one of one sample residents (Resident 27) by failure to apply gentle pressure to the lacrimal duct (a small tube that drains tear from the eyes) to prevent systemic absorption of the medication (medications are absorbed into the whole of an organism, rather than applied to one area.) of Carboxymethylcellulose sodium (medication is used to relieve dry, irritated eyes) ophthalmic (eye). This deficient practice had the potential for the resident to have an adverse reaction (an undesired harmful effect resulting from a medication). Findings, A review of Resident 27's Admission Record indicated Resident 27 was admitted to the facility on [DATE], with diagnoses that included Alzheimer's disease (a progressive brain disorder that disables a person from performing everyday activities) and hyperlipidemia (a condition in which there are high levels of fat particles (lipids) in the blood). A review of the Minimum Data Set (MDS, a standardized assessment and care-screening tool), dated 2/27/24, indicated Resident 27 had severely impaired cognitive skills (mental action or process of acquiring knowledge and understanding) in decision making. The MDS indicated Resident 27 required partial/moderate assistance (helper does less than half the effort) with toileting hygiene and shower/bathe self. A review of the History and Physical Examination (H&P) dated 9/27/23, indicated Resident 27 does not have the capacity to understand and make decisions. A review of Resident 27's Order Summary Report (a summary of all currently active physician orders), dated 5/23/24, indicated a physician's order to administer Carboxymethylcellulose sodium ophthalmic solution to instill one drop in both eyes four times a day for dry eyes. During a record review of Resident 27's MAR for May 2024, indicated Resident 27 was scheduled to receive Carboxymethylcellulose sodium) ophthalmic everyday at 9AM. During a medication pass (Med Pass) observation on 5/23/24 at 9:49 AM, Licensed Vocational Nurse (LVN 2) prepared the Carboxymethylcellulose sodium ophthalmic solution to administer to Resident 27. During the same Med Pass observation, on 5/23/24 at 9:49 AM, LVN 2 was observed washing hands and donning (putting on) gloves and administering Carboxymethylcellulose sodium ophthalmic solution to both eyes by having Resident 27 tilt her head back, pull down the lower lid, and administered one drop to each eye. LVN 2 wiped excess meds from eyes with two separated tissues. LVN 2 did not place one finger at the corner of the eye near the nose and apply gentle pressure to the lacrimal duct area to prevent the medication from draining away from the eye. LVN 2 removed gloves and washed hands. After administration of the eye drop medication, LVN 2 documented on the Medication Administration Record (MAR). (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with LVN 2 on 5/23/24 at 10:13 AM, LVN 2 stated she was not aware of the need to apply pressure to lacrimal duct to prevent systemic absorption of medication. LVN 2 was observed searching web site, Webmed.com for reference on the laptop which was placed on top of the med cart. LVN 2 then stated she should place one finger at the corner of the eye and apply gentle pressure to prevent the medication from draining away from the eye. During an interview with the Director of Nursing (DON) on 5/25/25 at 3:12 PM, the DON stated LVN 2 should gently press the finger to the inside corner of the eye for about one minute to keep the liquid from draining into the tear duct. The DON stated LVN 2 should read the instruction on the product package carefully before administering the eye drop. Reference: https://www.webmd.com/drugs/2/drug-18521/carboxymethylcellulose-sodium-ophthalmic-eye/details To apply eye ointment/drops/gels: Tilt your head back, look up, and pull down the lower eyelid to make a pouch. For drops/gels, place the dropper directly over the eye and squeeze out 1 or 2 drops as needed. Look down and gently close your eye for 1 or 2 minutes. Place one finger at the corner of the eye near the nose and apply gentle pressure. This will prevent the medication from draining away from the eye.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44018 Based on observation, interview, and record review, the facility failed to assist four of five sampled residents (Residents 19, 87, 98 and 17) who were unable to carry out activities of daily living (ADL) to maintain good grooming, and personal and oral hygiene by failing to 1. Assist Resident 19 and Resident 87 to trim the residents' fingernails during shower. These deficient practices had the potential to result in a negative impact on Resident 17 and Resident 87's quality of life and self-esteem. 2. Assist Resident 98 with oral care. This failure resulted in Resident 98's inconsistent oral care since 3/7/24 and which had a potential to result in dental carries, teeth and gum infections, lung infection, that could lead to hospitalization for higher level of care. Findings, 1. A review of the admission record indicated Resident 19 was originally admitted to the facility on [DATE] and readmitted on [DATE] with contracture (a condition of shortening and hardening of muscles, tendons, and other tissue) of right and left wrist. A review of Resident 19's Minimum Data Set (MDS - a comprehensive standardized assessment and screening tool), dated 4/9/24, indicated Resident 19's cognitive skill (mental action or process of acquiring knowledge and understanding for daily decision-making) was impaired. The MDS indicated Resident 19 required total dependence (full staff performance) on staff for oral hygiene, toilet hygiene, and personal hygiene. During an observation in Resident 19's room on 5/23/24 at 8:32 AM, Resident 19 was observed lying in bed. Resident 19's fingernails were observed untrimmed and with blackish substance underneath the fingernails. A review of Resident 19's Care Plan (a document that outlines the facility's plan to provide personalized care to a resident based on the resident's needs) indicated resident has a self-care deficit related to contractures of the right and left wrist, initiated on 1/18/23. Staff interventions included assisted with grooming and trimming of fingernails. 2. A review of Resident 87's admission record indicated resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with contracture of right and left elbow. A review of Resident 87's MDS, dated [DATE], indicated Resident 87's cognitive skill was severely impaired. The MDS indicated Resident 87 required total dependence (full staff performance) on staff for oral hygiene, toilet hygiene, and personal hygiene. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation in Resident 87's room on 5/23/24 at 8:33 AM, Resident 87 was observed lying in bed. The resident's fingernails were observed untrimmed and with yellow substance underneath the fingernails. A review of Resident 87's Care Plan, initiated on 3/11/23, indicated the resident has an ADL self-care deficit related to late Cerebral Vascular Accident (CVA- is an interruption in the flow of blood to cells in the brain) with right hemiparesis (weakness on one side) and contractures (tightening of the muscle). Staff interventions included to assist Resident 87 with grooming and trimming of fingernails. During a concurrent interview and observation in Residents 87's shared room on 5/23/24 at 8:40 AM, Certified Nursing Assistant 2 (CNA 2) stated Resident 19 and Resident 87's fingernails on both hands were long and dirty. CNA 2 stated the assigned CNA was responsible for cutting the residents' fingernails after residents' shower or bath. During an interview with the Director of Nursing (DON), on 5/23/24 at 11:49 AM, the DON stated nails care is part of grooming for the residents. The DON stated nail care is a duty of a CNA, and as a part of the routine care that was done on bath day and as necessary. A review of the facility`s undated policy titled, Nail Care, the purpose to the policy was to ensure that resident's nails are clean and trimmed to reduce risks of infection and to promote dignity. 47467 2. A review of Resident 98's Admission Record indicated Resident 98 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis that included muscle weakness, abnormalities of gait and mobility, blindness of left eye, dementia (a loss of brain function that affects memory, thinking, language, judgment, or behavior), anemia, and Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks.) A review of Resident 98's MDS, dated [DATE] indicated, Resident 98's cognitive skills for daily decision making was moderately impaired and needed partial/moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) for oral hygiene (the ability to use suitable items to lean teeth) and personal hygiene (the ability to maintain personal hygiene, including combing hair, washing/drying face and hands). A review of Resident 98's Care Plan revised 2/13/24 indicated Resident 98 had self-care deficits with activities of daily living and impaired mobility due to anemia and respiratory failure (failure of the lungs to meet the body's oxygen demand). The care plan goal was to ensure Resident 98 was kept clean, dry and well groomed daily, The care plan interventions included to assist with ADLs as needed, dental/oral care two times a day and as needed, and to provide assistive device for ADLs as needed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 98's Care Plan, dated 2/14/24 indicated, Resident 98 had alteration in oral/dental status secondary to resident had some of natural teeth missing and the interventions included to ensure good oral hygiene; to observe for signs and symptoms of dental disorders such as swollen gums, pin, presence of oral lesions (a break in the skin that occurs on the moist, inner lining of the mouth); and to set up oral hygiene material and assist resident as needed. During a concurrent observation and interview on 5/21/24 at 8:53 AM with Resident 98, Resident 98's teeth was observed with red gums and food sticking close to the gum line. Resident 98 ' s bedside table and drawer was observed with no oral care kit. Resident 98 stated, since admission, he had never had any teeth cleaning after meals. Resident 98 stated, he had been always very uncomfortable with the uncleanliness of his teeth. Resident 98 stated, the staff had never offered or assisted him to brush his teeth and never brought any toothbrush or toothpaste to him. During a concurrent observation and interview on 5/23/24 at 1:18 PM in Resident 98 ' s room, Resident 98 ' s teeth was observed with discoloration, food sticking around the teeth. Resident 98 stated, the staff had not offered or assisted him to have his teeth brush this morning yet and his teeth and mouth had been very uncomfortable. During a concurrent observation and interview on 5/23/24 at 2:44 PM with Licensed Vocational Nurse (LVN) 2 and CNA 3 in Resident 98's room, Resident 98's teeth was observed. LVN 2 stated, Resident 98's teeth looked discolored with plaque and food was stuck in his teeth. CNA 3 stated, she did not brush Resident 98's teeth this morning. During a concurrent record review and interview on 5/23/24 at 3 PM with LVN 2, Resident 98 ' s Dental Notes, dated 4/19/24 was reviewed. LVN 2 stated, according to the record, Resident 98 had poor oral hygiene. During an interview on 5/24/24 at 10:45 AM with CNA 3, CNA 3 stated, since admission, Resident 98 was not comfortable when CNA 3 provided oral care, so she did not brush Resident 98's teeth. CNA 3 stated, Resident 98's teeth condition looked like they were very sensitive. CNA 3 stated, she started providing oral care to Resident 98 a few days ago when Resident 98's family member requested. When surveyor asked why it had been charted that oral care had been done in Resident 98's medical record, CNA 3 stated, the ADL charting was to assess the level of assistance that Resident 98 needed for oral care. CNA 3 stated, the charting did not mean that oral care was done. During an interview on 5/24/24 at 12:32 PM with the DON, the DON stated, the CNAs were expected to brush the resident's teeth and provide oral care as part of their daily task. CNA 3 should have reported to the Charge Nurse once the resident appeared uncomfortable with the oral care so they could assign another CNA that the resident was more comfortable with to receive the care. The DON stated, with inconsistent oral care, the resident was at high risk for teeth infection, dental carries, rotten teeth, heart or lung infection, and could hospitalization . A review of the facility's Policy and Procedure titled A.M. Care, undated, indicated A.M. Care included oral hygiene prior to breakfast by assisting each resident in brushing their teeth or dentures.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47467 Based on observation, interview, and record review, the facility failed to ensure the facility ' s nurses were competent in ensuring their residents' low air loss mattress (LALM, a mattress that designed to distribute the body weight over a broad surface area and help prevent skin breakdown) were maintained with the correct setting based on residents weight. This failure had a potential to result in the resident's to develop pressure ulcer or worsened pressure ulcer (a skin injury due to prolonged unrelieved pressure or being in one position for a long time). Findings: A review of Resident 35's Admission Record indicated Resident 35 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis that included type 2 diabetes mellitus (a disease that occurs when the body ' s blood sugar is too high) with hyperglycemia (high blood sugar), dementia (a loss of brain function that occurs with certain diseases that affects one or more brain functions such as memory, thinking, language, judgment, or behavior), and left-hand contracture (disorder in which a skeletal muscle is permanently tightened). A review of Resident 35's Care plan, revised on 5/14/24, indicated Resident 35 was at risk for developing pressure sore and other type of skin breakdown related to sacrum (a thick, triangular bone situated near the lower end of the spinal column) scar issue, reduced mobility, impaired cognition, fragile skin, poor/variable food intake, diabetes, aging, and incontinence with the goal was to minimize the risk of skin breakdown/bruising/pressure sore daily and the interventions included to use pressure relieving devices as needed. A review of Resident 35's Order Summary Report, dated 7/29/23, indicated Resident 35 had a physician order for LALM for skin maintenance. During an observation on 5/21/24 at 8:50 AM in Resident 35's room, Resident 35's LALM's setting was observed at 80 pounds (lbs- unit of weight) During an observation on 5/21/24 at 12:40 PM in Resident 35's room, Resident 35 was observed lying on LALM with the setting at 120 lbs. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/21/24 at 12:45 PM with the Minimum Data Set Nurse (MDSN), the MDSN stated, the LALM's setting was supposed to be set based on the weight of the resident. The MDSN stated, the LALM's setting options on the machine was 40 lbs apart. The MDSN stated, the resident's LALM should be set to lower limit based on the resident weight. The MDSN stated, he did his facility rounds (touring the facility unit) in the morning and found at least four residents with the wrong LALM settings, so he adjusted them according to the residents' weight. The MDSN stated, Resident 35's most recent weight was 134 lbs, so he adjusted the LALM's setting from 80 lbs to 120 lbs. The MDSN stated, LALM was utilized for residents with identified high risk for skin breakdown, and pressure injury. The MDSN stated, if the bed setting was incorrect, it would not maximize the effectiveness of the LALM to prevent skin breakdown. During an interview on 5/21/24 at 3:50 PM with Licensed Vocational Nurse (LVN) 3, LVN 3 stated, the LALM's setting was based on the weight of the residents. LVN 3 stated, she would set the LALM to the closet to the resident's weight closest one. LVN 3 stated, she could not recall if there was any in-service for LALM. LVN 3 stated she had not seen the policy for the LALM. LVN 3 stated, all licensed nurses can change the LALM's setting. During an interview on 5/21/24 at 3:55 PM with LVN 4, LVN 4 stated, she did not know how to set the LALM and could not recall if there was any training given. LVN 4 stated, she did not check the resident's LALM setting because it was the responsibility of the treatment nurse. During an interview on 5/21/24 at 4 PM with LVN 5, LVN 5 stated, she would set the LALM to the upper limit based on the resident's weight. LVN 5 stated, she could not remember when the in-service for LALM was and believed that the facility had never addressed how to correctly set the mattress. During an interview on 5/21/24 at 4:06 PM with the Director of Staff Development (DSD), the DSD stated, the LALM's setting should not be set close to resident's weight, the higher limit setting can could cause the resident to sink while lying in bed. The DSD stated, for example, if the resident weighted 130 lbs, the setting should be set up to 160 lbs instead of lower down to 120 lbs. The DSD stated all LVNs were responsible to check the LALM's setting and not just the treatment nurse to make sure they were set correctly which is part of their round with the residents. During an interview on 5/21/24 at 4:16 PM with the Treatment Nurse (TN), the TN stated, she always checked the resident's LALM setting and would adjust it as needed if the setting was incorrect because incorrect setting could lower the effectiveness of preventing skin breakdown and further worsen of the resident ' s pressure wounds. The TN stated, the setting should be adjusted to the lower limit according to the resident's weight. The TN stated, if the resident weighted 130 lbs, the setting should be set to 120 lbs, not 160 lbs. During an observation on 5/22/24 at 11:49 AM in Resident 35's room, Resident 35 who weight 134 lbs. was observed lying on the LALM with the setting of 160 lbs. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/23/24 at 10:57 AM with the Quality Assurance Consultant (QAC), the QAC stated, the facility just recently changed the LALM company, and the device had a different setting than the old device that the facility staffs were more familiar using. The QAC stated, the product's manual did not specify how to adjust the LALM ' s setting. The QAC stated, she just spoke to the company's specialist and was provided with guidance that the setting should be close to the resident's actual weight. The QAC stated, for example, if the resident's actual weight was 130 lbs, the LALM was supposed to be set at 120 lbs. During an interview on 5/24/24 at 12:14 PM with the Director of Nurses (DON), the DON stated, the LALM setting guidance should be verified and provided with LALM in-service prior to the new products rolled out so that all staff were aware and received the same guidelines. The DON stated, LALM was for skin integrity maintenance, helped to heal the wound, and prevent skin breakdown. The DON stated, the LALM should be set as guidelines to support skin healing to serve the purpose of it. The DON stated, if not set correctly as directed, the resident's wound could decline, prolong healing and get worse. A review of the facility's Policy and Procedure titled Pressure-Reducing mattresses, undated, indicated pressure-reducing mattress was used to prevent and/or minimize pressure on the skin and to provide comfort if resident prefers.

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San Gabriel Conv Center	8035 E Hill Drive Rosemead, CA 91770

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 44018 Based on observation, interview and record review, the facility failed to ensure safe provision of pharmaceutical services when one (1) of seven (7) medication cart was left unlocked before entering a resident's room to administer medications. This deficient practice had the potential for non-authorized staff or residents to access the medication cart, which can result to diversion or if the medications were ingested, may cause serious injury/harm. Findings: During a medication pass observation on 5/23/24 at 10:01 AM, the Licensed Vocational Nurse 2 (LVN) did not lock the medication cart before going to Room A to administer medications. Two (2) staff were observed standing across the room in the hallway, where the opened medication cart was located. One resident was observed walking and passing by in front of the unlocked medication cart. During an interview on 5/23/24 at 10:03 AM, LVN 2 stated she forgot to lock the medication cart before entering Room ' s room and stated the cart always had to be locked because the residents might access and take medications in the cart. LVN 2 also stated the cart had to be locked for the safety of the residents. During an interview on 5/23/24 at 2:32 PM, the Director of Nursing (DON) stated the medication nurse had to lock the medication cart for safety reasons because anybody can access the medications in the cart if left unlocked. The DON also stated, Medication cart is to be always locked unless it is in use. A review of the facility's policy and procedure titled, Preparation and General Guidelines, dated October 2017, indicated that during administration of medications, the medications carts is kept closed, locked and secure. The medication cart needs to be secured and locked when unattended.

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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. 36925 Based on observation, interview, and record review, the facility failed to follow proper sanitation, preparation, and food handling practices, to prevent the outbreak of foodborne illness (an illness caused by contaminated food) in accordance with the facility's policy and procedure and professional standards for food service and safety by failing to: Replace a can opener that had rust (a reddish or yellowish-brown coating of iron oxide that is formed on iron or steel by oxidation (a process that occurs when atoms or groups of atoms lose electrons) especially in the presence of moisture), and chrome plating (a technique of electroplating a thin layer of chromium onto a metal object) that was peeling off from the kitchen device. Ensure the chlorine level in the water used in the dishwasher had a chlorine level between 50 - 100 PPM (unit of measurement-parts per million) in accordance with the facilities policy and procedure titled Dish Washing Procedures - Dish Machine. The dietary staff did not compare the color of the test strip to the color chart (a chart used as a reference to determine the amount of chlorine that was added to a solution in the dishwasher for disinfection) in the test strip container to determine if the chlorine level in the dishwasher was within the acceptable range to disinfect the dinnerware used by the residents. These deficient practices had the potential to contaminate the food (the unintended presence of potentially harmful substances, including, but not limited to microorganisms, chemicals, or physical objects in food and a transfer of bacteria from one object to another) and dinnerware the residents use which could cause foodborne illnesses, hospitalization , or death. Findings: During a kitchen observation on 5/22/24 at 8:56 AM, a can opener that was heavily rusted with dark brown flaky debris was on top of a three-compartment sink. The can opener also had its chrome plating peeling off on an area that touches the lid of the can that needs to be opened. During a concurrent interview with the Kitchen Cook (Cook 1), he stated he used the can opener this morning to open a canned food. During an interview on 5/22/24 at 11:36 AM, the Certified Dietary Manager (CDM) stated that the facility has only one can opener, and they need to replace it due to rust formation on the device and chrome peeling from it. The CDM stated, It ' s time to replace it. The chrome falling off from the can opener could potentially contaminate the food in the container. A review of the facility's undated policy titled, Safety Guidelines, revised in 2019, indicated, Equipment should be kept in proper working condition. Any unsafe items should be reported to the Dietary Service Supervisor immediately. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation of the dishwashing process on 5/22/24 at 9:18 AM, the Dietary Assistant (DA 1) took a chlorine test strip from a container and dipped it on top of a plastic drinking cup that went through the dish washing cycle. The DA 1 did not compare the color of the test strip to the color chart in the test strip container to determine if the amount of chlorine that was added to the dishwasher was between 50 - 100 PPM. During a concurrent interview with the DA 1, he stated he used the test strip this morning but did not compare the color of the test strip to the color chart because he knew the right color from memory and experience. A review of the dishwashing procedure written by the manufacturer who services the facility, indicated to use the correct chlorine test strip to test for proper chlorine sanitizer levels at no less than 50 PPM and no higher than 100 PPM. A review of the facility's undated policy titled, Dish Washing Procedures - Dish Machine, indicated that dishes will be properly sanitized through the dish machine with a chlorine level between 50 - 100 PPM. A chlorine log will be kept and maintained by the dish washer to ensure that the chlorine level is within manufacturer ' s guidelines.

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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** 47467 Based on observation, interview, and record review, the facility failed to implement the facility's policy and procedure for infection control and facility's protocol titled Enteral Feedings (also known as Gastrostomy tube [GI] feeding, a tubing inserted into the stomach used to deliver fluids, liquid nutrition and medications into the stomach or small intestine) to one of three sampled residents (Resident 6), who was found with GT feeding on the floor on 5/22/24. This failure had a potential to result in a risk of contracting infections, which could lead to a decline in the resident's health. Findings: A review of Resident 6's Admission Record indicated Resident 6 was admitted to the facility on [DATE] with diagnosis that included hypertensive heart disease (heart problems that occur because of high blood pressure that is present over a long time) with heart failure (a condition that develops when the heart doesn't pump enough blood for the body's needs), gastrostomy (a surgical procedure used to insert a tube, often referred to as a G-tube, through the abdomen and into the stomach) muscle weakness, and dementia (a loss of brain function that affects memory, thinking, language, judgment, or behavior). A review of Resident 6's Minimum Data Set (MDS- a comprehensive assessment and care screening tool) dated 10/19/23 indicated, Resident 6's cognitive skills for daily decision making was severely impairment (difficulty with or unable to make decisions, learn, remember things), and was dependent (Helper does all of the effort. Resident does none of the effort to complete the activity) in eating, oral and personal hygiene. A review of Resident 6's Order Summary Report, dated 8/15/23 and continued on 5/24/24 indicated Resident 6 had enteral feed physician order for Glucerna 1.2 (a type of tube feeding formula) via feeding pump to turn on at 12 PM and turn off at 8 AM or until dose completed. During a review of Resident 6's Care Plan (a document that outlines the facility ' s plan to provide personalized care to a resident based on the resident ' s needs), revised 5/17/21 indicated Resident 6 was receiving GT feeding and was at risk for infection. The record indicated the interventions included to change tubing per policy or as ordered. During a review of Resident 6's Care Plan, revised 11/30/23 indicated Resident 6 was at risk for infection. To prevent infection the facility's interventions included cleaning and disinfection of equipment as indicated, and provide standard precaution at all times. During an observation on 5/22/24 at 10 AM and again at 12 PM in Resident 6's room, Resident 6's tube feeding was on the floor with an uncovered port/tip on the floor while attached to a feeding pump machine that was off. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 5/22/24 at 12:15 PM in Resident 6's room, Certified Nurse Assistant (CNA) 3 and CNA 5 were observed assisting Resident 6 to reposition in bed, then CNA 5 was observed picking up Resident 6's GT with uncovered port from the floor and reconnected the GT port to Resident 6's GT port that was connected to Resident 6's GT site. Then CNA 5 covered the GT feeding tube connected to the resident with a towel. During an observation on 5/22/24 at 12:23 PM outside Resident 6's room, Registered Nurse (RN) 2 was observed being called by CNA 3 to Resident 6's room and informed RN 2 that Resident 6's GT feeding pump machine was turned on. During an interview on 5/22/24 at 12:25 PM with CNA 5, CNA 5 stated, she found the GT feeding port on the floor and thought it was disconnected from the feeding port, so she picked it up, left the GT tube close to Resident 6's GT port, then covered them with a towel. CNA 5 stated, she called RN 2 to restart the tube feeding because the machine was off. During an interview on 5/22/24 at 12:35 PM with RN 2, RN 2 stated, RN 2 was told by CNA 3 that the feeding port was leaking so she came in assess the GT feeding site. RN 2 stated the GT feeding connector was a little loose so she tightened it up and restarted the GT feeding. RN 2 stated, Resident 6 had a physician order to have feeding turn off at 8 AM and turn on at 12 PM. RN 2 stated, when the GT feeding was not in use, the GT supposed to either still connect to the feeding port from the resident's GT site in the stomach or covered by a clean bag and hang on the GT feeding pump pole to prevent infection. RN 2 stated, if the GT feeding accidentally dropped on the floor, the tube feeding must be changed due to infection issues. RN 2 stated, she did not know that the tube feeding was on the floor, so she just continued with the same tube that was hanging when she came in Resident 6 ' s room. During an interview on 5/24/24 at 9:20 AM with Infection Prevention Nurse (IPN), the IPN stated, when the GT feeding was found on the floor, CNA 5 supposed to let RN 2 know because they needed to change the whole GT feeding system from the formula bottle to the water bag and the feeding tube. The IPN stated, when the GT feeding touched the floor and we did not know how long it had been on the ground, it was already contaminated. The IPN stated, the resident could contract infection, and her health could decline because of the infection. The IPN stated, the old tube feeding that was touching the floor supposed to be disposed. During an interview on 5/24/24 at 12:27 PM with the Director of Nurses (DON), the DON stated, the CNA that found the tube feeding on the floor supposed to notify the Charge Nurse right away to have the tube feeding system changed. The DON stated, the resident could be at risk for infection and ended up in the acute hospital. A review of the facility ' s policy and procedure (P&P) titled, Enteral Feedings, revised March 2023, indicated the following: -Preventing contamination: Maintain aseptic technique at all times when working with enteral nutrition systems and formulas - use closed enteral nutrition systems when possible. -Change administration sets if there is a damage or is contaminated. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility ' s P&P titled, Infection Control, undated, indicated the facility had established and would maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission od disease and infection

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46779 Based on observation, interview and record review, the facility failed to ensure resident's bedroom measured at least 80 square feet (sq. ft.-a unit of measurement) per resident in multiple resident bedrooms for 27 out of 50 rooms. Rooms 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 201, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 218, and 220 that measured less than 80 sq. ft. per resident. This deficient practice had the potential to impact the ability to provide safe nursing care and privacy to the residents. Findings: During a concurrent interview and record review on 5/23/2024 at 1:30 PM, with the Administrator (ADM), the Client Accommodations Analysis (CAA- a form used to identify the room sizes and number of beds in the room), dated 5/21/24, indicated there were 27 resident ' s bedrooms in the facility that measured less than 80 sq. ft. per resident care area. The CAA indicated 27 resident ' s bedrooms did not measure 80 sq. ft. per resident as listed below: Rooms 101 to 110, 201 and 203 to 218 had 3 occupied resident ' s beds in each room with a square footage of 216, providing each resident 72 Sq. Ft. space area. room [ROOM NUMBER] size was 216 sq. Ft that was occupied by 2 residents but had three bed capacity. During an interview on 5/23/24 at 1:57 PM with Licensed Vocational Nurse (LVN) 2, LVN 2 stated there was enough space in the room for her to perform tasks effectively and safely. During an interview on 5/23/24 at 2:01 PM with Resident 120, Resident 120 stated she had two roommates in the room, but she had enough space to walk around in the room. Resident 120 stated she did not have any concerns about the current room size. During a concurrent observation and interview with on 5/23/24 at 2:05 PM, with Certified Nursing Assistant (CNA) 3. In Resident 35's room, Resident 35 was lying on the bed. CNA 3 moved Resident 35's bedside tray table toward the head of the bed, then she pushed Resident 35's wheelchair and locked it next to the right side of the bed. CNA 3 assisted Resident 35 sit up on the bed and transferred her to the wheelchair. CNA 3 stated the current room size was a little tight, especially when they had to use a mechanical lift (a device used to assist with transfers and movement of individuals who require support for mobility) in the room to transfer a resident, but they were able to make enough space to provide care by adjusting the angle of the equipment or moving the bedside tray table aside. CNA 3 stated the current room did not affect the staff providing care to the residents safely. During a concurrent observation and interview on 5/23/24 at 2:14 PM, in Resident 28 ' s room, Resident 28 was sitting on a wheelchair. Resident 28 stated there was enough space in her room and her care was not affected by the current room size. (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	During the course of the re-certification survey between 5/21/24 and 5/24/24, the above listed rooms had sufficient space for the residents' freedom of movement. The rooms had adequate space to provide nursing care, privacy during care, and the ability to maneuver resident care equipment with the room. The room size did not present any adverse effect on the residents' personal space, nursing care, and comfort. The facility' s variance request (a request that allow minor deviations from zoning requirements that regulate how a room may be developed), dated 5/21/24, indicated that granting the variance will not adversely affect the residents' health and safety or impede the ability of any residents to obtain their highest level of partible wellbeing.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44018 Based on observation, interview, and record review, the facility failed to provide and maintain a functioning call light for one of 21 sampled residents (Resident 103) This deficient practice had the potential to result in a delay in meeting the resident ' s needs for assistance and had the potential to lead to accidental falls/accidents. Findings: During an initiated tour on 5/21/24 at 10:35 AM, call lights were randomly checked in Unit Station 1. Resident 103 was residing in Station 1 and her call light in the bathroom was not functioning properly, the metal switch was rusted and loose and could not be activated with the pulling cord. A review of Resident 103 ' s Admission Record indicated the resident was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE], with diagnoses that included type 2 diabetes mellitus (a medication condition characterized by the body ' s inability to regulate blood sugar level) and history of fall. A review of Resident 103 ' s Minimum Data Set (MDS, a standardized assessment and care-screening tool), dated 2/27/24, indicated Resident 103 was cognitive skill (mental action or process of acquiring knowledge and understanding for daily decision-making) was moderately impaired. Resident 103 required partial/moderate assistance (helper does less than half the effort) with toileting hygiene, shower/bathe self, and lower body dressing. During a concurrent observation and interview with Resident 103 on 5/21/24 at 10:35 AM, Resident 103 stated she did not know the call light in the bathroom was not working. The Resident 103 stated she did not feel safe to go in the bathroom knowing the call light was not working. During a concurrent interview with Certified Nursing Assistant 1 (CNA) and observation in Resident 103 ' s room on 5/21/24 at 10:37 AM, the CNA 1 activated Resident 103 ' s call light in the bathroom and confirmed the call light was not working due to rust and loosened call light switch. CNA 1 stated Resident 103 could not use the call light to call for help when in the bathroom. CNA 1 stated she will report the problem to Maintenance Supervisor (MS). During a concurrent interview with MS and observation on 5/21/24 at 11:10 AM, the MS stated he performed monthly call light checks for the whole facility. The MS stated he relied on communication between nursing staff and the maintenance department to let him know what was broken and this was not being reported. During an interview with Administrator (Adm) on 5/23/24 at 4:34 PM, the Adm stated the MS was supposed to make sure that the call light was functional, performed monthly checks, and performed maintenance when problems are reported. The Adm stated the call light is vital communication tool for residents to ask for assistance from the bathroom to avoid fall and injury. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of facility ' s undated policy and procedure titled, Physical Environment Policy, indicated the facility will ensure that physical environment is free from hazard for maximum safety of residents, visitors, and staff. The policy also indicated that maintain all essential mechanical, electronical and patient care equipment in safe operation condition such as scales, mechanical lifts, beds, bedrails, wheel locks, bed cranks, nightstand, dressers, closets, overbed table, shower curtains, wheelchairs, Geri chairs (a large, padded chair that is designed to help seniors with limited mobility.), and call light.