STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055203	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunny Village Care Center	1428 S. Marengo Ave. Alhambra, CA 91803

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - 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** 45456 Based on observation, interview, and record review, the facility failed to promote dignity and respect for three (3) of 18 residents (Residents 10, 244, and 58) as indicated on the facility's policy when facility staff labeled Residents 10, 244, and 58 as feeders during dining observation on 1/27/2025. This deficient practice had the potential to affect Resident Residents 10, 244, and 58's sense of self-worth and self-esteem which could result in problems with emotional and mental well-being. Findings: 1. During a review of Resident 10's Admission Record, the admission record indicated Resident 15 was admitted to the facility on [DATE] and re- admitted on [DATE]. Resident 15's diagnoses included metabolic encephalopathy (ME, occurs when problems with your metabolism cause brain dysfunction), diabetes mellitus (DM, is a metabolic disease, involving inappropriately elevated blood glucose levels), dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), and dysphagia (difficulty swallowing). During a review of Resident 10's Minimum Data Set (MDS, a resident assessment tool), dated 11/25/2024, the MDS indicated Resident 10 has severely impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 10 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) in toileting hygiene, toilet transfer, and tub/ shower transfer. Resident 10 needed partial/ moderate assistance (helper does less than half the effort, helper lifts, hold, or supports trunk or limbs but provides less than half the effort) in eating, oral hygiene, and personal hygiene. During a concurrent observation in the dining room on 1/27/2025 at 11:57 AM, Resident 10 finished eating a bowl of porridge. Certified Nursing Assistant 3 (CNA 3) was sitting next to the residents. CNA 3 stated, Resident (Resident 10) wants to go and eat in her room with a family member. She is a feeder. During an interview with CNA 1 at 1/27/2025 at 12:20 PM, CNA 1 stated, We do not call residents feeders when they need feeding assistance. (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 interview with the Director of Nursing (DON) on 1/28/2025 at 1:55 PM, the DON stated, The staff should not call residents who are dependent, and needing feeding assistance as feeders because of resident's dignity. During a concurrent record review of facility's policy Assistance with Meals and interview with DON on 1/28/2025 at 1:57 PM, the DON stated, The staff should address the residents with their names and avoid labeling residents as feeders because that affects the resident's dignity. During a review of facility's policy and procedure (P&P) titled, Assistance With Meals, revised 3/2022, the P&P indicated residents who cannot feed themselves will be fed with attention to safety, comfort and dignity, avoiding the use of labels when referring to residents (e.g. feeders) 2) During a review of Resident 244's Admission Record, the admission record indicated Resident 244 was admitted to the facility on [DATE]. Resident 244 's diagnoses included hyperglycemia (a condition where the blood glucose [sugar] levels are abnormally high), dementia, and chronic kidney disease (CKD, is a condition in which the kidneys are damaged and cannot filter blood as well as they should) During a review of Resident 244's MDS, dated [DATE], the MDS indicated Resident 244 has moderately impaired cognitive skills for daily decision making. The MDS indicated Resident 244 was dependent in toileting hygiene, toilet transfer, and tub/ shower transfer. Resident 244 needed setup or clean-up assistance (helper sets up or cleans up; resident completes activity. helper assists only prior to or following the activity) for eating. During an observation in the dining room with CNA 3 on 1/27/2025, at 12:05PM, CNA 3 while addressing Resident 244, stated, [NAME], do you want your lunch tray? Resident 244 looked at CNA 3 then shook his head. During an interview with CNA 1 on 1/27/2025 at 12:23 PM, CNA 1 stated, We should not call residents Mama or [NAME]. Residents have their name. We should address the residents with their first or last name. There are some residents that does not like to be called Mama or [NAME]. 3. During a review of Resident 58 's Admission Record, the admission record indicated Resident 58 was admitted to the facility on [DATE] and re- admitted on [DATE], Resident 58 's diagnoses included dementia, hypertension (high blood pressure), and hyperlipidemia (a condition characterized by abnormally high levels of lipids [fats] in the blood) During a review of Resident 58's MDS, dated [DATE], the MDS indicated Resident 58 has severely impaired cognitive skills for daily decision making. The MDS indicated Resident 58 needed substantial/ maximal assistance (helper does more than half the effort. helper lifts, holds trunk or limbs, and provides more than half the effort) in oral hygiene, lower body dressing. Resident 58 needed setup or clean-up assistance for eating. During an observation in the dining room with Licensed Vocational Nurse 5 (LVN 5) on 1/27/2025 at 12:11 PM, LVN 5 addressed Resident 58 as Mama repeatedly while supervising the resident during meals. LVN 5 stated, Eat Mama, eat Mama. (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 with LVN 5 on 1/27/2025 at 12:25PM, LVN 5 stated, We should not address the residents' as Mama and [NAME] because the residents have a name. During interview with CNA 3 at 1/27/2025 at 12:26PM, CNA 3 stated, We should not randomly call residents mama or [NAME] if we do not know their names. Residents might get offended, so we should not do that. During an interview with the DON on, 1/28/2025 at 1:58 PM, DON stated, The staff should address the residents with their first or last names instead of calling them Mama or [NAME]. During a review of the P&P, Dignity, revised 2/2021, the P&P indicated each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life and feelings of self-worth and self-esteem. Residents are treated with dignity and respect at all times. Staff speak respectfully to Resident to residents at all times, including addressing the Resident by his or her name of choice and not labeling or referring to the resident by his or her room number, diagnosis, or care needs. 49537 The following reflects the findings of the California Department of Public Health during the investigation of a complaint and the Annual Recertification Survey conducted on 1/30/2025. Complaint number: CA00943608 Total Resident Population: 90 Total Resident Sample: 18 Highest Severity and Scope: E No deficiencies for Complaint number CA00943608.

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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** 51192 Based on observation, interview, and record review, the facility failed to ensure the resident or resident's representative was informed in advance of the treatment risks and benefits, options, and alternatives by a physician or other practitioner or professional for the use of antipsychotic medication (a class of drugs used to treat mental health conditions characterized by psychosis [mental health condition characterized by a loss of contact with reality], such as schizophrenia [a mental illness that is characterized by disturbances in thought] and bipolar disorder [extreme mood swings that include mania {emotional highs} and depression { mood disorder that causes a persistent feeling of sadness and loss of interest } which may lead to impaired functioning]) for one of five sampled residents (Resident 14). This failure had the potential to affect Resident 14's right to direct their own medical treatment. Findings: During a review of Resident 14's Admission Record, the admission record indicated Resident was admitted on [DATE]. Resident 14's diagnoses indicated dementia (a general term for a group of brain disorders that cause a gradual decline in cognitive abilities, such as memory, thinking, reasoning, and judgment), psychotic disturbance (also known as psychosis), and mood disturbance. During a review of Resident 14's physician order, dated 11/15/2024, the physician indicated Seroquel (an antipsychotic medication) 25 milligrams (mg, unit of measurement) via gastrostomy tube (GT - a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) twice a day for psychosis manifested by striking out without any reason and hitting with fist during care pinching episodes. During a review of Resident 14's Minimum Data Set (MDS - a resident assessment tool), dated 11/19/2024, the MDS indicated Resident 14 was severely impaired with cognitive skills for daily decision making. During a review of Resident 14's medical record, the medical records did not have an informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) obtained from Resident 14 or Resident 14's representative prior to the use antipsychotic medication. During an interview on 1/30/2025 at 10:10 AM with Licensed Vocational Nurse 4 (LVN 4), LVN 4 stated, the facility's informed consent for antipsychotic medication titled, Resident/Surrogate Decision Maker Informed Consent for Antipsychotic Medication, should have been obtained from Resident 14 representative after getting the order from the physician. During an interview on 1/30/2025 at 10:40 AM with Medical Records Designee (MRD), MRD stated, the facility's informed consent when resident has orders for antipsychotic medication titled, Resident/Surrogate Decision Maker Informed Consent for Antipsychotic Medication, should have been obtained from Resident 14 representative after getting the order from the physician and should always be in the Resident 14's chart. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/30/2025 at 11:09 AM with Registered Nurse 1 (RN 1) RN 1 stated, the facility's process in obtaining informed consent for the antipsychotic medication order were as follows: a. RN or LVN will ask the family or representative if the resident is unable to give the consent. b. RN or LVN will explain the risks and benefits and obtain the consent. RN1 stated, not having a consent for the use of antipsychotic potentially violated Resident 14 or Resident 14 representative's rights. During a review of the facility's policies and procedures (P&P) titled, Antipsychotic Medication Use, revised on 7/2022, the P&P indicated, residents and /or their representatives will be informed of any treatment recommendations, risks, benefits, purposes, including the potential adverse consequences of antipsychotic medications, and residents and their representatives may refuse medications of any kind.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44018 Based on observation and interview, the facility failed to maintain a comfortable and safe environment for four (4) of 18 sampled residents (Resident 187, Resident 18, Resident 54, and Resident 69) by failing to: 1. 2. And 3. Failing to maintain the residents' room temperature level between 71- and 81-degree Fahrenheit (F) of Resident 187, Resident 18, and Resident 54). This deficient practice resulted in the residents' increased level of discomfort which can negatively impact the residents' quality of life, increase the residents' risk of dehydration (excessive loss of body water), hypothermia (a condition where the body's core temperature drops below 95 F), and/or hyperthermia (condition where the body's core temperature is higher than 98 F). 4. ensure Resident 69's belongings were safe and missing items were addressed. This deficient practice had a potential for Resident 69 losing personal items which could negatively affect resident's emotional wellbeing. Findings: 1. During a review of Resident 187's Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included abnormalities of gait and mobility and hypertension (high blood pressure). During a review of the Minimum Data Set (MDS- resident assessment tool), dated 1/22/2025, the MDS indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making was impaired. Resident 187 required partial/moderate assistance (Helper does less than half the effort. The helper lifts, holds, or supports trunk or limbs, but provide less than half the effort.) from staff for oral hygiene, upper body dressing, and lower body dressing. During an observation and interview in Resident 187's room, on 1/27/2025, at 8:32 AM, Resident 187 was observed in a cocoon (envelop or surround in a protective or comforting way) position with a thick blanket while sitting in bed. Resident 187 stated it had been freezing cold in his room. Resident 187 further stated, I don't want to get sick. During an observation and interview in the presence of the Maintenance Supervisor (MS) on 1/27/2025 at 8:50 AM, the MS checked Resident 187's room temperature using the facility's laser temperature thermometer. Resident 187's room temperature registered at 66-degree Fahrenheit (F). MS stated the room was cold and he could adjust the thermostat to adjust the room temperature. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Director of Nursing (DON) on 1/29/2025 at 10:44 AM, the DON stated, Residents spent most of their time in the room, keeping the room temp in a 71-81 range would optimize residents' health and comfort. The DON further stated, Resident (Resident 187)'s room temperature was 66 (F), it was too cold. Resident 187 could get hypothermia. 2. During a review of Resident 18's Admission Record, the Admission Record indicated the facility initially admitted Resident 18 on 7/13/2019 and readmitted on [DATE] with diagnoses that included but not limited to, hemiplegia (paralysis on one side of the body after a stroke) and hemiparesis (refers to weakness in one side of the body) following cerebral infarction (a medical condition where blood flow to the brain is interrupted, leading to death of brain cells), chronic kidney disease (long term condition in which the kidneys gradually lose their ability to filter waste products for the blood and maintain fluid balance), and dementia (chronic condition that causes a person to lose cognitive functioning such as thinking, remembering, and reasoning to the point that it interferes with daily life). During a review of Resident 18's MDS, dated [DATE], the MDS indicated Resident 18 had severely impaired cognitive skills for daily decision making and was dependent (Helper does all the effort. Resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity) with eating, oral/toileting/personal hygiene, showering/bathing self, upper and lower body dressing and putting on/taking off footwear. During a review of Resident 18's Care Plan addressing the problem potential for communication impairment related to language barrier and limited speech, revised on 1/15/2025, the Care Plan included interventions to check resident frequently to monitor her needs, comfort, safety, and to observe resident for non-verbal cues such as gestures and facial expressions. 3. During a review of Resident 54's Admission Record, the Admission Record indicated the facility admitted Resident 54 on 11/25/2022 with diagnoses that included, but not limited to cerebral infarction, developmental disorder of scholastic skills (persistent difficulties in acquiring academic skills, such as reading, spelling or writing), and dehydration (occurs when the body loses more fluids that it takes in). During a review of Resident 54's MDS dated [DATE], the MDS indicated Resident 54 had severely impaired cognitive skills for daily decision making and was dependent with eating, oral/toileting/personal hygiene, showering/bathing self, upper and lower body dressing and putting on/taking off footwear. During a review of Resident 54's Care Plan addressing impaired communication related to aphasia (loss of ability to understand or express speech, caused by brain damage), revised on 9/12/2024, the Care Plan included interventions to check resident frequently to monitor her needs, comfort, safety, and to observe resident for non-verbal cues such as gestures and facial expressions. During a concurrent observation and interview on 1/27/2025 at 12:37 PM, inside Residents 18 and 54's room, with the Maintenance Assistant (MA), the MA measured the room temperature using the facility's laser thermometer. Residents 18 and 54's room temperature reading was 86 F. The MA stated the room was too hot. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/30/2025 at 9:33 AM with Registered Nurse 1 (RN 1), RN 1 stated the rooms should be within comfortable temperature levels. RN 1 stated it was important to keep the residents comfortable and prevent harm such as dehydration and hyperthermia, especially the residents that cannot speak or verbalize if the room was too cold or hot. During a concurrent interview and record review on 1/30/2025 at 10:23 AM with the MA, the facility's undated Policy and Procedure (P&P) titled Homelike Environment, revised February 2021 and Air Temperature Readings, were reviewed. The MA stated room temperature of 86 F was out of range and the acceptable range for the temperature was 71-81 F according to the policy. The MA stated that routine checks of ambient air temperatures are not required and/or may check as needed according to the policy but both him and the MS check the temperatures of all the resident rooms daily and record the reading in the temperature log. The MA stated it was not okay as the residents can become sick if the rooms were too cold or too hot. During a review of the facility's P&P titled, Homelike Environment, revised February 2021, the P&P indicated the facility will ensure residents were provided with a safe, comfortable, and homelike environment. the policy further stated that the comfortable and safe temperatures was 71 F - 81 F. 42223 4. During a review of Resident 69's Admission Record, the Admission Record indicated resident was originally admitted on [DATE] and was readmitted on [DATE] with the following diagnoses hemiplegia (paralysis that affects only one side of the body) and malignant neoplasm (cancerous tumor) of colon (longest part of the large intestine). During a review of Resident 69's MDS, dated [DATE], the MDS indicated resident was independent in cognitive (the ability to understand and make decisions) skills for daily decision making. The MDS also indicated Resident 69 required substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with toileting hygiene and putting on/taking off footwear and required partial/moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with shower/bathe self, upper body dressing, and lower body dressing. During an observation and interview on 1/27/2025 at 10:24 AM in Resident 69's drawer, Resident 69 stated he had his sweatpants missing. Resident 69 also stated that he told Laundry Staff (LS), but it was not addressed. During a concurrent observation, record review of Resident 69's Inventory List, and interview with Social Service Assistant (SSA) on 1/30/2025 at 9:32 AM in Resident 69's room, the SSA stated personal items are put in the inventory list and if it was missing, it would be reported and a search would be done. SSA stated there was one pair of pants documented on the inventory list that was missing for Resident 69. SSA added if there was an item missing and if not found, the item will be replaced/paid back to the resident. During an interview on 1/30/25 at 9:49 AM with Laundry Staff (LS), LS stated she does remember Resident 69 telling her about her missing pants three weeks ago. LS also stated that she did not but should have reported Resident 69's missing item. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/20/2025 at 10:38 AM, Administrator (ADM) stated if the resident was missing an item, it would be reported to him and there would be an immediate (within 72 hours) search. ADM also stated that he was not notified of Resident 69's missing items. During a review of the facility's Policy and Procedure (P&P) titled, Theft and Loss Program, dated 11/11/11, the P&P indicated all losses will be reported to the administrator within 24 hours. The P&P also indicated the facility will facilitate an immediate search/investigation in an attempt to locate the missing property. 49537

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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. 51192 Based on interview and record review, the facility failed to ensure accurate assessment of the Minimum Data Set (MDS, a resident assessment tool) for one (1) of three (3) sampled residents (Resident 84) by failing to include the resident's correct discharge status. This failure resulted in the facility's inaccurate MDS and care screening tool reporting to the Centers for Medicare & Medicaid Services (CMS). Findings: During a review of Resident 84's Physician's Orders, dated 12/12/2024, the Physician's Orders indicated Resident 84 will be discharged home on 12/13/2024 with home health. During a review of Resident 84's Notice of Transfer/Discharge form, dated 12/13/2024, the Notice of Transfer/Discharge indicated that Resident 84 was discharged to home. During a review of Resident 84's Post Discharge Plan of Care, dated 12/13/2024, the Post Discharge Plan of Care indicated Resident 84 was discharged /transferred to home on 12/13/2024. During a review of Resident 84's Physician's Discharge Summary, dated 12/13/2024, the Physician's Discharge Summary indicated Resident 84 was discharged to home on 12/13/2024 because Resident's 84 health conditions have improved. During an interview on 1/29/2025 at 2:37 PM with the MDS Coordinator (MDSC), the MDSC stated, she documented and transmitted Resident 84's MDS discharge status on 12/27/2024. The MDS discharge status reflected Resident 84 was discharged to the short-term general hospital, instead of home under care of organized home health service organization. The MDSC also stated she realized she made a mistake completing the MDS discharge status and thought it was for the MDS admission status. MDSC stated the potential outcome for the inaccurate assessment of the MDS discharge status will impact the facility's quality of care reporting for the discharge section. During a review of the facility's policy and procedure (P&P) titled, Resident Assessments, revised on 3/2022, the P&P indicated, the resident assessment coordinator is responsible for the appropriate resident assessments and reviews .for admission, quarterly, annual, significant change in status, significant correction to prior comprehensive, and discharge assessments.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51192 Based on observation, interview, and record review, the facility failed to ensure the completion and implementation of the baseline care plan within 48 hours of the resident's admission for one of one sampled resident (Resident 14). This failure had the potential to affect Resident 14's health and safety by not promoting continuity of care and communication among the nursing home staff regarding the initial plan for delivery of care and services. Findings: During a review of Resident 14's Admission Record, the Admission Record indicated Resident 14 was admitted on dated 11/15/2024. Resident 14's diagnoses included dementia (a general term for a group of brain disorders that cause a gradual decline in cognitive abilities, such as memory, thinking, reasoning, and judgment), psychotic disturbance (also known as psychosis [mental health condition characterized by a loss of contact with reality]), and mood disturbance. During a review of Resident 14's physician order, dated 11/15/2024, the physician order indicated Seroquel 25 (an antipsychotic medication) milligrams (mg - a unit of measurement) will be administered twice a day for psychosis manifested by striking out without any reason and hitting with fist during care pinching episodes. During a review of Resident 14's Minimum Data Set (MDS - a resident assessment tool), dated 11/19/2024, the MDS indicated Resident 14 is with severe impairment of cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. During a review of the Resident 14's medical record, it did not contain the baseline care plan for Resident 14's antipsychotic medication use as indicated on the physician's order. During an interview on 1/28/2025 at 1:00 PM with Licensed Vocational Nurse 4 (LVN 4), LVN 4 stated that Resident 14's antipsychotic medication baseline care plan should be started once the resident was admitted on [DATE] from the hospital. During an interview on 1/30/2025 at 10:06 AM with LVN 3, LVN 3 stated, Resident 14's antipsychotic medication baseline care plan should be signed by the admitting Registered Nurse (RN), should be done within 14 to 30 days from admission, and should be always kept in the resident's chart. The potential outcome for not having the baseline care plan in the chart is affecting the resident's quality of care.

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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 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** 42223 Based on observation, interview, and record review, the facility failed to ensure two (2) of 18 sampled residents (Resident 15 and 73) were provided and were using a communication board (a sheet of symbols, pictures or photos that the resident can point to, to communicate with the staff) when the resident needed assistance. This deficient practice had the potential for a delay in the necessary care and services for Resident 15 and 73. Findings: 1.During a review of Resident 15 Admission Record, the Admission Record indicated resident was originally admitted on [DATE] and was readmitted on [DATE] with the following diagnoses of muscle wasting and atrophy and fracture of second lumbar vertebra (point of the spinal cord [bundle of nerves and tissues]). During a review of Resident 15 Minimum Data Set (MDS - a resident assessment tool), dated 12/12/2024, the MDS indicated resident was moderately impaired with cognitive (the ability to understand and make decisions) skills for daily decision making. The MDS indicated Resident 15 was able to make self-understood and has the ability to understand others. The MDS also indicated Resident 15 was dependent (helper does all of the effort. Resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity) with oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene. During a review of Resident 15's Care Plan, dated 12/12/2024, with focus on impaired communication, the care plan indicated to use a communication board as needed. During an observation on 1/29/2025 at 1:32 PM, Resident was observed speaking in a Non-English language complaining about pain and had asked Certified Nurse Assistant 2 (CNA2) and Licensed Vocational Nurse 3 (LVN 3) for assistance, but the staff did not understand the resident. During a concurrent observation and interview on 1/29/2025 at 1:38 PM, LVN 3 stated Resident 15 had a communication board that was hidden in between the bed and the bedside table. LVN 3 stated that the communication board was not but should have been used to help Resident 15 to communicate her needs to the staff. During an interview on 1/30/2025 at 8:56 AM, Registered Nurse 1 (RN 1) stated it is important for the resident to use a communication board as it helps the resident communicate their needs to the staff. 44018 (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During a review of Resident 73's Admission Record, the Admission record indicated Resident 73 was admitted to the facility on [DATE], with diagnoses of hypotension (low blood pressure) and Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movement, chiefly affecting middle-aged and elderly people). During a review of Resident 1's History and Physical Examination (H&P) dated 11/6/2024, the H&P indicated Resident 73 could make needs known but not make medical decisions. During a review of Resident 73's MDS, dated [DATE], the MDS indicated Resident 73's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making were moderately impaired. The MDS indicated Resident 73 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) for toileting hygiene, shower/bathe self, lower body dressing, sit to lying, and sit to stand. During a review of Resident 73's Care Plan, indicated Resident 73 had a potential for impaired communication related to language barrier, initiated on 11/6/2024. Staff inventions included using a communication board as needed. During a concurrent observation and interview on 1/27/2025 at 10:12 AM in Resident 73's room. Resident 73 was observed sitting upright in bed with the head of bed (HOB) 90 degrees up, Resident 73's legs was bending. Resident 73 was observed not using the dominant language of the facility to speak to Certified Nursing Assistant 2 (CNA2). Resident 73 requested CNA 2 to lower the HOB and to change his position. CNA 2 stated she was not able to assist Resident 73 because she did not understand and speak Resident 73's language. CNA 2 was observed looking for communication board and was nowhere to be found in the room. During an interview on 1/30/2025 at 4:25 PM with the Director of Nursing (DON), the DON stated it was facility policy to provide communication board to residents who had communication language barrier. DON stated the communication board should be easy access to the residents to ensure resident receive the care they need. During a review of the facility's undated policy and procedure titled, Communication with Limited English Proficient Persons, the P&P indicated the facility policy was to ensure that persons with limited English proficiency were identified and that the facility was capable of communicating information to such persons efficiently by providing a communication board at the bedside, and/or with patients to provide proper communication methods and translation. The P&P indicated accurate and effective communication between the facility and limited English proficient (LEP) persons, including current and prospective residents and family, is necessary to ensure the LEP persons have a meaningful opportunity to apply for, receive or participate in, and benefit from the services offered. The P&P also indicated the facility will provide a communication board at the bedside, and/or with patients to provide proper communication methods and translation.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44018 Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 44) was provided care and services to maintain good grooming and personal hygiene. This deficient practice had the potential to result in a negative impact on Resident 44 's self-esteem. Findings: During a review of Resident 44's Admission Record, the Admission Record indicated Resident 44 was admitted to the facility on [DATE] with Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movement, chiefly affecting middle-aged and elderly people), hypertensive (high blood pressure) heart disease without heart failure, and muscle weakness. During a review of Resident 44's Minimum Data Set (MDS- resident assessment tool), dated 11/14/24, the MDS indicated Resident 44 was independent with cognitive (a mental process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 44 required partial/moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.) with toilet hygiene, personal hygiene, and shower/bath self. During a review of Resident 44's plan of care initiated on 8/15/2024, the plan of care indicated Resident 44 had self-care deficits due to limited mobility secondary to right side weakness. The goal would be for the resident to be clean, well groomed, and neatly dressed daily. The staff interventions were to assist resident with ADL (Activities of Daily Living) needs and keeping resident clean. During an observation in Resident 44's room on 1/27/2025 at 9:59 AM and interview with Resident 44, Resident 44 was observed lying in bed. Resident 44's fingernails were observed untrimmed (long) and blackish in color underneath the fingernails. Resident 44 stated her nails were supposed to be trimmed weekly and they had not trimmed for one month. Resident further stated, Look, they are long and ugly. I feel dirty. During a concurrent observation in Resident 44's room and interview with Certified Nursing Assistant 5 (CNA5), on 1/27/2025 at 10:04 AM, CNA 5 stated Resident 44's fingernail on both hands were long, and dirty. CNA 5 stated the resident's fingernails needed to be trimmed. During a concurrent observation in Resident 44's room and interview with Registered Nurse (RN) 1, on 1/30/2025 at 9:09 AM, RN 1 stated it was CNA's duties to trim and smooth residents' nail to prevent the residents from accidentally scratching and injury their skin and preventing infection. RN 1 stated Resident 44 was at risk for skin breakdown and risk for infection because of the dirty and long fingernails. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Director of Nursing (DON) on 1/30/2025 at 09:28 AM, the DON stated it was a duty of a CNA to provide fingernails care as part of the grooming and it was done on bath day. The DON further stated the purpose of nail care was to provide cleanliness and to prevent infection. During a review of the facility's policy titled, Fingernails/Toenails, revised February 2018, indicated the purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections.

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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** 45456 Based on observation, interview, and record review, the facility failed ensure the low air loss mattress (LAL, mattress used for residents who are at risk for developing sores or already have pressure ulcer designed to circulate a constant flow of air for the management of pressure sores) was on the correct settings for one (1) of 1 sampled residents (Residents 15), in accordance with the facility's Pressure Injury (painful wound caused as a result of pressure or friction) policy and procedure (P&P). This deficient practice had the potential for Resident 15 to have worsening stage 4 pressure ulcer (Full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) which can negatively affect resident's overall well-being.) Findings: During a review of Resident 15's Admission Record, the admission record indicated Resident 15 was admitted to the facility on [DATE] and re- admitted on [DATE]. Resident 15's diagnoses included sick sinus syndrome (SSS, is a disease in which the heart's natural pacemaker located in the upper right heart chamber [right atrium] becomes damaged and is no longer able to generate normal heartbeats at the normal rate, muscle wasting/ atrophy (decrease in size and wasting of muscle tissue) and stage 4 pressure ulcer of the left buttock. During a review of Resident 15's Minimum Data Set (MDS, a resident assessment tool), dated 12/12/2024, the MDS indicated Resident 15 has moderately impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 15 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) in oral hygiene, toileting hygiene, shower/bathe self, lower body dressing, putting on/ taking off footwear, personal hygiene, roll left and right, sit to lying, lying to sitting on side of the bed, chair/bed-to chair transfer, toilet transfer, and tub/ shower transfer. During a review of Resident 15's Physician's Order, dated 12/7/2024, the physician's order indicated LAL Mattress therapy bed for wound management. During a review of Resident 15's Braden Scale (a standardized, evidence-based assessment tool commonly used in health care to assess and document a client's risk for developing pressure injuries), dated 12/29/2024, the Braden Scale indicated Resident 15 has a total score of 10, which indicated Resident 15 was high risk for skin breakdown. During a concurrent observation in Resident 15's room and interview with Licensed Vocational Nurse 2 (LVN 2) on 1/28/2025 at 2:25 PM, Resident 15 was observed in bed with the LAL set at 180 millimeters of mercury (mmHg, unit of pressure). LVN 2 stated, LAL was set incorrectly. Resident's (Resident 15) weight was 124 pounds (lbs., unit of measure) LAL should be set based on the resident's weight. It will not be effective with the resident's (Resident 15) wound management. (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 in Resident 15's room and interview with LVN 3 on 1/29/2025 at 9:29 AM, Resident 15 was observed in bed with the LAL set at 140 mmHg. LVN 3 stated, Resident's (Resident 15) weight was 124 lbs., and LAL was set on 140 mmHg which is incorrect. It should be set at 130 mmHg. If LAL was set up incorrectly, it will not help with the resident's (Resident 15) wound management. During a review of the Manufacturer's User Manual titled, Med Aire Assure 5 Air + 3 Foam Base Alternating Pressure and Los Air Loss Mattress System, dated 2018, the manual indicated mattress are intended to help reduce the incidence of the pressure ulcers while optimizing patient comfort. Turn the pressure adjust knob to set a comfortable pressure level by using the weight scale as a guide. During a review of the facility's P&P titled, Support Surface Guidelines, revised on 9/2013, the P&P indicated Low air loss mattress setting is according to the weights of the resident or according to the manufacturer guidelines.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42223 Based on observation, interview and record review, the facility failed to keep the foley catheter bag (bag that collects urine that drains through the urinary catheter [a hollow tube inserted into the bladder to drain or collect urine]) below the level of the bladder for one of two sampled residents (Resident 15), in accordance with the facility's policy. This deficient practice had the potential for Resident 15 to develop urinary tract infection (UTI - an infection in the bladder/urinary tract) due to urine back flow. Findings: During a review of Resident 15 Admission Record, the Admission Record indicated resident was originally admitted on [DATE] and was readmitted on [DATE] with the following diagnoses of muscle wasting and atrophy and fracture of second lumbar vertebra (point of the spinal cord [bundle of nerves and tissues]). During a review of Resident 15 Minimum Data Set (MDS - a resident assessment tool), dated 12/12/2024, the MDS indicated resident was moderately impaired with cognitive (the ability to understand and make decisions) skills for daily decision making. The MDS also indicated Resident 15 was dependent (Helper does all of the effort. Resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity) with oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene. The MDS indicated Resident 15 had an indwelling catheter (a flexible tube used to empty the bladder and collect urine in a drainage bag). During a review of Resident 15's Physician Orders, dated 12/7/2024, the Physician Orders indicated foley catheter (drains urine from the bladder into a collection bag) 17 French (Fr - unit of measure)/ 10 cubic centimeters (cc - unit of measure) to continue drainage for urinary retention (unable to empty all the urine from the bladder) and wound management every shift. During a review of Resident 15's Care Plan with focus on catheter related to urinary retention, revised 12/8/2024, the Care Plan indicated the goal of adequate catheter care. During an observation on 1/29/2025 at 1:32 PM during peri-care (cleaning the private areas of the resident) in Resident 15's room, with Licensed Vocational Nurse 3 (LVN 3), Certified Nursing Assistant 2 (CNA 2) moved Resident 15's foley catheter bag from the side of the bed (below the level of the bladder) to the foot of the bed and on top of blankets (above the level of the bladder). During an observation on 1/29/2025 at 2PM in Resident 15's room, CNA 2 was observed holding Resident 15's foley catheter bag above the level of the bladder while untangling it. Urine was observed flowing back to the resident. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/29/2025 at 2:09 PM in Resident 15's room, LVN 3 stated Resident 15's foley catheter bag was not below the level of the bladder and moving the foley catheter bag up can cause a back flow of urine to the resident which would be a potential for UTI. During an interview on 1/29/2025 at 2:45 PM, Infection Preventionist Nurse (IPN) stated the foley bag should always be below the level of the bladder and if it needs to be moved, the catheter should be clamped to prevent the back flow of urine. IPN also stated it is a potential for Resident 15 to develop UTI. During a review of the facility's Policy and Procedure (P&P) titled, Urinary Catheter Care, revised 8/2022, the P&P indicated to position the drainage bag lower than the bladder at all times to prevent urine from flowing back into the urinary bladder.

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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** 42223 Based on observation, interview and record review, the facility failed to provide the necessary respiratory care services for three (3) of 3 sampled residents (Resident 15, Resident 71, and Resident 73) by failing to ensure: 1. Resident 15's nasal cannula (NC - a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) was in the resident's nostrils while receiving oxygen. 2. To follow Resident 71's physician orders for oxygen use. This deficient practice placed Resident 15 and Resident 71 at risk for experiencing complications such as respiratory distress (a condition that occurs when the body needs more oxygen, resulting in difficulty breathing, rapid breathing, and low blood oxygen level) that can lead to serious illness and/or death. 3. Resident 73's nasal cannula (NC, device used to deliver supplemental oxygen placed directly on a resident's nostril) tubing was changed weekly. This deficient practice had the potential for the residents to develop a respiratory infection, cause complications, associated with oxygen therapy, and result in the spread of diseases and infection. Findings: 1. During a review of Resident 15 Admission Record, the Admission Record indicated resident was originally admitted on [DATE] and was readmitted on [DATE] with the following diagnoses of muscle wasting and atrophy and fracture of second lumbar vertebra (point of the spinal cord [bundle of nerves and tissues]). During a review of Resident 15's Physician Orders, dated 12/9/2024, the Physician's Orders indicated Oxygen 2 liters (l - unit of measure)/minute via NC continuously every shift. During a review of Resident 15 Minimum Data Set (MDS - a resident assessment tool), dated 12/12/2024, the MDS indicated resident was moderately impaired with cognitive (the ability to understand and make decisions) skills for daily decision making. The MDS also indicated Resident 15 was dependent (Helper does all of the effort. Resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity) with oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene. The MDS also indicated Resident 15was on oxygen therapy. During a review of Resident 15's Care Plan with focus on Oxygen continuously as ordered, dated 12/14/2024, the Care Plan indicated O2 at 2 l/minute via nasal cannula continuously as ordered. During an observation in Resident 15's room on 1/27/2024 at 12:01 PM, Resident 15 was observed not having the NC in her nostrils. (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 concurrent observation and interview on 1/27/2025 at 12:05 PM, Registered Nurse 1 (RN 1) was observed fixing Resident 15's NC and stated the nasal prongs should be in the nose so the resident can get the oxygen as ordered. During an interview on 1/29/2025 at 11:37 AM, the Director of Nursing (DON) stated the nasal cannula should be placed in the nostrils of the resident so the resident can get the oxygen as ordered. 2. During a review of Resident 71's Admission Record, the Admission Record indicated resident was admitted on [DATE] with the following diagnoses of pneumonia (an infection/inflammation in the lungs) and hemiplegia (loss of muscle function that affects one side of the body). During a review of Resident 71's MDS, dated [DATE], the MDS indicated resident was severely impaired with cognitive skills for daily decision making. The MDS also indicated Resident 71 was dependent in toileting hygiene, lower body dressing, and putting on/taking off footwear. Resident 71 also required substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with shower/bath self and upper body dressing. During an observation and interview on 1/29/2025 at 11:43 AM, Resident 71 oxygen was noted at seven (7) l/minute. The DON stated Resident 71's oxygen orders should not have been at seven (7) liters/ minute. The DON also stated Resident 71's physician orders were not followed. During an interview on 1/30/2025, at 9:06 AM, Registered Nurse 1 (RN 1) stated the oxygen administration was not but should follow the physician's orders. During a review of the facility's Policy and Procedure (P&P), revised 10/2010, the P&P indicated to review the physician's order for oxygen administration. The P&P also indicated the nasal cannula is a tube that is placed approximately one-half inch into the resident's nose. It is held in place by an elastic band placed around the resident's head. 44018 3. During a review of Resident 73's Admission Record, the admission record indicated Resident 73 was admitted to the facility on [DATE], with diagnoses of hypotension (low blood pressure) and Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movement, chiefly affecting middle-aged and elderly people). During a review of Resident 73's MDS, dated [DATE], the record indicated Resident 73's cognitive skills for daily decision making were moderate impaired. The MDS indicated Resident 73 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) for toileting hygiene, shower/bathe self, lower body dressing, sit to lying, and sit to stand. The MDS indicated Resident 73 was on oxygen therapy. During a review of Resident 73's Physician's Order Summary Report, dated 2/3/2025, the record indicated oxygen administration 2 l/minute via NC PRN (as needed) to maintain oxygen saturation (SpO2, amount of oxygen in the blood or how well a resident is breathing) at 92 %. (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 concurrent observation and interview on 1/27/2025 at 8:27 AM in Resident 73's room with Certified Nursing Assistant 2 (CNA2), CNA 2 stated the oxygen tubing was labeled on 12/24/2024 and was not placed in the plastic bag to protect it from dust. CNA 2 stated she would notify charge nurse to change it. During a concurrent observation and interview on 1/27/2025 at 4:15 PM in Resident 73's room with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated the oxygen tubing was labeled on 12/24/2024. LVN 1 stated the label indicated that the tubing was last changed on 12/24/2024 (tubing used 37 days). LVN 1 stated staff were supposed to change the oxygen tubing every Tuesday (7 days). LVN stated Resident 73 might inhale some particles in the oxygen tubing which could irritate Resident 73's airway and lead to respiratory infection. During an interview on 1/30/2024 at 10:12 AM with the Director of Nursing (DON), the DON stated oxygen tubing used to deliver oxygen should be changed weekly. The DON added oxygen tubing should be stored in a plastic bag at the resident's bedside to protect the equipment from dust and dirt when not in use. During a review of the facility's P&P titled, Oxygen Administration, revised dated October 2010, the P&P indicated that the facility was to provide guidelines for safe oxygen administration and changed oxygen tubing weekly.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 49537 Based on observation, interview and record review, the facility failed to administer Metformin hydrochloride (medication used to treat high blood sugar levels that are caused by DM type 2 [a disorder characterized by difficulty in blood sugar control and wound healing]) within one hour of the prescribed time in accordance with the physician's order for one (Resident 23) of three (3) sampled residents. This deficient practice had the potential to result in ineffectively managing Resident 23's medical condition, which could result to harm, hospitalization , and death. Findings: During a review of Resident 23's Admission Record, the Admission Record indicated Resident 23 was admitted by the facility on 2/3/2024 with diagnoses that included but not limited to DM, cerebral infarction (a medical condition where blood flow to the brain is interrupted, leading to damage or death of brain tissue), dysphagia (difficulty swallowing), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body). During a review of Resident 23's Minimum Data Set (MDS-a resident assessment tool), dated 11/12/2024, the MDS indicated Resident 23 had moderate cognitive impairment for daily decision making. The MDS indicated Resident 23 required set up or clean up assistance (Helper sets up or cleans up; resident completes activity, helper assists only prior to or following the activity) with eating. The MDS indicated Resident 23 required partial/moderate assistance (Helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs) with personal hygiene. The MDS also indicated Resident 23 required substantial/maximal assistance (Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with oral hygiene and was dependent (Helper does all the effort, resident does none of the effort to complete the activity. Or the assistance of two or more helpers is required for the resident to complete the activity) with toileting hygiene, shower/bathing self, upper and lower body dressing, and putting on/taking off footwear. During a review of Resident 23's Order Summary, the Order Summary indicated Metformin hydrochloride 500 milligrams (mg-a unit of measurement of mass in the metric system equal to a thousandth of a gram) one tablet to be given by mouth twice a day for DM with meals. During a concurrent observation and interview on 1/29/2025 at 9:06 AM, outside Resident 23's room, Licensed Vocational Nurse 1 (LVN 1) was observed preparing all medications for Resident 23 and administering them. LVN 1 stated she gave the Metformin hydrochloride late. LVN 1 stated it should have been given at 7:15 AM with meals. LVN 1 stated she forgot that the order for Metformin hydrochloride was with meals. LVN 1 stated it was not acceptable and she did not follow the physician order which could cause Resident 23's blood sugar to go up or down if given late. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 1/30/2025 at 9:20 AM with Registered Nurse 1 (RN 1), the facility's Policy and Procedure (P&P) titled, Administering Medications, dated October 2024, was reviewed. RN 1 stated the P&P indicated medications are administered within one hour of the prescribed time and medication time can be specified as before or after meals. RN 1 stated it was important to given medications on time, especially metformin as it can cause hypoglycemia (blood sugar level drops too low) or hyperglycemia (blood sugar level is higher than normal) and to give with meals as ordered to prevent stomach upset. RN 1 stated, if medications were not given on time, it can cause harm to the residents, especially DM medications. Residents could experience an emergency and transferred to the hospital. During a review of the Medication Administration Audit Report, the Medication Administration Audit Report indicated metformin was scheduled to be given at 7:15 AM and metformin was documented as given at 9:22 AM. During a review of the facility's P&P titled, Administering Medications, reviewed October 2024, the P&P indicated: 1. Medications are administered in a safe and timely manner, and as prescribed. 2. Medications are administered in accordance with prescriber orders, including any required time frame. 3. Medications are administered within one hour of their prescribed time. Medications can be given one hour before or one hour after. 4. Medication time can be specified for example, before and after meal orders.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. 51192 Based on observation, interview, and record review, the facility failed to ensure laboratory orders were done for one of 18 sampled residents (Resident 14). This failure had the potential to result in Resident 14's delayed treatment and increased risk of complications, such as another heart attacks or strokes if high cholesterol remains undetected. Findings: During a review of Resident 14's Admission Record, the Admission Record indicated Resident 14 was admitted on dated 11/15/2024. Resident 14's diagnoses included hypertensive heart disease (HHD - a condition that occurs when the heart is damaged by long-term high blood pressure) without heart failure, and hyperlipidemia (a medical condition characterized by elevated levels of fats in the bloodstream). During a review of Resident 14's physician's orders, dated 11/15/2024, the physician orders indicated pravastatin sodium (a drug to lower the amount of cholesterol in the blood and to prevent stroke and heart attack) 40 milligrams (mg - a unit of measurement) one tablet at bedtime. During a review of Resident 14's Consultant Pharmacist's Note to Attending Physician, dated 12/24/2024, the report indicated a recommendation to obtain Resident 14's lipid panel (a blood test that measures the levels of various fts in the bloodstream) and liver panel (a group of blood tests that assess the health and function of the liver) tests and every six (6) months thereafter regarding Resident 14 taking pravastatin sodium. During a review of Resident 14's Consultant Pharmacists Monthly Regimen Review (MRR) from 1/1/2025 to 1/8/2025, the report indicated Resident 14's lipid and liver panel were requested on 12/24/2024. During a review of Resident 14's physician's orders, dated 12/2024 to 1/2025, the physician's orders did not indicate Resident 14 had laboratory orders for a lipid and liver panel. During an interview on 01/29/2025 at 9:10 AM with Registered Nurse 1 (RN 1) RN 1 stated, RN supervisors verify orders from the physician after signing the Consultant Pharmacist's Note to Attending Physician and enters in the electronic medical records. The orders are confirmed through a confirmation number, and laboratory services are provided the next day. RN 1 confirmed that the lipid and liver panel tests were not carried out and were not done.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42223 Based on observation, interview, and record review, the facility failed to ensure food that accommodated resident's preference was provided for one of 18 sampled residents (Resident 9). This deficient practice had the potential for resident's poor meal intake which could lead to weight loss. Findings: During a review of Resident 9's Admission Record, the Admission Record indicated resident was admitted on [DATE] with the following diagnoses of dysphagia (difficulty swallowing) and dementia (a progressive state of decline in mental abilities). During a review of Resident 9's Physician Orders, dated 11/25/2024, the Physician Orders indicated low sodium, low fat and low cholesterol diet dysphagia pureed (a smooth, creamy substance made of liquidized food) meat and vegetables with lunch and dinner with thin liquids (liquid that is thin and easy to pour such as water), no cold drinks, no beef and no milk. During a review of Resident 9's Care Plan with focus indicating family brings food from outside, dated 1/2025, the Care Plan indicated staff intervention included was to respect resident's choice. During a review of Resident 9's Minimum Data Set (MDS - a resident assessment tool), dated 1/3/2025, the MDS indicated resident was severely impaired with cognitive (the ability to understand and make decisions) skills for daily decision making. The MDS also indicated Resident 9 was dependent (Helper does all of the effort. Resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity) with eating, oral hygiene, toileting hygiene, shower/bathe self, lower body dressing and putting on/taking off footwear. The MDS indicated Resident 9 was on a therapeutic diet (low salt, diabetic, low cholesterol) and on a mechanically altered diet (require change in texture of food or liquids (pureed food, thickened liquids). During an observation and interview on 1/28/2025 at 9:47 AM, Resident 9's Responsible Party (RP) stated the food is on the thicker side making it difficult for Resident 9 to eat. RP also stated her mother would gag because the food was too thick and gooey. RP was observed putting liquid in the pureed food making it less thick. RP also stated that she told Dietary Supervisor (DS) about the food being too thick and making it difficult for Resident 9 to eat. During an observation on 1/29/2025 at 11:45 AM, a test tray of a pureed diet with white rice, meat, bread and cheesecake was provided. The pureed diet was noted to be thick. During an interview on 1/30/2025 at 10:20 AM, DS stated RP informed him about the pureed food being too thick a few months ago (DS does not remember the exact date). DS also stated he did not but should have followed up with RP addressing the pureed diet being too thick. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's Policy and Procedure (P&P) titled, Quality and Palatability, revised 2/2023, the P&P indicated food will be palatable, attractive, and served at a safe and appetizing temperature.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49537 Based on observation, interview and record review, the facility failed to ensure meal trays were served timely for two (2) of 2 sampled residents (Residents 287 and 38) when Resident 287 and Resident 38 were served lunch at 12:45 PM and 12:47 PM respectively. This deficient practice resulted in residents receiving meals late and had the potential to negatively affect the psychosocial wellbeing of the residents. Findings: 1. During a review of Resident 287's Admission Record, the Admission Record indicated the facility admitted Resident 287 on 1/8/2025 with diagnoses that included but not limited to colon cancer (cancerous tumor that develops in the colon), presence of gastrostomy (surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) and colostomy (a surgical procedure that creates an opening in the abdomen to divert stool away from the colon or rectum. This opening, called a stoma, is where a bag is placed to collect waste). During a review of Resident 287's Minimum Data Set (MDS-a resident assessment tool), dated 1/17/2025, the MDS indicated Resident 287 had intact cognitive skills for daily decision making. The MDS indicated Resident 287 required set up or clean up assistance (Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity) with eating. The MDS also indicated Resident 287 required partial/moderate assistance (Helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with oral and personal hygiene, shower/bathe self, upper and lower body dressing and putting on/taking off footwear. The MDS further indicated Resident 287 required substantial/maximal assistance (Helper does more than half the effort. Helper lifts or holds trunk or limbs and provide more than half the effort) with toileting hygiene. During an observation on 1/27/2025 at 12:09 PM, in Resident 287's room, resident was observed asleep and no lunch tray on the table. During a concurrent observation and interview on 1/27/2025 at 12:30 PM in Resident 287's room, resident was observed awake. Resident 287 stated she was hungry and thought the staff had forgotten to bring her lunch tray. During an observation on 1/27/2025 at 12:45 PM, in Resident 287's room, lunch tray was on the resident's table and resident was preparing to eat. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During a review of Resident 38's Admission Record, the Admission Record indicated the facility admitted Resident 38 on 4/26/2021 with diagnoses that included but not limited to cellulitis (bacterial skin infection) of left lower leg, type II type 2 diabetes mellitus (a medication condition characterized by the body's inability to regulate blood sugar level), and major depression (a common and serious medical illness that negatively affects how the person feels, the way they think and how they act). During a review of Resident 38's MDS, dated [DATE], the MDS indicated Resident 38 had intact cognitive skills for daily decision making. The MDS indicated Resident 38 required set up or clean up assistance with eating. The MDS also indicated Resident 38 required partial/moderate assistance with oral, toileting, and personal hygiene. During an observation on 1/27/2025 at 12:23 PM, in Resident 38's room, resident 38 was observed sitting on wheelchair in front of bedside table. no lunch tray on the bedside table. During a concurrent observation and interview on 1/27/2025 at 12:42 PM at Resident 38's room, Resident 38 stated she was hungry. Resident 38 stated she did not know why Certified Nursing Assistant (CNA) (unidentified) brought a lunch tray to her roommate (who was not in the room) while Resident 38 was waiting for her lunch tray and did not receive one. During a concurrent observation on 1/27/2025 at 12:47 PM, in Resident 38's room, lunch tray was on the resident's bedside table. CNA 5 was observed setting up and resident was preparing to eat. CNA 5 stated lunch was supposed to be served at 12:15 PM - 12:30 PM. CNA 5 stated Resident 38 received her lunch tray at 12:45 PM. CNA 5 stated she was busy with other residents in the dining room. During an interview on 1/30/2025 at 1:48 PM with Dietary Supervisor (DTS), the DTS stated the trays were delivered late. The DTS stated it was not acceptable that the trays were served late as residents could get hungry, upset and affect their well-being. During a review of the facility's Meal Time schedule, the Meal Time schedule indicated lunch was at 12 noon. During a review of the facility's Policy and Procedure (P&P) titled, Frequency of Meals, revised 10/2022, the P&P indicated: 1. The Dining Service Director coordinates with the residents, administrator and/or Director of Nursing Services to establish the meal and snack times that are comparable with the normal times in the community. 2. A schedule of meal service times will be provided to the nursing staff and available in the resident/patient care areas. 3. The Dining Services Director will ensure that each meal is served within the designated time frames unless there is an emergency situation or a resident request.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45456 Based on observation, interview, and record review, the facility failed to follow proper food handling practices in accordance with its policy and procedure by failing to: 1. Label food in the preparation area, refrigerators, and freezers in the kitchen with item name, and date opened. 2. Ensure kitchen equipment and kitchen surfaces were clean and free of food debris. 3. Ensure trash bins were not placed next to the clean serving trays. 4. Ensure dietary staff (Cook 1 and [NAME] 2) perform hand hygiene (is the act of cleaning the hands with soap or handwash and water to remove viruses/bacteria/microorganisms, dirt, grease, or other harmful and unwanted substances stuck to the hands) and change gloves during cooking and tray line assembly. These deficient practices had the potential to result in pathogen (germ) exposure to residents, which could place the residents at risk for developing foodborne illness ([food poisoning] with symptoms including upset stomach, stomach cramps, nausea, vomiting, diarrhea, and fever) and can lead to other serious medical complications and hospitalization . Findings: During the initial observation in the kitchen and interview with Dietary Supervisor (DTS) on 1/27/2025 at 7:57 AM, three (3) large food containers were observed outside the dry storage room with two (2) empty boxes and 2 food trays were left on the top of the containers. DTS stated, The food containers did not have any labels. They were supposed to have labels. I do not know what happened. DTS added the labels were to let the kitchen staff know when the food came in and how long has it been since food items were received. During a concurrent observation in food preparation area and interview with DTS on 1/27/2025 at 7:58 AM, the following were observed: a) food preparation area had food debris, scotch tape holder and dirty rag left on top of the surface of the food preparation table. b) Two empty boxes, food trays, green bucket, labeler machine, plastic food wrapper, 2 stainless tray, multiple food containers and lids were left on top of the chest freezer. c) One container of peanut butter had peanut butter all over the lid. d) One opened water bottle left on the shelf of the food assembly counter. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	DTS stated, The peanut butter container was dirty, and we should not leave opened water bottles on the shelf. We should keep the containers and all the surfaces clean to prevent food contamination. During a concurrent observation in the walk-in freezer and interview with DTS on 1/27/2025 at 8:01 AM, the following were observed: a) One bag of noodles without a label. b) One used/dirty dessert tray was left on top of the boxes. c) One opened pack of hotdogs inside a steel container did not have a label indicating date opened. d) Four big boxes of ice cream cups did not have a label indicating date opened. DTS stated, The tray should not be left on top of another food item. If there was no label or date opened on the items, we should throw it away because the residents might get sick. During a concurrent observation in food preparation area and interview with DTS on 1/27/2025 8:14 AM, the following were observed: a) Three containers of condiments containing ginger powder, seasoned salt and ground allspice had no date opened. b) one bag of opened burger buns was left on top of the counter and did not have a label to indicate opened date. DTS stated, We should have placed a label to indicare date opened on the container of the condiments when we started using it. We need to toss the burger buns because we do not know when it was opened. During a concurrent observation of Fridge 2 and interview with DTS on, 1/29/2025 at 8:18 AM, four bowls with AS written on the lids were not labeled with the date when they were prepared. DTS stated, Those were apple sauce. We just put AS as the initials, and we do not usually put a date on them because we make it every day and we just give it to the nurses. During an observation in the drying area and interview with DTS on 1/29/2025 at 10:30 AM, Two trash containers were placed next to the drying rack of the clean serving trays. DTS stated, Trash bins should be placed further away from the clean tray racks to prevent contamination of the equipment used for food preparation. During a concurrent observation of Fridge 1 and interview with DTS on 1/29/2025 at 10:44 AM, the following were observed. a) Two opened bottles of smart water b) One bag of sandwich meats without an opened date label (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During concurrent observation and interview with [NAME] 1 on 1/29/2025 at 10:48 AM, the stove surfaces have food debris. A ladle was placed on the stove surface. [NAME] 1 stated, We should not have left the ladle there. We need to wipe the stove, counters and kitchen surfaces to prevent bacteria because it will make the residents sick. During concurrent observation and interview with DTS on 1/29/2025 at 10:50AM, the bread toaster was observed with breadcrumbs all over the equipment. DTS stated, The bottom tray of the toaster has breadcrumbs because we just used it for breakfast preparation this morning. We need to clean it to avoid food contamination. During a concurrent observation of Fridge 2 and interview with Dietary Aide 2 (DA 2) on 1/29/2025 at 11AM, the bottom shelf of Fridge 2 has food debris. DA 2 stated, Fridge 2 was not clean, there were food particles at the bottom shelf of the fridge. We need to clean the fridge once a day to prevent food contamination. During observation of the tray line assembly on 1/29/2025 at 12:02PM, [NAME] 1 put on a new set of disposable gloves without performing hand washing after removing the mitten that was used to grab the stainless tray from the oven during food assembly. During observation of the tray line assembly on 1/29/2025 at 12:05PM, [NAME] 1 was observed assembling trays then walked to Fridge 1 to grab a stainless container with tofu. [NAME] 1 observed pouring the tofu inside the cooking pan and added tomato sauce using the same gloves. During observation of the tray line assembly on 1/29/2025 at 12:08 PM, [NAME] 1 touched the pan with his bare hands and put on new set of gloves without performing handwashing and proceeded to continue the tray assembly. During a concurrent observation of the tray line assembly and interview with [NAME] 2 on 1/29/2025 at 12:20 PM, [NAME] 2 warmed up a pan with tortilla on the stove then went to Fridge 1 to get a bag of cheese while using the same gloves. [NAME] 2 stated, We perform handwashing and replace new gloves every time we grab different stuff or do different task. During a concurrent observation of the tray line assembly and interview with [NAME] 1 on 1/29/2025 at 12:25 PM, [NAME] 1 grabbed a stainless container in the oven using a mitten while wearing disposable gloves. [NAME] 1 stated, We performed handwashing to prevent spread of bacteria and prevent food contamination. During a concurrent observation and interview with DA 3 on 1/29/2025 at 12:34PM, two trash bins were placed too close to the drying rack where the clean trays were placed. DA 3 stated, The trash bins should not be too close to the clean trays, or they might get dirty. During a concurrent record review of the monthly cleaning log of the ice machine and interview with DTS on 1/30/2025 at 1:48 PM, DTS stated the facility only have a monthly cleaning log for the ice machine. DTS stated, We do not have weekly cleaning log for the ice machine. We do not have any proof that the kitchen staff cleaned the ice machine weekly. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent record review of the ice machine policy on 1/30/2025 at 1:50 PM, policy indicated the exterior of the ice machine will be cleaned weekly. DTS stated, There was no weekly log for the kitchen staff, so it means we are not following the policy for the ice machine. During a concurrent record review of the undated weekly kitchen cleaning schedule and interview with the Dietary Manager (DTM) on 1/30/2025 at 2:15 PM, DTM provided a weekly cleaning schedule task for the kitchen including the kitchen equipment. The weekly cleaning schedule has no date and month, name and signature of the kitchen staff and which task was completed. DTM stated, This schedule was enough for us that kitchen staff was cleaning the ice machine in the kitchen. During a review of the facility's policy and procedure (P&P) titled, Ice revised on 10/2022, the policy indicated the exterior of the ice machine will be cleaned weekly. Ice bins will be cleaned monthly and as needed. During a review of the facility's P&P titled, Food Storage: Cold Foods revised on 2/2023, the policy indicated all foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination. During a review of the facility's P&P titled, Food Storage: Dry Goods revised on 2/2023, the policy indicated storage areas will be neat, arranged for easy identification, and date marked as appropriate. During a review of the facility's P&P titled, Food: Preparation revised on 2/2023, the P&P indicated: 1. All staff will practice proper hand washing techniques and glove use. 2. Dining Services staff will be responsible for food preparation procedures that avoid contamination by potentially harmful physical, biological, and chemical contamination. 3. All utensils, food contact equipment and all food contact surfaces will be cleaned and sanitized after every use.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055203	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunny Village Care Center	1428 S. Marengo Ave. Alhambra, CA 91803

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 51192 Based on observation, interview, and record review, the facility failed to ensure that the nurses were documenting the complete orthostatic blood pressure (the measurement of blood pressure when a person stands up from a sitting or lying position) for the lying position for one of 18 sampled residents (Resident 14). This failure had the potential to result in Resident 14's orthostatic BP lying a risk for fall incident from hypotension (a medical condition characterized by abnormally low blood pressure) or from dizziness. Findings: During a review of Resident 14's Admission Record, the Admission Record indicated Resident 14 was admitted on dated 11/15/2024. Resident 14's diagnoses included dementia (a general term for a group of brain disorders that cause a gradual decline in cognitive abilities, such as memory, thinking, reasoning, and judgment), psychotic disturbance (also known as psychosis [mental health condition characterized by a loss of contact with reality]), and mood disturbance. During a review of Resident 14's physician order, dated 11/15/2024, the physician order indicated Seroquel 25 (an antipsychotic medication) milligrams (mg - a unit of measurement) to be administered twice a day for psychosis manifested by striking out without any reason and hitting with fist during care pinching episodes. During a review of Resident 14's physician's orders, dated 11/15/2024, the physician order indicated to monitor Resident 14's blood pressure (BP), sitting and lying, every Sunday while on Seroquel. During a review of Resident 14's Minimum Data Set (MDS - a resident assessment tool), dated 11/19/2024, the MDS indicated Resident 14 is with severe impairment of cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. During a review of Resident 14's Medication Administration Record (MAR), dated 12/2024 to 1/2025, the MAR indicated Resident 14's BP in the lying position: Date: BP: 12/1/2024 - Not applicable (N/A). 12/8/2024 - 83. 12/15/2024 - N/A. 12/29/2024 - N/A. 1/5/2025 - N/A. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/12/2025 -146. 1/19/2025 -155. 1/26/2025 - N/A. During an interview on 1/29/2025 at 11:04 AM with Registered Nurse 1 (RN 1) RN 1 stated, the facility's process is to follow the physician's order and document the resident's BP. If the nurses are unable to do it, they must document a reason in the progress notes. The potential outcome for not checking Resident 14's orthostatic BP will contribute to Resident 14 risk for fall and injury. During an interview on 1/30/2025 at 10:06 AM with Licensed Vocational Nurse 3 (LVN 3), LVN 3 stated, the LVNs document the BP in the resident's medical record. If unable to do it, they must document in the progress note so the physician could modify the dose of the medication. The potential outcome for not checking Resident 14's orthostatic BP will put Resident 14 at risk for fall. During a review of the facility's policy and procedure (P&P) titled, Antipsychotic Medication Use, last revised on 7/2022, the P&P indicated, nursing staff will observe, document, and report to the resident's attending physician information regarding the effectiveness of any interventions, monitoring, and reporting adverse effects/side effects of antipsychotic medications.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42223 Based on observation, interview, and record review, the facility failed to ensure facility staff doff (take off) Personal Protective Equipment (PPE; protective clothing, goggles, or other garments to prevent or minimize exposure to and spread of infection or illness) and perform hand hygiene (cleaning hands to prevent germs) after providing peri-care (cleaning the genitals and anal area) for one of 18 sampled residents (Resident 15), in accordance with the policy. This deficient practice has the potential to spread infection to staff and residents. Findings: During a review of Resident 15's Admission Record, the Admission Record indicated resident was originally admitted on [DATE] and was readmitted on [DATE] with the following diagnoses of muscle wasting and atrophy and fracture of second lumbar vertebra (point of the spinal cord [bundle of nerves and tissues]). During a review of Resident 15 Minimum Data Set (MDS - a resident assessment tool), dated 12/12/2024, the MDS indicated resident was moderately impaired with cognitive (the ability to understand and make decisions) skills for daily decision making. The MDS also indicated Resident 15 was dependent (Helper does all of the effort. Resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity) with oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene. The MDS indicated Resident 15 had an indwelling catheter (a flexible tube used to empty the bladder and collect urine in a drainage bag). During an observation on 1/29/2025 at 1:45 PM, Certified Nursing Assistant 2 (CNA 2) was observed providing peri-care to Resident 15. CNA 2 was also observed not changing the gloves and not performing hand hygiene after providing peri-care for the resident. CNA2 was observed using the same gloves CNA 2 touched Resident 15's clean bed pad and bed sheets while changing the bed pad and fixing the bed sheets. During an interview on 1/29/25 at 2 PM, CNA 2 stated she should have removed her gloves, performed hand hygiene and changed gloves prior to touching Resident 15's bed pad and bed sheets to prevent the spread of infection. During an interview on 1/29/2025 at 2:45 PM, Infection Preventionist Nurse (IPN) stated CNA 2 should have removed her gloves, perform hand hygiene and put on new gloves. IPN also stated CNA 2 should not have touched the bed pad and the bed sheets after providing peri-care to a resident because it can spread infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's Policy and Procedure (P&P) titled, Handwashing/Hand Hygiene, revised 8/2019, the P&P indicated to perform hand hygiene after contact with blood or bodily fluids, and before moving from a contaminated body site to a clean body site during resident care. The P&P also indicated the use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 45456 Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary and comfortable environment by failing to ensure there was no water leak in the kitchen ceiling from 1/26/2025 to 1/27/2025. This deficient practice had the potential to result in unsafe and non-functional kitchen. Findings: During an initial observation in the kitchen on 1/27/2025 at 7:48 AM, there were moderate amount of water on the floor near the dishwashing area. There was a wet/dry vacuum (a specialized piece of cleaning equipment designed to handle both wet and dry debris pickup) in the middle of the area and suctioning water from the floor. There were rolled bed sheets placed on the floor surrounding the puddle of water t. During a concurrent observation in the kitchen and interview with Dietary Supervisor (DTS) on 1/27/2025 at 8:23 AM, DTS stated, there is a puddle of water on the floor near the dishwashing area and it is coming form the leak from the ceiling. During an interview with Maintenance Supervisor (MTS) on 1/27/2025 at 12:41 PM, MTS stated, the metal duct for the ventilation in between the roof and the ceiling has a hole at the bottom. The metal duct has collected water from the rain last night, and it was the source of the water leak from the ceiling. During an interview with the DTS on 1/29/2025 at 11:10 AM, DTS stated, the water leak was reported by my staff on Sunday (1/26/2025) night. I do not think the maintenance staff checked the building last Friday (1/24/2025). We usually do not know if maintenance made rounds. It is not okay to have water leaks because if that happens, we cannot use the kitchen. During an interview with Maintenance Assistant (MTA) on 1/30/2025 at 10:28 AM, MTA stated, I was informed by the MTS about the water leak in the kitchen ceiling, Monday morning. There was leaking water coming down from the ceiling when I inspected the kitchen last Monday around 8AM. During an interview with MTA on, 1/30/2025 at 10:30 AM, MTA stated, Food contamination is possible in the kitchen from the water leak. If that happens, there will be no food for the residents. During an interview with MTS on 1/30/2025 at 10:54 AM, MTS stated, if it rained really hard and the ceiling has water leaking, the kitchen might get flooded, and the facility would not be able to use the kitchen and therefore no food will be served for the residents. During a review of the facility's policy and procedure titled, Maintenance Service, revised 12/2009, indicated the maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. Functions of maintenance personnel include but are not limited to maintaining the building in good repair and free from hazards.