STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055202	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rosemead Healthcare Center	4096 Easy Street El Monte, CA 91731

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36924 Based on observation, interview, and record review the facility failed to maintain the resident's dignity for two of two residents (Residents 75 and 80) by failing to: a. Ensure facility staff provided privacy while putting on the undergarment and pants onto Resident 80 that Resident 80 had removed. b. Ensure facility staff provided privacy when providing peri-care to Resident 75. These failures resulted in Residents 75 and 80's privacy not being maintained and Residents 75 and 80's dignity not being protected. Findings: a. During a review of Resident 80's Admission Record (AR), the AR indicated the facility readmitted Resident 80 to the facility on [DATE], with diagnoses that included hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body), urinary tract infection (illness in any part of the urinary tract), and cerebral atherosclerosis (build-up of plaque in blood vessels of the brain). During a review of Resident 80's History & Physical (H&P), dated 11/16/24, the H&P indicated Resident 80 did not have the capacity to understand and make decisions. During a review of Resident 80's Minimum Data Set (MDS, a resident assessment tool), dated 12/8/24, the MDS indicated Resident 80 was moderately cognitively impaired (ability to understand and process thoughts), and required substantial/maximal assistance with chair/bed-to-chair transfer. The MDS indicated Resident 80 was dependent on staff for showering/bathing, upper and lower body dressing, and personal hygiene. During an observation at 2/4/2025 at 11:40 a.m., Resident 80 was observed trying to get out of bed with one of Resident 80's pant leg around Resident 80's left ankle and the other pant leg was off Resident 80's other leg. Resident 80's genitalia was exposed, and pieces of Resident 80's incontinent pad were observed under Resident 80, on the floor, and on Resident 80's bedside table. Resident 80 did not respond when asked if Resident 80 knew how to use the call light for assistance. There was no privacy curtains observed for Resident 80. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 2/4/2025 at 11:48 a.m., Certified Nurse Assistant (CNA) 3, CNA 5, and CNA 6 entered Resident 80's room to assist Resident 80. Resident 80's genitalia was observed exposed to the hallway and the visitor of Resident 80's roommate (Resident 73). During an interview on 2/4/2035 at 11:49 a.m. with CNA 5, CNA 5 stated there were no privacy curtains in Resident 80's room because Resident 80's room was being deep cleaned. CNA 5 stated there was no privacy provided for Resident 80. During an interview on 2/4/2025 at 11:53 a.m. with CNA 6, CNA 6 stated CNA 6 should have closed the door when CNA 6 was assisting Resident 80 with Resident 80's incontinent pad and pants. CNA 6 stated CNA 6 should have provided decency to Resident 80 and not expose Resident 80's private parts. During an interview, on 2/4/2025, at 3:11 p.m. with the Maintenance Supervisor (MS), the MS stated the residents were kept out of their rooms during the deep cleaning process and while the privacy curtains were removed. The MS stated select residents' rooms in both stations were deep cleaned each day from 10:45 a. m. to 11:30 a.m. and a schedule was provided to staff. The MS stated staff brought Resident 80 back to Resident 80's room too early. The MS stated providing privacy to the residents were 100 percent important. During an interview on 2/7/2025, at 12:27 p.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 stated usually the residents were not in their rooms during deep cleaning. LVN 3 stated staff can provide privacy to the residents by providing care in the restroom or closing the door. LVN 3 stated providing privacy to residents was important to respect residents' rights and dignity. 48905 b. During a review of Resident 75's AR, the AR indicated Resident 75 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included hyperlipidemia (high levels of cholesterol in the blood), hypertension (high blood pressure), and dementia (impaired ability to remember, think, or make decisions that interfere with doing everyday tasks). During a review of Resident 75's History and Physical (H&P, formal document of a medical provider's examination of a patient) dated 7/11/2024, the H&P indicated Resident 75 did not have the capacity to understand and make decisions. During a review of Resident 75's MDS, dated [DATE], the MDS indicated Resident 75 was dependent on staff to provide perineal care after voiding or having a bowel movement, and rolling left and right. During an observation on 2/4/2025 at 9:34 AM in Resident 75's room, Certified Nursing Assistant 9 (CNA 9) was observed changing Resident 75's adult incontinence brief with the curtain open, exposing Resident 75 to Resident 75's roommate. During an interview on 2/4/2025 at 11:24 AM with CNA 9, CNA 9 stated the curtain was opened and should have been closed when CNA 9 was providing perineal care to Resident 75. CNA 9 stated, It would make the resident feel uncomfortable and would not respect the resident's dignity if the curtain was left open when the resident was exposed during changing. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/6/2025 at 12:08 PM with the Assistant Director of Nursing (ADON), the ADON stated when staff provide perineal care to the resident, the curtain needs to be drawn completely closed to ensure privacy. The ADON stated if the curtain was left open during perineal care, it could make the resident feel embarrassed and unhappy because the resident's private areas would be exposed. During a review of the facility's policy and procedure (P&P) titled, Resident Rights-Quality of Life, dated 10/1/2023, the P&P indicated for facility staff are to promote, maintain, and protect resident privacy, including bodily privacy, when assisting with personal care and during treatment procedures.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36924 Based on interview and record review, the facility failed to obtain a signed Informed Consent from the resident's responsible party (RP) prior to the administration of Ativan (medication used to treat anxiety disorders) 1 milligram (mg), for one of five sampled residents (Resident 26). This deficient practice violated Resident 26 and the RP's right and had the potential for Resident 26 to receive medication Resident 26's RP did not desire. Findings: During a review of Resident 26's Admission Record (AR), the AR indicated the facility readmitted to the facility on [DATE] with diagnoses that included toxic encephalopathy (neurologic disorder), cerebral infarction (causes necrotic-death of living tissue in the brain), and chronic obstructive pulmonary disease (lung diseases that block airflow). During a review of Resident 26's History & Physical (H&P), dated 1/5/25, the H&P indicated Resident 26 did not have the capacity to make medical decisions. During a review of Resident 26's Minimum Data Set (MDS, a resident assessment tool), dated 1/8/25, the MDS indicated Resident 26 was moderately cognitively impaired (ability to understand and process thoughts), and required substantial/maximal assistance with sit to stand and upper body dressing. The MDS indicated Resident 26 was dependent for lower body dressing and toileting hygiene. During a record review of Resident 26's Physician Order (PO), dated, 2/3/25, the PO indicated Ativan Oral Tablet 1 mg, give one tablet by mouth every twelve hours as needed for anxiety manifested by (m/b) verbalization of feeling anxiety for fourteen days. During a concurrent interview and record review, on 2/7/25, at 12:23 p.m., of Resident 26's clinical record, with the Assistant Director of Nursing (ADON), an Informed Consent for Ativan 1 mg was not found. The ADON stated the purpose of consents was to inform Resident 26's RP about Ativan and to obtain the consent for the administration of Ativan. The ADON stated consents for psychotropic medication is important because of the adverse effects of the medication and to ensure the resident and the RP understands risks and benefits of the medication. The ADON stated Informed Consents should be done before the medication administration. During a record review of the undated facility's Policy & Procedure (P&P) titled, Psychotherapeutic Drug Management, indicated when obtaining consent for use of psychotherapeutic drugs, the resident will be informed of the risks and benefits for the use of these medications. When admitted with orders for psychotherapeutic drugs, licensed staff will verify with resident that the risk and benefits have been explained to them prior to consent or use. The consent will remain in place until medications discontinued or until consent is revoked by resident/responsible party.

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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** 42781 Based on observation, interview, and record review, the facility failed to provide reasonable accommodation of residents' needs for three of three sampled residents (Residents 20, 50, and 55) by failing to ensure the resident's call light was always within reach. These failures had the potential to result in residents to not receive care and a delay in services to meet the residents' needs and could result in a fall or injury. Findings: a. During a review of Resident 20's Admission Record (AR), the AR indicated Resident 20 was admitted to the facility on [DATE] with diagnoses that included a history of falling and unspecified dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning. During a review of Resident 20's Care Plan dated 12/6/2024, the Care Plan indicated Resident 20 was as risk for falls and/or injuries related to a history of fall and fracture (break in the continuity of a bone). The Care Plan interventions indicated for the nursing staff to attach a call light within reach and encourage Resident 20 to use it for assistance as needed. During a review of Resident 20's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 12/10/2024, the MDS indicated, Resident 20 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated, Resident 20 was dependent (helper does all of the effort) on staff for oral hygiene, toileting, showers, upper/lower body dressing, and personal hygiene. During a concurrent observation and interview on 1/7/2025 at 10:22 a.m., Resident 20 was awake, lying in bed. Resident 20's call light was hanging on the oxygen concentrator near the left side of the bed, approximately three feet away. Resident 20 stated she could not reach her call light. During an observation on 2/4/2025 at 9:05 am, Resident 20 was in bed, and the call light was on the floor below Resident 20's bed. During a concurrent observation and interview on 2/4/2025 at 9:06 am, with Certified Nurse Assistant 3 (CNA 3), CNA 3 stated, Resident 20's call light was on the floor below Resident 20's bed. CNA 3 stated Resident 20 could not reach the call light. CNA 3 stated the call light needed to be in reach at all times in case residents needed anything from the staff. b. During a review of Resident 55's AR, the AR indicated Resident 55 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included unspecified dementia. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 55's Care Plan dated 3/3/2024, the Care Plan indicated Resident 55 was as risk for falls related to gait (a person's manner of walking) /balance problems. The Care Plan interventions indicated the nursing staff are to be sure Resident 55's call light was within reach and to encourage the resident to use the call light for assistance. The Care Plan interventions indicated Resident 55 needed a prompt response to call requests for assistance. During a review of Resident 55's MDS dated [DATE], the MDS indicated, Resident 55 had moderately impaired cognition for daily decision making. The MDS indicated, Resident 55 was dependent (helper does all of the effort) to staff for toileting hygiene, shower, putting on/taking off footwear and personal hygiene. The MDS indicated Resident 50 needed maximum assistance (helper does more than half of the effort) upper and lower body dressing. During an observation on 2/4/2024 at 9:58 am, Resident 55 was awake and lying in bed. Resident 55's call light was hanging on the right-side rails. Resident 55 stated I could not reach my call button (call light). During a concurrent observation and interview on 2/4/2025 at 9:34 am, with Registered Nurse 1 (RN 1), RN 1 stated, Resident 55's call light needed to be in reach all the time. During an interview on 2/5/2025 at 10:44 a.m. with the facility's Director of Nursing (DON), the facility's DON stated, residents call light needed to be in reach and as close as possible for residents to use it when they needed staff assistance. The DON stated the call light was the resident's mode of communication to the staff. 40438 c. During a review of Resident 50's AR, the AR indicated Resident 50 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included Parkinson's Disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow movements), muscle weakness (lack of muscle strength) and osteoarthritis (a progressive disorder of the joints, caused by gradual loss of cartilage) of both knees. During a review of Resident 50's Care Plan (CP) revised on 12/18/2023, the CP indicated Resident 50 had self-care performance deficit for Activities of Daily Living (ADL) related to Parkinson's Disease and osteoarthritis. The CP interventions included to encourage the resident to use the bell to call for assistance. During a review of Resident 50's MDS dated [DATE], the MDS indicated Resident 50 had severely impaired cognition. The MDS indicated Resident 50 required setup or clean-up assistance (helper sets up or cleans up; resident completes activity) with eating and oral hygiene, and supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with toileting, shower, upper and lower body dressing and personal hygiene. During review of Resident 50's Fall Risk Assessment (FRA) dated 1/27/2025, the FRA indicated Resident 50 was high risk for fall with a Morse Fall Risk (a tool used to assess a patient's risk of falling) Score of 70 (Score of 45 and higher indicate high risk for fall). (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 and interview on 2/4/2025 at 9:20 am with Certified Nurse Assistant 1 (CNA 1) inside Resident 50's room, Resident 50 was sitting on the right side of the bed and the resident's call light was hanging on the left side of the bed on the back of the headboard. CNA 1 stated Resident 50's call light should be placed next to the resident where the resident could see it to be able to use it and call when help was needed. During an interview on 2/5/2025 at 10:44 am with the Director of Nursing (DON), the DON stated the resident's call light should be placed near and on the strong arm/hand of the resident to use every time the resident needed help and assistance. During a review of the facility's policy and procedure (P&P) titled, Communication - Call System, dated 10/1/2023, the P&P indicated, The facility will provide a call system to enable residents to alert the nursing staff from their beds and toileting/bathing facilities. The call system should be accessible to a resident lying on the floor in toileting and bathing facilities.

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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** 42781 Based on interview and record review, the facility failed to provide information regarding an Advance Directive (AD, a written preferences regarding treatment options, a process of communication between individuals and their healthcare agents to understand, reflect on, discuss, and plan for future healthcare decisions for a time when individuals are not able to make their own healthcare decisions) for four of six sampled residents (Residents 24, 36, 55 and 190) in accordance to the facility's policy titled Advance Directives. These failures had the potential to result in the facility staff to provide medical or surgical treatment against Residentd 24, 36, 55, and 190's will. Findings: a. During a review of Resident 55's Admission Record (AR), the AR indicated Resident 55 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included unspecified dementia. During a review of Resident 55's MDS dated [DATE], the MDS indicated, Resident 55 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 55 was dependent (helper does all of the effort) on staff for toileting hygiene, shower, putting on/taking off footwear and personal hygiene. The MDS indicated Resident 55 needed maximum assistance (helper does more than half of the effort) upper and lower body dressing. During an interview and concurrent record review on 2/4/2025 at 3:08 p.m., with the Assistant Social Service Director (ASSD), of Resident 55's medical records (PointClickCare - PCC, a cloud-based software used in long-term and post-acute care facilities), the ASSD stated the AD Acknowledgement Form should be filled out completely and needed to be discussed with the resident or responsible party. The ASSD stated, the AD Acknowledgement Form needed to be signed and initialed completely to follow the residents wishes and wants. b. During a review of Resident 24's Admission Record (AR), the AR indicated Resident 24 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD- type of obstructive lung disease characterized by long-term poor airflow) and chronic respiratory failure - a condition when the lungs cannot get enough oxygen into the blood. During a review of Resident 24's MDS dated [DATE], the MDS indicated, Resident 24 had severely impaired cognition for daily decision making. The MDS indicated, Resident 24 was dependent on staff for oral hygiene, toileting hygiene, shower, upper and lower body dressing, putting on/taking off footwear and personal hygiene. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/4/2025 at 3:03 pm, with the facility's ASSD, the ASSD stated the AD Acknowledgement Form was not filled out completely. The ASSD stated, the AD Form should be filled out completely and needed to be discussed with the resident or responsible party. The ASSD stated, the AD Acknowledgement Form needed to be signed and initialed completely to follow residents wishes and wants. During an interview on 2/5/2025 at 10:51 am, with the facility's Director of Nursing (DON), the DON stated, AD Acknowledgement Form needed to be filled up completely upon admission by Social Services to assess if resident executed an AD. The facility's DON stated, AD form would not be valid if it was not filled up completely. 40438 c. During a review of Resident 36's AR, the AR indicated Resident 36 was admitted to the facility on [DATE] with diagnoses that included chronic kidney disease (kidneys were damaged and could not filter blood the way they should) and dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed). During a review of Resident 36's MDS dated [DATE], the MDS indicated Resident 36 had a moderately impaired cognition. The MDS indicated Resident 36 was dependent (helper did all of the effort, resident did none of the effort to complete the activity) with oral hygiene, toileting, shower, upper and lower body dressing and personal hygiene. During a concurrent interview and record review on 2/4/2025 at 3:03 pm with Licensed Vocational Nurse 1 (LVN 1), Resident 36's medical records (chart) and PointClickCare (PCC, a cloud-based software) were reviewed. LVN 1 stated, Resident 36's Advance Directive Acknowledgement Form was incompletely filled out. Resident 36's AD Acknowledgement Form was not initialed indicating Resident 36 was not given information about the resident's rights to accept or refuse medical treatment, and the rights to formulate an AD. LVN 1 stated the Advance Directive Acknowledgement Form should be filled out completely to determine the kind of care and treatment the resident preferred while in the facility. d. During a review of Resident 190's AR, the AR indicated Resident 190 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included respiratory failure (a condition when the lungs cannot get enough oxygen into the blood), pulmonary embolism (a condition in which one or more arteries in the lungs become blocked by a blood clot) and atrial fibrillation (an irregular, often rapid heart rate that commonly cause poor blood flow). During a review of Resident 190's MDS dated [DATE], the MDS indicated Resident 190 had a moderately impaired cognition and dependent with oral hygiene, toileting, shower, upper and lower body dressing and personal hygiene. During a concurrent interview and record review on 2/4/2025 at 3:09 pm with LVN 1, Resident 190's medical records and PointClickCare were reviewed. LVN 1 stated there were no copies of Physician Orders for Life-Sustaining Treatment (POLST, a form that contains written medical records for healthcare professionals regarding specific medical treatments that can or cannot be done at the end of life) and AD Acknowledgement Form in the Resident 190's chart or uploaded in the PCC. LVN 1 stated, a copy of the POLST and ADA form should be in the resident's chart or in the PCC for the staff to know the resident's wishes in case of emergency and how to take care of the resident in the facility. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/4/2025 at 3:14 am with the Social Services Assistant (SSA), SSA stated, all residents or responsible parties were asked for the presence of an AD or given information on how to formulate an AD upon admission. SSA stated, a copy of an AD or AD Acknowledgement Form would be placed in the resident's chart and/or uploaded in the PCC for staff to provide care and services according to the wishes of the resident. During an interview on 2/5/2025 at 10:44 am with the Director of Nursing (DON), the DON stated, all AD and AD Acknowledgement Form should be filled out completely and uploaded in the PCC as soon as possible upon admission to be accessible to staff in case of emergency and for the staff to be aware of the resident's wishes. During a review of the facility's Policy and Procedure (P&P) titled, Advance Directives, dated 10/1/2023, the P&P indicated if no advance directive exists, the Facility provides the resident with an opportunity to complete the Advance Directive Form upon resident request. The P&P indicated a copy of the Advance Directive was maintained as part of the resident's medical record. The P&P indicated if the resident is incapacitated at the of admission and is unable to receive information or articulate or not he or she had executed an Advance Directive, the Facility may give Advance Directive information to the resident's representative in accordance with state law. The P&P indicated the choice not to complete the Advance Directive Form is recorded in the residents medical record.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42781 Based on interview, and record review, the facility failed to ensure one of three sampled residents (Resident 85) discharge destination was coded correctly. Resident 85 was discharged to home or community. Skilled Nursing Facility (SNF - care provided by trained registered nurses in a medical setting under a doctor's supervision) but was coded in the Minimum Data Set (MDS - a federally mandated resident assessment tool) as being discharged to a short-term general hospital. This deficient practice resulted in an inaccurate reporting to the Centers of Medicare and Medicaid (CMS, a federal agency that administers the Medicare program and works with state governments to administer the Medicaid and health insurance portability standards) agency and had the potential to result in Resident 85 to not receive interventions to address specific care concerns. Findings: During a review of Resident 85's Admission Record (AR), the admission record indicated Resident 85 was admitted to the facility on [DATE] with diagnoses that included muscle weakness. During a review of Resident 85's Order Summary Report, dated 1/10/2025, the report indicated to discharge Resident 85 to home today. During a review of Resident 85's Progress Notes, dated 1/10/2025, at 4:55 pm, the notes indicated that Resident 85 was discharged to return to board and care and was given all belongings and medication upon discharge. During a review of Resident 85's MDS, dated [DATE], the MDS indicated Resident 85 was discharged to a short-term general hospital. During a concurrent interview and record review of Resident 85's MDS on 2/6/2025 at 11:50 am, with the facility's Director of Nursing (DON), the DON stated Resident 85 was coded as discharged to short-term general hospital. The DON stated, Resident 85 was discharged to home/community on 1/10/2025 and not to a general hospital. The DON stated, Resident 85's MDS assessment needed to be coded discharged to home/community. The DON stated Resident 85's MDS assessment needed to be coded accurately to provide accurate information to the Centers for Medicare and Medicaid services. During a review of the facility's policy and procedure (P&P) titled, RAI process, dated 10/1/2023, the P&P indicated, the facility will utilize the Resident assessment Instrument (RAI) process as the basis for the accurate assessment if each resident's functional capacity and health status. The P&P indicated, each resident's assessment will be coordinated by and certified as completed by a registered nurse, and all individuals who complete a portion of the assessment will sign and certify to the accuracy of the portion of the assessment he or she completed.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40438 Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 189) was provided with a communication device with the language that the resident understood. This failure had the potential to affect Resident 189's communication with the staff and the potential to delay the provision of care, treatment, and services the resident needed. Findings: During a review of Resident 189's Admission Record (AR), the AR indicated Resident 189 was admitted to the facility on [DATE] with diagnoses that included Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow movements) and bipolar disorder (mental disorder with periods of depression and periods of elevated mood). The AR indicated Resident 189's primary language was Spanish and Castillan (a variety of Spanish spoken in Spain). During a review of Resident 189's Minimum Data Sheet (MDS, a resident assessment tool) dated 1/30/2025, the MDS indicated Resident 189 was Mexican in ethnicity. During a concurrent observation and interview on 2/4/2025 at 10:03 am with Resident 189 inside the resident's room, Resident 189 stated, no hablo [NAME], no intiendo [NAME],. There was no communication board in Resident 189's room. During an interview on 2/4/2025 at 10:05 am with Registered Nurse Supervisor 1 (RN1), RN 1 stated Resident 189 only spoke Spanish. RN 1 stated all non-verbal and non-English speaking residents should have a communication board with the language the resident understood to be able to communicate their needs to the staff. During an interview on 2/5/2025 at 9:36 am with RN 2, RN 2 stated, non-English speaking residents needed a translator or a communication board at bedside for the resident to communicate effectively to the staff to prevent miscommunication. During a review of the facility's Policy and Procedure (P&P) titled, Translation or Interpretation Services, dated 10/1/2023, the P&P indicated, Translation and interpretation services are provided in a way that is culturally relevant and appropriate to the limited English Proficiency (LEP) individual. In addition to the use of interpreters and translators, the Facility may use electronic devices, written materials and communication boards to address language barriers.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48905 Based on observation, interview and record review, the facility failed to provide care in accordance with professional standards of practice for one of one sampled resident (Resident 292) by failing to turn and reposition Resident 292 every two hours. These failures had the potential for Resident 292 to develop pressure ulcers/bedsores (PU, injuries to the skin and underlying tissue that are result of pressure on the skin for long periods of time). Findings: During a review of Resident 292's Admission Record (AR), the AR indicated Resident 292 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included hemiplegia (inability to move one side of the body) and hemiparesis (weakness on one side of the body) affecting the right side, dependence on dialysis (procedure that filters blood to remove waste and excess fluid when the kidneys are not working), and peripheral vascular disease (PVD, occurs when the blood vessels become narrow reducing blood flow to the arms and legs). During a review of Resident 292's History and Physical (H&P, formal document of a medical provider's examination of a patient) dated 1/18/2025, the H&P indicated Resident 292 was able to make decisions and was alert and oriented to person, place, time, and situation. During a review of Resident 292's Minimum Data Set (MDS, a resident assessment tool) dated 1/24/2025, the MDS indicated Resident 292 was dependent on assistance for eating, oral hygiene, toileting hygiene, and rolling left and right. The MDS indicated Resident 292 was at risk for developing PU's. During a review of Resident 292's untitled care plan (CP) dated 1/20/2025, the CP indicated Resident 292 was at risk for skin breakdown. The intervention was to turn and reposition Resident 292 every two hours. During a concurrent observation and interview on 2/4/2025 at 10:19 AM with Resident 292 in Resident 292's room, Resident 292 was lying on Resident 292's back in bed. Resident 292 stated staff do not turn Resident 292 because it takes too long (to turn Resident 292). During a concurrent observation and interview on 2/6/2025 at 8:47 AM, 9:59 AM, 10:47 AM, and 11:51 AM Resident 292 was lying on Resident 292's back in bed. At 11:51 AM Resident 292 stated no one has turned Resident 292. During an interview on 2/6/2025 at 12:00 PM with the Assistant Director of Nursing (ADON), the ADON stated residents who spend majority of time in bed would need to be turned and repositioned every two hours or as needed. The ADON stated residents who required dialysis are at a higher risk of skin breakdown and would need to be turned and repositioned every two hours to promote blood circulation. The ADON stated the risk of not turning and repositioning was putting the resident at risk of developing a PU. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/6/2025 at 12:22 PM with Certified Nursing Assistant 11 (CNA 11), CNA 11 stated it was CNA 11's first time taking care of Resident 292 and CNA 11 was unfamiliar with Resident 292's care. CNA 11 stated the risk of not turning Resident 292 every two hours was that the resident could develop wounds. During a review of the facility's policy and procedure (P&P) titled, Positioning and Body Alignment, dated 10/1/2023, the P&P indicated for staff to change the resident's position every two hours.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48905 Based on observation, interview and record review, the facility failed to provide treatment and services in accordance with professional standards to prevent the development of pressure ulcers (PU, injuries to the skin and underlying tissue that are result of pressure on the skin for long periods of time) for one of two sampled residents (Resident 27) by failing to: a. Ensure bilateral heel protectors were on Resident 27 per Medical Doctor (MD) order. b. Ensure Resident 27's low air loss mattress (LAL, medical mattress designed to reduce pressure on the skin to help prevent the development of PUs) was on the correct setting. These failures had the potential for Resident 27 to develop a PU. Findings: During a review of Resident 27's Admission Record (AR), the AR indicated Resident 27 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included peripheral vascular disease (PVD, chronic condition that occurs when arteries narrow or block, reducing blood flow to the arms and legs), paraplegia (inability to voluntarily move the lower parts of the body), and contracture of muscles (muscle, tendons, joints, or other tissues tighten or shorten causing a deformity). During a review of Resident 27's Braden Scale for Predicting Pressure Sore Risk (BSPPSR) dated 10/1/2024 timed at 11:54 AM, the BSPPSR indicated Resident 27 was a high risk for developing a PU. During a review of Resident 27's History and Physical (H&P, formal document of a medical provider's examination of a patient) dated 10/2/2024, the H&P indicated Resident 27 did not have the capacity to understand and make decisions. During a review of Resident 27's Order Summary Report (OSR) dated 10/15/2024 and 12/13/2024, the OSR indicated Resident 27 had an order for heel protectors when in bed as tolerated every shift and to have a LAL mattress for PU management with settings based on the resident's current weight every. During a review of Resident 27's Minimum Data Set (MDS, a resident assessment tool) dated 12/8/2024, the MDS indicated Resident 27 had problems with short-term and long-term memory and was dependent on staff for dressing the lower body and rolling left and right. The MDS indicated Resident 27 was at risk for developing PUs. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 2/4/2025 at 11:35 AM with Licensed Vocational Nurse 2 (LVN 2) in Resident 27's room, the LAL mattress was set at 150 pounds (lbs, unit of measurement for weight) and Resident 27 did not have heel protectors on Resident 27's bilateral feet. LVN 2 stated Resident 27 weighed 122 lbs and the LAL mattress was on the wrong setting. LVN 2 stated Resident 27 had an MD order for heel protectors and LAL mattress to set per resident's weight. LVN 2 stated the risk of not having the bilateral heel protectors on per MD order was that the resident could develop a deep tissue injury (DTI, injury to the deeper layers of tissue under the skin caused by prolonged pressure on a bony area) on the heels. During an interview on 2/4/2025 at 12 PM with Treatment Nurse 2 (TN 2), TN 2 stated the setting for the LAL mattress was not correct for Resident 27's weight. TN 2 stated the risk of having the LAL on the wrong setting was that Resident 27 could develop a PU. During an interview on 2/6/2025 at 12:02 PM with the Assistant Director of Nursing (ADON), the ADON stated LAL mattresses and heel protectors are used to prevent the development of a PU. The ADON stated all nurses should be checking if the LAL mattress is working and on the correct setting. The ADON stated the risk of not having the LAL mattress on the correct setting was that it could put added pressure of a wound. The ADON stated if heel protectors are not the resident's feet on per MD order, the resident would be at risk of developing a DTI because the bilateral heels were not offloaded (Offloading refers to minimizing or removing weight placed on the foot to help prevent and heal ulcers). During a review of the facility's policy and procedure (P&P) titled, Wound Management, dated 10/1/2023, the P&P indicated An assessment of care needs for PU will emphasize mechanical offloading and pressure reducing devices. During a review of the user manual titled, Med-Aire 8, Alternating Pressure Mattress Replacement System with Low Air Loss, undated, the user manual indicated the pressure dial is adjusted to the patient's/resident's weight and comfort.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42781 Based on observation, interview and record review, the facility failed to ensure one of one resident (Resident 238) received care and services for the provision of a midline intravenous (IV) catheter (a long, thin, flexible tube that is inserted into a large vein in the upper arm used to safely administer medication into the bloodstream, similar to a cannula [a small tube that is inserted into a vein]) consistent with professional standards of practice, in accordance with the facility's policy and procedure (P&P) titled Midline Dressing Changes and the resident's care plan (a care plan details why a person is receiving care, assessed health or care needs, medical history, personal details, expected and aimed outcomes, and what care and support will be delivered, how, when and by whom). These failures had the potential to result in an infection to Resident 238 and worsen the residents' health condition. Findings: During a review of Resident 238's Admission Record (AR), the admission record indicated Resident 238 was admitted to the facility on [DATE] with diagnoses that included osteomyelitis (inflammation of bone or bone marrow, usually due to infection) ankle and foot and type 2 diabetes mellitus a disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in elevated levels of glucose/sugar in the blood and urine) with hyperglycemia (high blood sugar). During a review of Resident 238's MDS, dated [DATE], indicated, Resident 238 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. During a review of Resident 238's Physicians Order (PO) dated 1/27/2025, the PO indicated to administer Ertapenem Sodium (a substance used to kill bacteria and to treat infections) Injection Solution Reconstituted, one gram (unit of measurement) IV one time a day for septic arthritis (a painful infection of the joint space) with osteomyelitis to the right ankle until 2/24/2025. During a review of Resident 238's PO, dated 1/28/2025, the PO indicated to change the midline catheter, dressing every seven (7) days. During a review of Resident 238's care plan, the care plan indicated Resident 238 required intravenous therapy for antibiotic (medications used to treat or prevent infections) therapy dated 1/27/2025. The Resident 238's care plan indicated the nursing staff were to change and label the IV dressing site as per the facility's protocol. The care plan indicated to administer IV Therapy as ordered. During a concurrent observation and interview on 2/4/2025 at 9:15 a.m. with Resident 238, Resident 238 was awake and in bed. Resident 238 stated, she did not receive the antibiotics yesterday, 2/3/2025. Observed right upper arm with midline intravenous site not labeled to when the dressing was changed. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 2/4/2025 at 9:38 a.m. with Registered Nurse 1 (RN 1), Resident 238 was awake lying in bed with a midline intravenous site which was not dated as to to when the dressing was changed. RN 1 stated Resident 238's midline site needed to be labeled with the date to know when the dressing was changed for infection control. During a concurrent interview and record review of Resident 238's medical record (PointClickCare - PCC, a cloud-based software used in long-term and post-acute care facilities) on 2/4/2025 at 9:41 a.m., Resident 238 did not receive IV antibiotics on 2/3/2025. RN 1 stated, there was no other clinical documentation that Resident 238 received IV antibiotics on 2/3/2025. During an interview with the facility's Assistant Director of Nursing (ADON) on 2/5/2025 at 10:46 am, the ADON stated IV antibiotics were not administered to Resident 238 on 2/3/2025. The facility ADON stated, RN Supervisor, ADON and Director of Nursing (DON) was responsible to administer all IV antibiotics. The facility ADON stated, it was important not to miss antibiotic administration because it could delay Resident 238's healing process and could worsen infection. During an interview with the facility's DON on 2/5/2025 at 10:48 am, the DON stated the IV site should be labeled with the date and the licensed nurse's initials to identify and know who and when was it changed to prevent infection. During a review of the facility's P&P titled, Midline Dressing Changes, revised 4/2016, the P&P indicated, the purpose of this procedure is to prevent catheter-related infections associated with contaminated, loosened or soiled catheter-site dressings. The P&P indicated to change the midline catheter dressing 24 hours after catheter insertion, every 5 to 7 days, or if it is wet, dirty, not intact, or compromised in any way. The P&P indicated to apply a sterile transparent dressing or gauze with a transparent dressing to the area, . etc.and label with the initials, date and time. During a review of the facility's P&P titled, Medication Administration, dated 10/1/2023, the P&P indicated medication will be administered by a Licensed Nurse per the order of an Attending Physician or licensed independent practitioner.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48905 Based on observation, interview and record review, the facility failed to implement the facility's policy titled, Oxygen Administration, for three of three sampled residents (Residents 24, 43 and 292) by failing to: a. Ensure Resident 292's Nasal Cannula (NC, thin flexible tube that delivers oxygen through the nose) tubing was dated. b. Ensure Resident 43's inhalation tubing set was dated and create a care plan (CP) for oxygen use and breathing treatments for Resident 43. c. Place the NC in both nostrils for Resident 24 and post a no smoking sign outside of Resident 24's room when Resident 24 required the use of oxygen. These failures had to the potential for Residents 24, 43 and 292 to experience complications related to oxygen therapy. Findings: a. During a review of Resident 292's Admission Record (AR), the AR indicated Resident 292 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included respiratory failure (occurs when the lungs cannot get enough oxygen into the blood or remove carbon dioxide). During a review of Resident 292's History and Physical (H&P, formal document of a medical provider's examination of a patient), dated 1/18/2025, the H&P indicated Resident 292 was able to make decisions, alert and oriented to person, place, time, and situation. During a review of Resident 292's Minimum Data Set (MDS, a resident assessment tool), dated 1/24/2025, the MDS indicated Resident 292 was dependent on assistance from staff for eating, rolling left and right, and dressing the upper and lower body. During a review of Resident 292's Order Summary Report (OSR), dated 1/29/2025, the OSR indicated a Medical Doctor (MD) ordered to change the NC every week on Sunday and as needed with the name and date labeled. During a concurrent observation and interview on 2/6/2025 at 9:52 AM with Licensed Vocational Nurse 1 (LVN 1) in Resident 292's room, Resident 292's NC tubing was observed with no date. LVN 1 stated there was no date on the NC tubing. LVN 1 stated the risk of not having the NC dated was that staff would not know when the NC was last changed because the NCs need to be changed every Sunday. During an interview on 2/6/2025 at 11:58 AM with the Assistant Director of Nursing (ADON), the ADON stated all connections of the oxygen tubing needs to be dated and changed every week on Sunday or as needed. The ADON stated not dating NC tubing put the resident at risk for infection due to using contaminated NC because staff would be unsure when the NC tubing was placed or when it was changed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled, Oxygen Administration, the P&P indicated all oxygen tubing will be changed and labeled weekly and when visible soiled. 40438 b. During a review of Resident 43's AR, the AR indicated Resident 43 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included chronic embolism and thrombosis (condition where blood clots (thrombi) form in a vein, usually in the legs, and then break off, travel through the bloodstream, and lodge in the lungs causing a long-term blockage) and atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow). During a review of Resident 43's MDS dated [DATE], the MDS indicated Resident 43 had a severely impaired cognition. The MDS indicated Resident 43 required partial/moderate assistance (helper did less than half the effort) with eating, toileting, shower and lower body dressing. Resident 43 was dependent (helper did all of the effort, resident did none of the effort to complete the activity) with personal hygiene. During a review of Resident 43's OSR dated 12/5/2024, the OSR indicated Resident 43 had an order for Ipratropium Bromide Inhalation Solution (a medication used to treat respiratory conditions) via nebulizer (a device for producing a fine spray of liquid) every four hours as needed for shortness of breath or wheezing (high-pitched whistling sound that occurs when air moves through narrowed airways in the lungs) and oxygen (a colorless, odorless gas) at 2 liters (L) via nasal cannula as needed for comfort. During a concurrent observation and interview on 2/4/2025 at 9:35 am with Certified Nurse Assistant 2 (CNA 2) inside Resident 43's room, Resident 43 had an inhalation tubing set on top of the bedside table. CNA 2 stated the inhalation tubing set did not have a label when it was changed, and the tubing set was not being used. During an interview on 2/4/2025 at 10:20 am with Registered Nurse Supervisor 1 (RN 1), RN 1 stated, the resident's inhalation tubing should be labeled with the date when it was changed and placed in a clear plastic bag intended for respiratory supplies for infection control. During a concurrent interview and record review on 2/5/2025 at 10:44 am with RN 1, Resident 43's Care Plan (CP) were reviewed. RN 1 stated there was no care plan developed for Resident 43 on the use of oxygen and inhalation treatment. RN 1 stated, a care plan should be developed to ensure staff provided care and interventions specific for the resident. During an interview on 2/5/2025 at 11:09 am with the Director of Nursing (DON), the DON stated, oxygen and inhalation tubing should be labeled with the date when it was changed. The DON stated oxygen and inhalation tubing should be kept inside the clear, plastic bag to keep it clean and to prevent cross-contamination (the physical movement or transfer of harmful bacteria from one person, object or place to another). The DON stated care plan should be developed to communicate among staff the interventions specific for the resident. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's Policy and Procedure (P&P) titled, Administering Medications through a Small Volume (Handheld Nebulizer), revised 10/2010, the P&P indicated, The purpose of the procedure is to safely and aseptically administer aerosolized particles of medication into the resident's airway. When equipment is completely dry, store in a plastic bag with the resident's name and the date on it. Change the equipment and tubing every seven days, or according to facility protocol. 42781 c. During a review of Resident 24's Admission Record (AR), the AR indicated Resident 24 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD- type of obstructive lung disease characterized by long-term poor airflow) and chronic respiratory failure (a condition when the lungs cannot get enough oxygen into the blood). During a review of Resident 24's Physician Order's, dated 10/14/2024, indicated to apply oxygen at three (3) liters per minute (L/min) via nasal cannula every shift for shortness of breath. During a review of Resident 24's MDS dated [DATE], the MDS indicated, Resident 24 had severely impaired cognition for daily decision making. The MDS indicated, Resident 24 was dependent to staff for oral hygiene, toileting hygiene, shower, upper and lower body dressing, putting on/taking off footwear and personal hygiene. During an observation on 2/4/2025 at 9:48 am, Resident 24 was asleep lying in bed with a nasal cannula not placed in both nostrils. There was no sign posted on Resident 24's door indicating oxygen was in use in the room or that smoking was prohibited. During a concurrent observation and interview on 2/4/2025 at 9:48 am, with Licensed Vocational Nurse 1 (LVN 1), Resident 24 was awake lying in bed. LVN 1 stated, there was no sign posted on Resident 24's door indicating oxygen was in use in the room or that smoking was prohibited. LVN 1 stated a smoking sign needed to be posted outside the resident's room to remind visitors or residents not to smoke inside the room because oxygen can ignite and can cause fire. During a concurrent observation and interview on 2/4/2025 at 10:06 am, with Infection Prevention Nurse (IPN, a healthcare professional who specializes in preventing the spread of infections in healthcare settings), observed Resident 24's nasal cannula was not placed in both nostrils. The IPN stated, the nasal cannula needed to be inside Resident 24's nostrils to receive the proper oxygen delivered that was ordered by the medical doctor. The IPN stated, if the nasal prongs were not placed in both nostrils. Resident 24 was getting less oxygen and oxygen saturation (a measurement of oxygen level carried in the blood) might go down and can cause respiratory distress. During an interview on 3/14/2024 at 9:56 a.m., with the facility's Assistant Director of Nursing (ADON), the ADON stated the nasal cannulas needed to be inside the nostrils for Resident 24 to receive the oxygen needed. The ADON stated, a smoking sign needed to be posted at the entrance door of the rooms of residents receiving oxygen therapy to let the visitor and residents know not to smoke inside the residents' room to avoid fire and for residents' safety. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Oxygen Administration, dated 10/1/2023, the P&P indicated, a physician's order is required to initiate oxygen therapy. The order shall include the method of administration (e.g. nasal cannula). The P&P indicated, oxygen tubing, humidifiers, masks and cannulas used to deliver oxygen will be changed and labeled weekly and when visibly soiled. The P&P indicated, residents using oxygen will have an Oxygen in Use sign placed on the door frame of their room. The P&P indicated no smoking is allowed around oxygen therapy equipment.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36924 Based on interview and record review, the facility failed to provide pain management for one of one resident (Resident 140) as indicated in Resident 140's care plan for pain by falling to: 1) Provide non-pharmacological interventions/measures for pain. 2) Notified Resident 140's Medical Doctor (MD) when Resident 4's pain was uncontrolled with the current pain medication/pain management. These failures resulted in Resident 140 experienced pain on the abdomen and had to wait for more than one hour to received pain medication. Findings: During a review of Resident 140's Admission Record (AR), the AR indicated the facility admitted to the facility on [DATE] with diagnoses that included sepsis (a life-threatening complication of an infection), gastric ulcer with perforation (untreated ulcer in the stomach), and encounter for surgical aftercare following surgery (continued care after surgery) on the digestive system. During a record review of Resident 140's Medication Administration Record (MAR), dated 1/1/25-1/31/25, the MAR indicated Resident 140 had a pain level between 8-9/10 on 1/29/25, 1/30/25, and 1/31/25. During a review of Resident 140's History & Physical (H&P), dated 1/29/25, the H&P indicated Resident 140 had the capacity to understand and make decisions. During a record review of Resident 140's Progress Note (PN), dated 1/30/25, the PN indicated Resident 140 had a left upper abdomen with intra-abdominal drainage tube due to (d/t) perforated bowel (a painful condition occurring when a hole develops in the gastrointestinal (GI) tract). During a record review of Resident 140's At Risk for Pain Care Plan (CP), initiated on 1/30/25, the Care Plan indicated to provide non-pharmacological measures for pain such as a gentle range of motion (ROM-extent to which a joint or muscle can move without pain/discomfort)), meditation, positioning, massage, music, and document response and report uncontrolled pain to MD for further evaluation and treatment. During a record review of Resident 140's MAR, dated 2/1/25-2/28/25, the MAR indicated Resident 140 had a pain level between 8-9/10 on 2/3/25, 2/4/25, and 2/5/25. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 140's Physician Orders (PO), dated 2/5/25, the PO indicated Resident 140 was given Gabapentin (medication used to treat nerve pain) Oral Capsule 300mg, two capsules, by mouth, every eight hours for neuropathic (chronic pain caused by sensory nervous system damage or dysfunction) pain management; Oxycodone Hydrochloride (opioid/controlled medication used to treat severe pain) Oral tablet 5mg, give three tablets, by mouth, every four hours as needed for pain management; Acetaminophen Oral (Tylenol, medication used to treat mild pain) Tablet 325mg , give two tablets, by mouth, every six hours as needed for mild pain 1-3/10. Resident 140's Physician Orders (PO), dated 1/29/25, indicated to monitor pain level every shift using numerical rating scale (NRS): no pain= 0/10, mild pain =1-3/10, moderate pain = 4-6/10, severe pain 7-10/10. If pain identified, provide non-pharmacological interventions and record pain level. During an interview, on 2/5/25, at 10:44 a.m., Resident 140 complained of pain level 10/10 (pain scale 1-10- a numerical tool used to assess the intensity of pain) in the left side of Resident 140's abdomen. Resident 140 stated the pain gets so bad it hurts when Resident 140 breathes. Resident 140 stated Resident 140 was concerned about not being given pain medication each day between 8:45 a.m. and 12:45 p.m. During a concurrent interview and record review, on 2/6/25, at 11:37 a.m., with Licensed Vocational Nurse (LVN 3), LVN 3 stated at 7 a.m. Resident 140 was complaining of pain and Resident 140's pain medication was not due until 8:45 a.m. LVN 3 stated Resident 140 stated when Resident 140 started breathing it was hurting so bad. LVN 3 stated LVN 3 did not document Resident 40's complaint in Resident 140's medical record. LVN 3 stated LVN 3 explained to Resident 140 that Resident 140's pain medication was not due until 8:45 a.m. and LVN 3 provided Resident 140's pain medication time/medication schedule to Resident 140. LVN 3 stated Resident 140 continued to complain of (c/o) pain level 9/10 in Resident 140's left abdomen. LVN 3 stated about one hour and half later, Resident 140 continued to compliant of 9/10 pain in the left abdomen. Resident 140's PNs were review with LNV 3, the PNs indicated there was no documentation of non-pharmacological interventions (NPIs) were provided to Resident 140. LVN 3 stated, You're right we should have that. LVN 3 stated non-pharmacological interventions were important because Oxycodone is a narcotic and there is a risk for Residents to develop dependence to opioids. LVN 3 stated sometimes, the residents stressed out when they are in a different place and not at home, so distraction (IPIs) could help to decrease pain. LVN 3 stated it is important to provide NPIs to Resident 140 and documented the IPNs in Resident 140's medical record. During a record review of the facility's Policy & Procedure (P&P) titled, Psychotherapeutic Drug Management, indicated the facility will utilize individualized, non-pharmacological approaches to care (e.g., purposeful and meaningful activities). Meaningful activities are those that address the resident's customary routines, interest, preferences, and choices to enhance the resident's well-being. During a record review of the facility's Policy & Procedure (P&P), titled, Pain Management, indicated the facility is responsible for helping the resident attain or maintain their highest level of well-being while working to prevent or manage the resident's pain. Nursing Staff will also utilize non-pharmacological interventions by adjusting the resident's environment to reduce pain. The Licensed Nurse will document resident's pain and response to interventions in the medical record on the weekly summary and as indicated in the progress notes.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48905 Based on observation, interview and record review, the facility failed to ensure three of three sampled residents (Residents 36, 66 and 292) who received dialysis (process of removing waste products and excess fluid from the body) had a dialysis emergency kit (E-kit) at the bedside in accordance with standards of practice. These failures had the potential to delay in emergency treatment from complications of the dialysis access site for Residents 36, 66 and 292. Findings: a. During a review of Resident 292's Admission Record (AR), the AR indicated Resident 292 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included end stage renal disease (ESRD, final permanent stage of chronic kidney disease where the kidney function has declined to the point kidneys can no longer function on its own) and dependence on renal dialysis. During a review of Resident 292's History and Physical (H&P, formal document of a medical provider's examination of a patient) dated 1/18/2025, the H&P indicated Resident 292 was able to make decisions and alert and oriented to person, place, time, and situation. During a review of Resident 292's Minimum Data Set (MDS, a resident assessment tool) dated 1/24/2025, the MDS indicated Resident 292 was dependent on assistance from staff for eating, rolling left and right. The MDS indicated Resident 292 received hemodialysis (HD) treatment. During a review of Resident 292's Order Summary Report (OSR) dated 1/29/2025, the OSR indicated a Medical Doctor (MD) order to reapply pressure dressing to left upper extremity (LUE) arteriovenous shunt (AV shunt, surgical procedure that creates an artificial connection between an artery and a vein) as needed if noted with bleeding. During a review of Resident 292's untitled care plan (CP) dated 1/27/2025, the untitled CP indicated Resident 292 required HD treatment. The goal was for Resident 292 to have immediate intervention should any sign or symptoms of complications from dialysis occur (such as bleeding from the AV shunt). b. During a review of Resident 66's AR, the AR indicated Resident 66 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included ESRD, and dependence on renal dialysis. During a review of Resident 66's H&P, dated 1/19/2025, the H&P indicated Resident 66 did not have the capacity to understand and make decisions. During a review of Resident 66's MDS, dated [DATE], the MDS indicated Resident 66's cognitive abilities (ability to think, learn, and process information) was severely impaired. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 66's untitled CP, dated 12/22/2024, the untitled CP indicated for staff to place a shunt clamp at the bedside for emergencies. During a concurrent observation and interview on 2/4/2025 at 11:52 AM with Registered Nurse Supervisor 1 (RN 1) in Resident 292 and 66's rooms, a dialysis ekit was observed to not be at the bedside for Residents 292 and 66. RN 1 stated there was no ekit at bedside for Residents 292 and 66. RN 1 stated there should be an ekit at bedside. RN 1 stated the risk of not having an ekit was that there could be bleeding from the dialysis site and no emergency supplies would be available to stop the bleeding. During an interview on 2/6/2025 at 11:57 AM with the Assistant Director of Nursing (ADON), the ADON stated dialysis residents should have an ekit at the bedside. The ADON stated the ekit contains pressure gauze for shunts and fistulas (surgical connection made between an artery and vein in the arm to allow easy access to draw blood during dialysis) and clamps for tunneled catheters (thin, flexible tube that is inserted into a vein and tunneled under the skin to administer medications, fluids, and blood products). The ADON stated the risk of not having an ekit at the bedside was the risk of bleeding during an emergency. The ADON stated an ekit would be considered as an immediate intervention as should be placed per CP. During a review of the facility's policy and procedure (P&P) titled, Dialysis Care, dated 10/1/2023, the P&P indicated the facility's Interdisciplinary Team (IDT) will ensure that the resident's CP includes documentation of the resident's renal condition and necessary precautions and indicated staff will educate the importance of compliance with the CP and MD orders. 40438 c. During a review of Resident 36's AR, the AR indicated Resident 36 was admitted to the facility on [DATE] with diagnoses that included Chronic Kidney Disease (CKD, kidneys were damaged and could not filter blood the way they should) and dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed). During a review of Resident 36's OSR dated 12/16/2024, the OSR indicated Resident 36 had an order for hemodialysis schedule on Tuesday, Thursday, and Saturday. The OSR indicated Resident 36 had a central venous catheter (CVC, a thin, flexible tube inserted into a large vein in the chest used to provide vascular access for hemodialysis) on the right upper chest for dialysis site. During a review of Resident 36's Care Plan (CP) dated 12/16/2024, the CP indicated Resident 36 needed hemodialysis on Tuesday, Thursday and Saturday. The CP goal included Resident 36 would have immediate intervention should any signs and symptoms of complications from dialysis occur. During a review of Resident 36's MDS dated [DATE], the MDS indicated Resident 36 had moderately impaired cognition. The MDS indicated Resident 36 was dependent (helper did all of the effort, resident did none of the effort to complete the activity) with oral hygiene, toileting, shower, upper and lower body dressing and personal hygiene. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 2/4/2025 at 10:09 am with Registered Nurse Supervisor 1 (RN 1) inside Resident 36's room, RN 1 stated, Resident 36 had no Emergency Kit (E-kit) at bedside. RN 1 stated all dialysis residents needed to have an E-kit at bedside to be used in case of bleeding from the dialysis access site. During an interview on 2/5/2025 at 10:44 am with the Director of Nursing (DON), the DON stated, an E-kit was needed to control bleeding from the dialysis access site if bleeding happened. During a review of the facility's policy and procedure (P&P) titled, Dialysis Care, dated 10/1/2023, the P&P indicated, The Licensed Nurse will monitor the integrity of the catheter dressing every shift and reinforce the dressing with tape as needed. The Licensed Nurse will inspect the catheter every shift for cracks, breaking or leakage and notify the physician immediately if signs are present.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40438 Based on observation, interview, and record review, the facility failed to implement its Policy and Procedure (P&P) on the use of grab bars (bars installed on the side of the bed)/bed rails/side rails (adjustable metal or rigid plastic bars attached to the bed) for two of two sampled residents (Residents 7 and 8). These failures placed Residents 7 and 8 at risk for entrapment (an event in which resident was caught, trapped, or entangled in the tight spaces around the bed), and injury from the use of grab bars. Findings: a. During a review of Resident 7's Admission Records (AR), the AR indicated Resident 7 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included osteoporosis (weak and brittle bones), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (muscle weakness on one side of the body that can affect the arm, legs, and facial muscles). During a review of Resident 7's Minimum Data Set (MDS, a resident assessment tool) dated 11/22/2024, the MDS indicated Resident 7 had moderately impaired cognition (ability to understand). The MDS indicated Resident 7 required substantial/maximal assistance (helper did more than half the effort) with oral hygiene, toileting, shower, upper and lower body dressing and personal hygiene. During a concurrent observation and interview on 2/4/2025 at 9:42 am with Certified Nurse Assistant 3 (CNA 3) inside Resident 7's room, Resident 7 was trying to sit in a wheelchair. Resident 7 had grab bars up on both sides of the bed. Resident 7 was not holding on to the grab bars while trying to sit in a wheelchair. CNA 3 stated the grab bars were used as enabler for Resident 7's mobility. CNA 3 stated Resident 7 was alert with periods of confusion. b. During a review of Resident 8's AR, the AR indicated Resident 8 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included generalized muscle weakness (lack of muscle strength), dementia (a progressive state of decline in mental abilities) and Alzheimer's disease (disease characterized by a progressive decline in mental abilities). During a review of Resident 8's MDS dated [DATE], the MDS indicated Resident 8 had moderately impaired cognition. The MDS indicated Resident 8 required partial/moderate assistance (helper did less than half the effort) with oral hygiene and dependent (helper did all of the effort, resident did none of the effort to complete the activity) with toileting, shower, upper and lower body dressing and personal hygiene. During a concurrent observation and interview on 2/4/2025 at 9:17 am with Licensed Vocational Nurse 1 (LVN 1) inside Resident 8's room, Resident 8 was in bed, on her back with grab bars up on both sides of the bed. LVN 1 stated the grab bars were used as enabler for Resident 8's bed mobility. LVN 1 stated Resident 8 was alert with periods of confusion. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 2/5/2025 at 9:36 am with Registered Nurse 2 (RN 2), Residents 7 and 8's medical records and PointClickCare (PCC, a cloud-based software used in long-term and post-acute care facilities) were reviewed. RN 2 stated, there were no documented evidence that appropriate alternative interventions were attempted and did not meet the needs of Residents 7 and 8 before the grab bars were installed. RN 2 stated there was no order from the attending physician and there was no informed consent obtained before grab bars were installed for Residents 7 and 8. RN 2 stated appropriate alternative interventions should be attempted before grab bars were installed for the safety of Residents 7 and 8. RN 2 stated, an order and a consent should be obtained before the grab bars were installed to ensure the resident understood and educated on the risks and benefits of using the grab bars. During an interview on 2/5/2025 at 10:44 am with the Director of Nursing (DON), the DON stated, the least restrictive measures and appropriate alternative interventions should be attempted first and did not meet the needs of the residents before grab bars would be installed because of its potential for entrapment and injury to the resident. The DON stated, the use of grab bars needed a physician's order and consented before its installation to make sure that risks and benefits of using grab bars were explained to the resident and was understood. The DON stated, grab bars, bed rails and side rails belong to the same category. During a review of the facility's P&P titled, Bed Rails, dated 10/1/2023, the P&P indicated, The Assessment of whether to use bed rails should include an evaluation of the alternatives to the use of bed rail that were attempted and how these alternatives failed to meet the resident's assessed needs. Alternatives that are attempted should be appropriate for the resident, safe and address the medical conditions, symptoms or behavior patterns for which bed a bed rail was considered. If a bed rail is used as an enabler, the resident/resident representative's informed consent will be obtained by a licensed nurse or the physician. The resident's plan of care will be updated to reflect the use of bed rails. The plan of care should also include documentation of the type of specific direct monitoring and supervision provided during the use of the bed rails and the identification of how needs will be met during the use of bed rails.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 40438 Based on interview and record review, the facility failed to provide a 24-hour sufficient nursing staffing on seven of thirteen Saturdays and eleven of thirteen Sundays for Quarter 4 of 2024 (July 1 - September 30) consistent with Payroll Based Journal (PBJ, a system for collecting and reporting staffing information from nursing homes and other long-term care facilities) Staffing Data Report. The facility did not meet the required 3.5 nursing hours per patient day on 7/6/2024, 7/7/2024, 7/13/2024, 7/14/2024, 7/21/2024, 8/11/2024, 8/18/2024, 8/25/2024, 8/31/2024, 9/1/2024, 9/8/2024, 9/15/2024, and 9/22/2024. The facility also did not meet the required 2.4 CNA direct care hours per patient day on 7/6/2024, 7/7/2024, 7/13/2024, 7/14/2024, 7/20/2024, 7/21/2024, 8/4/2024, 8/10/2024, 8/11/2024, 8/18/2024, 8/24/2024, 8/31/2024, 9/8/2024, 9/14/2024, 9/15/2024, and 9/22/2024. These failures had the potential to affect the quality of care and negatively affect the resident's quality of life in the facility. Findings: During a review of a letter to the Administrator from California Department of Public Health dated 6/14/2024, the letter indicated the facility's request for a workforce shortage waiver was denied. During a review of the facility's PBJ Staffing Data Report for Quarter 4 for 2024, from 7/1/2024 to 9/30/2024, the PBJ staffing Data Report indicated the facility had an excessively low weekend staffing. During a concurrent interview on 2/6/2025 at 3:39 pm with the facility's Business Office Manager (BOM) and record review, the Weekend Nursing Staffing Assignment and Sign in Sheet, from 7/1/2024 to 9/30/2024, the weekend Direct Care Service Hours Per Patient Day (DHPPD, refers to the actual hours of work performed per patient day by a direct caregiver) from 7/1/2024 to 9/30/2024, and the Staffing Summary report from 7/1/2024 to 9/30/2024, were reviewed. The BOM stated, the nursing staffing and sign in sheet and ending census were verified and calculated as actual DHPPD wherein 2.4 hours were actual Certified Nurse Assistant (CNA) DHPPD. The BOM stated completed DHPPD form were transmitted to the California Department of Public Health (CDPH). The BOM stated the facility did not meet the required 3.5 nursing hours per patient day on 7/6/2024, 7/7/2024, 7/13/2024, 7/14/2024, 7/21/2024, 8/11/2024, 8/18/2024, 8/25/2024, 8/31/2024, 9/1/2024, 9/8/2024, 9/15/2024, and 9/22/2024. The BOM stated the facility did not meet the required 2.4 CNA direct care hours per patient day on 7/6/2024, 7/7/2024, 7/13/2024, 7/14/2024, 7/20/2024, 7/21/2024, 8/4/2024, 8/10/2024, 8/11/2024, 8/18/2024, 8/24/2024, 8/31/2024, 9/8/2024, 9/14/2024, 9/15/2024, and 9/22/2024. The BOM stated the facility should have adequate staff for every shift to provide needed care and services for the residents. During an interview on 2/6/2025 at 3:52 pm with the Director of Nursing (DON), the DON stated the facility should have sufficient staff for every shift to provide care for the residents and meet the resident's needs. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's Policy and Procedure (P&P) titled, Nursing Department - Staffing, Scheduling and Postings, revised 1/2024, the P&P indicated, The facility will employ and schedule sufficient nursing staff to provide a minimum daily average of 3.5 nursing hours per patient day with 2.4 of those hours performed by certified nursing assistants (CNAs), unless otherwise indicated through the approval of a staffing waiver grated by the California Department of Public Health (CDPH).

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. 40438 Based on observation, interview, and record review, the facility failed to post actual nursing information for three of three recertification days inspected (2/4/2025, 2/5/2025 and 2/6/2025). These failure had the potential to misinform the residents and visitors of the actual staffing information and potentially affect the quality of nursing care provided to the residents. Findings: During an observation on 2/4/2025 at 9:09 am in Nursing Stations 1 and 2, the facility's Daily Staffing Grid (DSG) in Nursing Station 1 was dated 2/3/2025. Nursing Station 2 did not have DSG posted. During an observation on 2/5/2025 at 10:50 am in Nursing Station 2, Nursing Station 2 did not have DSG posted. During an observation on 2/6/2025 at 10:00 am in Nursing Station 2, Nursing Station 2 did not have DSG posted. During a concurrent interview and record review on 2/6/2025 at 10:35 am with the Director of Staff Development (DSD), DSGs dated 2/4/2025, 2/5/2025 and 2/6/2025 were reviewed. The DSD stated the DSG posted indicated the projected hours of staff working the 11 pm -7 am shift, 7 am - 3 pm shift, 3 pm - 11 pm shift and 11 pm to 7 am shift of the next day. The DSD stated, the DSG was posted at midnight and covering all four shifts. The DSD stated, the DSG was only posted in Station 1. The DSD stated the DSG should be posted in both Nursing Stations 1 and 2 to be accessible to the residents, visitors and staff. The DSD stated, residents, visitors and staff could only view the DSG in Nursing Station 1. During an interview on 2/6/2025 at 11:13 am with the facility's Business Office Manager (BOM), the BOM stated, the DSG should be posted in Nursing Stations 1 and 2 to be visible and accessible to the residents and visitors and to determine the facility had enough staff working for all shifts to provide care for all residents. During an interview on 2/6/2025 at 3:52 pm with the Director of Nursing (DON), the DON stated, the DSG should be posted in Nursing Stations 1 and 2 so everyone would be aware of the number of staff working to care for the residents, every shift. During a review of the facility's Policy and Procedure (P&P) titled, Nursing Department - Staffing, Scheduling & Posting, revised 1/25/2024, the P&P indicated, The facility will post the nurse staffing data specified, on a daily basis at the beginning of each shift. Data must be posted in a clear and readable format and in a prominent place readily accessible to residents and visitors.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36924 Based on observation, interview, and record review, the facility failed to ensure safe and sanitary conditions were maintained in the kitchen when expired chicken nuggets were observed in the refrigerator. This failure had the potential to result in foodborne illness if served to the residents. Findings: During a concurrent initial tour observation of the kitchen and interview on [DATE] at 9:30 a.m. with Dietary Staff (Dietary 1), a clear plastic bag of chicken nuggets was observed in the refrigerator with an expiration date of [DATE]. Dietary 1 stated the clear plastic bag of chicken nuggets expired on [DATE]. During an interview on [DATE] at 9:40 a.m. with the Consultant Registered Dietitian (RD 1), RD 1 stated the plastic bag of chicken nuggets was labeled expired on [DATE]. RD 1 stated the expired bag of chicken nuggets should not be in the refrigerator. RD 1 stated the importance of discarding expired food was residents could possibly get ill from consuming expired food. During an interview on [DATE] at 9:52 a.m. with the Dietary Supervisor (DS), the DS stated it was important to discard expired food to prevent bacteria to grow and to keep food safe. The DS stated facility did not want residents to have foodborne illnesses. During a review of the facility's policy & procedure (P&P) titled, Food Storage, dated [DATE], the P&P indicated food items will be stored, thawed, and prepared in accordance with good sanitary practice.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48905 Based on observation, interview and record review, the facility failed to implement and follow infection prevention procedures to prevent the transmission of infectious organisms for four of five sampled residents (Residents 66, 190, 238 and 294) by failing to: a. Post the correct isolation sign when an Enhanced Barrier Precaution (EBP, precautions that involve using a glove and gown during high-contact resident care activity for residents who are colonized or infected with an MDRO and those at a higher risk of developing an multidrug-resistant organisms [MDRO, bacteria that is resistant to many types of antibiotics], such as, residents with wounds or indwelling medical devices) sign was observed to be posted outside of Resident 294's door on 2/4/2025 instead of a Contact Isolation (type of isolation used with residents who have disease caused by bacteria and viruses that spread through direct and indirect contact) sign for carbapenem-resistant Enterobacterales (CRE, type of MDRO that cause infections that are difficult to treat and can cause outbreak in healthcare settings) and having a roommate (Resident 295) who did not have an active or colonized infection of CRE. b. Place a personal protective equipment (PPE, equipment that protects people from injury or illness in hazardous environments) cart and post a Contact Isolation Sign outside of Resident 66's door on 2/5/2025 when Resident 66 had physician orders for Contact Precautions for Vancomycin-resistant Enterococci (VRE, type of bacteria that is resistant to antibiotics and can spread through contact with contaminated surfaces or equipment, or from person to person) Enterococcus Bacteremia (serious infection where enterococci [type of bacteria] invade the bloodstream) and was observed to have a roommate (Resident 293) who did not have an active or colonized infection of VRE. c. Post an EBP sign outside of Resident 238's room. d. Ensure Certified Nurse Assistant 3 (CNA 3) donned the required PPE when placing Resident 190 on EBP in the Hoyer lift (lift used to safety transfer residents). These failures had the potential to transmit infectious microorganisms and increase the risk of infection from Residents 66, 190, 238 and 294 to other residents, staff and visitors. Findings: a. During a review of Resident 294's Admission Record (AR), the AR indicated Resident 294 was admitted to the facility on [DATE] with diagnoses that included osteomyelitis (bone infection) of the right ankle and foot, extended spectrum beta lactamase (ESBL, an enzyme produce by some bacteria that destroy some antibiotics making infections difficult to treat) resistance, and resistance to carbapenem (class of effective antibiotics that treat severe bacterial infections). During a review of Resident 294's History and Physical (H&P, formal document of a medical provider's examination of a patient), dated 1/23/2025, the H&P indicated Resident 294 can make needs know but cannot make medical decisions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 294's Minimum Data Set (MDS, a resident assessment tool), dated 1/28/2025, the MDS indicated Resident 294 required moderate assistance from staff for dressing the lower body and used a wheelchair and walker. During a review of Resident 294's Order Summary Report (OSR) dated 1/23/2025, the OSR indicated Resident 294 had a physician order for Contact Isolation for right foot osteomyelitis, MDRO, and CRE. During a review of Resident 294's untitled care plan (CP), dated 1/23/2025, the untitled CP indicated Resident 294 was admitted to the facility with multiple infections, such as, osteomyelitis of the right foot, MDRO Klebsiella Pneumonia (bacteria that is highly resistant to antibiotics and can cause pneumonia, bloodstream infections, and wound infections)/CR and indicated for staff to reduce expose to other residents while an infection was active. b. During a review of Resident 66's AR, the AR indicated Resident 66 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included immunodeficiency (decreased ability to fight infections and diseases), bacteremia (bloodstream infection), presence of gastrostomy tube (G-tube, tube that's inserted through the abdomen to provide food and liquid into the digestive system), and pneumonia (lung infection that causes inflammation in the air sacs of the lungs making it difficult to breathe). During a review of Residents 66's MDS, dated [DATE], the MDS indicated Resident 66's cognitive abilities (ability to think, learn, and process information) were severely impaired. The MDS indicated Resident 66 required maximal assistance from staff to roll left and right. During a review of Resident 66' s H&P, dated 1/19/2025, the H&P indicated Resident 66 did not have the capacity to understand or make decisions. During a review of Resident 66's OSR, dated 1/28/2025, the OSR indicated Resident 66 had a physician order for Contact Isolation Precautions for VRE enterococcus Bacteremia for 10 days. During an observation on 2/4/2025 at 10:40 AM in the hallway, an EBP sign was observed to be posted outside of Resident 66's room. During a concurrent observation and interview on 2/5/2025 at 8:58 AM with Licensed Vocational Nurse 3 (LVN 3), a PPE cart and isolation sign were not outside of Resident 66's door. Resident 66's roommate (Resident 293) was inside the room with a sitter (caretaker) at the bedside. Resident 294's roommate (Resident 295) was sitting in Resident 295's wheelchair inside Resident 294's room. LVN 3 stated there was no PPE cart and isolation sign posted outside of Resident 66's door. LVN 3 stated, It should be placed per MD order. LVN 3 stated the risk of not placing the proper isolation sign and PPE cart put the residents at risk for developing new infections or spreading it to other residents. LVN 3 stated Resident 66 has a roommate (Resident 293) and Resident 293 did not have orders for contact isolation. LVN 3 stated Resident 266 and 293 should have been separated. LVN 3 stated Resident 294 has a roommate (Resident 295) and Resident 295 did not have orders for Contact Isolation. LVN 3 stated Resident 294 has a bacterium for osteomyelitis and Resident 294 should be in a separate room. LVN 3 stated cohorting Residents 294 and 295 in the same room put both residents at risk for spreading infections. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/5/2025 at 9:13 AM with Registered Nurse Supervisor 1 (RN 1), RN 1 stated there was no isolation sign and PPE cart placed outside of Resident 66's door. RN 1 stated Resident 66 should be in Contact Isolation per the physician order. RN 1 stated the risk of not have the proper signage and PPE cart outside would put the residents at risk for cross contamination. RN 1 stated Resident 66 should not have a roommate and stated Resident 293 did not have orders for Contact Isolation and should have been chorted separately from Resident 66. RN 1 stated Resident 294 had osteomyelitis of the right foot and stated Residents 294 and 295 should not be in the same room because Resident 295 did not have an active infection for the same organism. RN 1 stated the risk of having a roommate in a Contact Isolation room was that if the roommate got an open wound, the resident would be at risk of getting it. During an interview on 2/5/2025 at 9:53 AM with the Infection Prevention Nurse (IPN), the IPN stated the wrong sign was posted outside of Resident 294's door. The IPN stated, It should be Contact Isolation for right foot osteomyelitis. The IPN stated Resident 294 should not have a roommate. The IPN stated Resident 66 had a roommate and Resident 295 did not have an active infection for VRE bacteremia. The IPN stated there was no isolation sign and PPE cart outside of Resident 66's door. The IPN stated residents would need to have the same organism to be cohorted together. The IPN stated the risk of not cohorting correctly was putting residents at risk for transmitting infectious organisms to others. The IPN stated the risk of not having the correct sign or PPE cart outside of an isolation room was not ensuring staff are taking preventing measure to protect the resident from transmitting infections to others. During an interview on 2/6/2025 at 12:11 PM with the Assistant Director of Nursing (ADON), the ADON stated Residents 294 and 66 are on Contact Isolation precautions and the roommates do not have the same organisms as Residents 294 and 66. The ADON stated cohorting residents without the same organism put the roommate at risk for exposure of getting the organism. The ADON stated the risk of not having a PPE cart and correct isolation sign was that staff would not be aware of the precaution and put residents at risk for spreading it to others. During a review of the facility's policy and procedure (P&P) titled, Resident Isolation-Categories of Transmission-Based Precautions, dated 10/1/2023, the P&P indicated Contact precautions are implemented for residents known or suspected to be infected with microorganisms that are transmitted by direct contact with the resident or indirect contact with environment surfaces, care items, and the resident's environment. The P&P indicated infections requiring Contact Precautions include infections or colonization with MDRO organisms, such as, MRSA, VISA, VRSA, VRE and Carbapenem-resistant Enterobacteriaceae (CRE). During a review of the facility's P&P titled, Personal Protective Equipment, dated 10/1/2023, the P&P indicated for staff to ensure the availability of PPE as required. 42781 c. A review of Resident 238's Admission Record (AR), the admission record indicated Resident 238 was admitted to the facility on [DATE] with diagnoses that included osteomyelitis (inflammation of bone or bone marrow, usually due to infection) of the ankle and foot and type 2 diabetes mellitus (a disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in elevated levels of glucose/sugar in the blood and urine) with hyperglycemia (high blood sugar). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 238's physicians order dated 1/28/2025, the order indicated to change the intravenous midline catheter dressing every seven (7) days. During a review of Resident 238's MDS, dated [DATE], indicated, Resident 238 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. During a concurrent observation and interview on 2/4/2025 at 9:41 a.m. while inside Resident 238's room with Registered Nurse 1 (RN 1), Resident 238 had a midline IV catheter on the upper right arm. Resident 238's room did not have ESP signage posted outside the room and there was no cart for PPE observed upon entering Resident 238's room. During an interview on 2/4/2025 at 10:12 a.m. with the Infection Prevention Nurse (IPN, a healthcare professional who specializes in preventing the spread of infections in healthcare settings), the IP stated Resident 238 had a midline IV and wound. The IP stated, there should be signage posted and a PPE cart placed outside Resident 238's room to notify staff, residents and visitors to wear the proper PPE before entering the room and to protect the resident who is a high risk for infection, and for staff not to spread infection to other residents. 40438 d. During a review of Resident 190's AR, the AR indicated Resident 190 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach) and pressure ulcer (localized damage to the skin and/or underlying tissue usually over a bony prominence) of the sacral region. During a review of Resident 190's MDS dated [DATE], the MDS indicated Resident 190 had a moderately impaired cognition and was dependent (helper did all of the effort, resident did none of the effort to complete the activity) with oral hygiene, toileting, shower, upper and lower body dressing and personal hygiene. During a review of Resident 190's OSR dated 1/20/2025, the OSR indicated Resident 190 was placed on Enhanced Barrier Precautions due to the g-tube/feeding tube (GT, a thin, flexible tube inserted through the abdominal wall and into the stomach). During a review of Resident 190's Care Plan (CP) dated 1/21/2025, the CP indicated Resident 190 required EBP due to GT and wound. The CP interventions included staff and visitors to practice hand hygiene and don applicable PPE during care. During an observation on 2/4/2025 at 2:49 pm inside Resident 190's room, Resident 190 was in the Hoyer lift, assisted by CNA 3 to go back to bed. CNA 3 was observed wearing gloves but did not wear a gown while providing care to Resident 190. During an interview on 2/5/2025 at 9:36 am with Registered Nurse Supervisor 2 (RN 2), RN 2 stated, all staff should wear gown and gloves all the time when interacting and providing care to residents on EBP to prevent spread of infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/5/2025 at 10:44 am with the Director of Nursing (DON), the DON stated, staff should wear gloves and gown when providing activities of daily living (ADLs) with residents on EBP because of risks of getting further complications and infections. During a review of thility's policy and procedure (P&P) titled, Standard and Enhanced Precautions, dated 10/1/2023, the P&P indicated, Enhanced standard precautions will be implemented for residents with a known MDRO and who are at high-risk for colonization and transmission. Resident characteristics that are associated with a high-risk of MDRO colonization and transmission include presence of indwelling devices (e. g., urinary catheter, feeding tube, endotracheal or tracheostomy tube, vascular catheters), wounds or presence of pressure ulcer (unhealed) and functional disability and total dependence on others for assistance with activities of daily living. PPE used for EBP hig-contact resident care activities were gloves and gown prior to the high-contract care activity.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42781 Based on interview and record review, the facility failed to complete a Surveillance Data Collection form for one of 12 sampled residents (Resident 66) receiving antibiotics. This deficient practice had the potential to result in increased antibiotic resistance and providing antibiotics without justification. Findings: During a review of Resident 66's Admission Record (AR), the AR indicated Resident 20 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included bacteremia (presence of bacteria in the blood). During a review of Resident 66's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 12/27/2024, the MDS indicated, Resident 66 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated, Resident 66 was dependent (helper does all the effort) on staff for oral hygiene, toileting, shower, upper/lower body dressing, putting on/off footwear and personal hygiene. During a review of Resident 66's Physicians Order (PO) dated 1/28/2025, the PO indicated to administer Daptomycin (Antibiotics, a substance used to kill bacteria and to treat infections) Intravenous Solution Reconstituted, 350 milligram (unit of measurement) IV every 48 hours for Vancomycin Resistant enterococci (VRE, a type of bacteria present in the gastrointestinal tract that develop resistance to many antibiotics, especially vancomycin) Enterococcus bacteremia until 2/8/2025. During an interview on 2/6/2025 at 10:23 am with the facility's Infection Preventionist Nurse (IPN a healthcare professional who specializes in preventing the spread of infections in healthcare settings), the IPN stated, she was unable to find Resident 66's Antibiotic Surveillance Form. The IPN stated, the form needed to be filled out to make sure Resident 66 was screened before initiating antibiotic therapy to ensure antibiotic use was appropriate and met the criteria for the provision of antibiotics. The IPN stated she was out for vacation on 1/6/2025 to 2/3/2025 and did not know why the form was not filled out. During an interview on 2/6/2025 at 10:23 am with the facility's Assistant Director of Nursing (ADON), the facility's ADON stated antibiotic stewardship needed to be done to determine if the residents meet the criteria before receiving antibiotic therapy. During a review of the facility's Policy and Procedure (P&P) titled, Antibiotic Stewardship Program, dated 10/1/2023, the P&P indicated the antibiotic stewardship Program (ASP) was designed to promote the appropriate use of antibiotics while optimizing the treatment of infections, and simultaneously reducing the possible adverse events associated with antibiotic use. The P&P indicated, the IP will collect and analyze infection surveillance data and monitor the adherence to the ASP.