STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055253	A. Building B. Wing	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St. John of God Retirement	2468 South St Andrews Place Los Angeles, CA 90018

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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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46144 Based on observation, interview, and record review, the facility failed to ensure one out of eight sampled Residents (Resident 47) was properly dressed daily. This deficient practice of not dressing Resident 47 daily had the potential of leaving Resident 47 feeling low self-worth and low self-esteem. Findings: During a review of Resident 47's Admission Record (Face Sheet), the Face Sheet indicated Resident 47 initially admitted to the facility on [DATE] and last readmitted on [DATE]. Resident 47's diagnoses included gastrostomy ([G-tube] a surgical opening in the stomach for nutrition, hydration, and medication), epilepsy(a chronic brain disorder that causes a person to have two or more unprovoked [seizures]-uncontrolled, abnormal electrical activity of the brain that may cause changes in the level of consciousness, behavior, memory or feelings), chronic kidney disease (a long-term condition where the kidneys are damaged and can't filter blood properly), and benign prostatic hyperplasia (BPH - non-cancerous condition that occurs when the prostate gland. During a review of Resident 47's History and Physical (H&P), dated 3/16/2024, the H&P indicated Resident 47 did not have the capacity to understand and make decisions. During a review of Resident 47's Minimum Data Set ([MDS] a federally mandated assessment tool), dated 8/28/2024 the MDS indicated, Resident 47's cognition (ability to learn, reason, remember, understand, and make decisions) was severely impaired. The MDS indicated Resident 47 was dependent on staff for personal hygiene, showering, and dressing. The MDS indicated it was Resident 47's preference to choose what clothes to wear. During a review of Resident 47's care plan titled, ADL (routine tasks/activities such as bathing, dressing, and toileting a person performs daily to care for themselves) Functional Impaired ADL Skill related to dressing ., dated 1/4/2022, the care plan indicated Resident 47's ADL needs will be met safely every day. The staff interventions indicated Resident 47 was to select what clothes to wear, provide simple choices, assist with decisions as needed, ensure clothing is available is clean, age appropriate, and in good repair. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observations on 10/1/2024 at 10:30 a.m., 12:30 p.m., 2:30 p.m. and 4:30 p.m., in Resident 47's room, Resident 47 was observed lying in bed wearing a hospital gown. During observations on 10/2/2024 at 8:00 a.m., 10:30 a.m., 12:30 p.m., 2:30 p.m. and 4:30 p.m., in Resident 47's room, Resident 47 was observed lying in bed wearing a hospital gown. During observations on 10/3/2024 at 8:00 a.m., 10:30 a.m., 12:30 p.m., 2:30 p.m., in Resident 47's room, Resident 47 was observed lying in bed wearing a hospital gown. During a concurrent observation and interview on 10/3/2024 at 11:41 a.m. with Licensed Vocational Nurse (LVN) 6, in Resident 47's room, Resident 47 was observed wearing a hospital gown. LVN 6 stated Resident 47 was bed bound and the only time his clothes were changed was when he was taken out of bed. LVN 6 stated it was important to dress Resident 47 daily it would give him a sense of dignity and respect. During a concurrent observation and interview on 10/3/2024 at 2:03 p.m. with Certified Nursing Assistant (CNA) 5, in Resident 47's room, Resident 47 was observed wearing a hospital gown. CNA 5 stated the residents should be dressed at least by 11:00 a.m. daily. CNA 5 stated when the residents were dressed it would make them feel happy and feel good during the day. During a concurrent observation and interview on 10/3/2024 at 2:40 p.m. with Certified Nursing Assistant (CNA) 6, in Resident 47's room, Resident 46 was observed wearing a hospital gown. CNA 6 stated when she dressed the residents that were not alert, she would match the clothing with the weather. CNA 6 stated Resident 47 should be dressed daily. During an interview on 10/3/2024 at 3:50 p.m. with the Director of Nursing (DON), the DON stated Resident 47 should have his clothes on during the day. The DON stated it would make Resident 47 feel like he was doing something during the day or going somewhere. The DON stated getting dressed daily would give Resident 47 something to look forward to doing daily and would mean a lot to the resident to choose his clothing and participate in his care. The DON stated being dressed could make Resident 47 depressed (a state of unhappiness). The DON stated dressing in clothing would help Resident 47 perk up his day. During a review of the facility's policy and procedure (P&P) titled, Dignity, dated 3/2024, 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. The P&P indicated Residents are treated with dignity and respect at all times. The P&P indicated the facility culture supports dignity and respect for residents by honoring resident goals, choices, and preferences throughout the resident's facility stay. The P&P indicated when assisting with care, residents are supported in exercising their rights to be groomed and to dress in clothing that they prefer.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41379 Based on observation, interview, and record review, the facility failed to ensure the call light (a device with a button that, when pressed, alerts healthcare providers that assistance is required) was within reach for one out of 30 sampled residents (Resident 14). This deficient practice had the potential to result in Resident 14 not being able to call for assistance and a delay in necessary care and services affecting resident's well-being. Findings: During a review of Resident 14's Admission Record , the Admission Record indicated Resident 14 was admitted on [DATE]. Resident 14's diagnoses included displaced (out of alignment) comminuted (broken into more than two pieced) fracture (broken bone) of shaft of the left femur (long portion of thigh bone), cerebral infarction (loss of blood flow to a part of the brain) with hemiplegia (total paralysis [inability to move] of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness or the inability to move on one side of the body), and unspecified dementia (a progressive state of decline in mental abilities). During a review of Resident 14's History and Physical (H&P), dated 12/30/2023, the H&P indicated Resident 14 did not have the capacity to understand and make decisions. During a review of Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 7/1/2024, the MDS indicated Resident 14 was dependent on staff for toileting, eating, dressing, showering, and personal hygiene. During a concurrent observation and interview on 10/1/2024, at 10:03 a.m., with Certified Nursing Assistant (CNA) 7, in Resident 14's room, Resident 14 was observed lying in bed with eyes open. Resident 14's speech was hard to understand. Resident 14's call light was placed on the dresser behind the bed away from Resident 14's reach. CNA 7 stated Resident 14's call light was not within Resident 14's reach and proceeded to bring the call light from the dresser and placed it near Resident 14's right hand. CNA 7 stated it was important to have the call light close to Resident 14 so Resident 14 can call for assistance when needed. During an interview on 10/3/24 at 2:11 p.m., with the Director of Nursing (DON), the DON stated call lights needed to be within residents reach so they could call for help when needed. During a review of the facility's policy and procedure (P&P) titled, Call Light, dated 4/2024, the P&P indicated the purpose of the policy was to assure the facility provides the resident with necessary means of communication with nursing staff by ensuring the call light is within the resident's reach.

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 47923 Based on observation and interview, the facility failed to post the complaint investigation results by California Department of Public Health ([CDPH] state licensing and certification agency) during the three preceding years in the areas of the facility that are prominent and accessible to the residents, family members, and visitors. This deficient practice placed the residents, family members or visitors at risk of not knowing the status of the facility non-compliance outcome results and past performance history. Findings: During a concurrent observation and interview on 10/1/2024 at 2:11 p.m. with the Director of Nursing (DON) at nursing station 2, the DON stated the survey binder hanging on the wall was incomplete and did not include the complaint investigation results by the CDPH and the facility's plan of correction in the past three years. The DON stated the complaint investigation results was placed in a separate binder and kept at her office. The DON stated the complaint investigation results should also be placed in the survey binder and posted in an area accessible to all residents, family members or visitors so they can read and review the findings of the state licensing agency and the plan of correction of the facility. The DON stated it was a violation of resident's rights by not posting the complaint investigation results by state licensing agency. During an interview on 10/1/2024 at 2:34 p.m. with the Administrator (ADM), the ADM stated it was his responsibility to post the survey binder as well as the complaint investigation results by the CDPH. The ADM stated the statement of deficiencies was a conclusion of the investigation and the facility's plan of action on how to address what was identified by the CDPH. During a review of the facility's policy and procedure (P&P) titled, Resident's Rights and [NAME] of Rights Compliance, dated 3/2024, the P&P indicated, To ensure all residents are informed of their rights as individuals in a long-term care setting and their rights are protected in accordance with applicable laws, including the [NAME] of Rights. During a review of the facility's admission packet, titled Attachment F Resident [NAME] of Rights, dated 5/2011, the form indicated A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination in a place readily accessible to residents and must post a notice of their availability.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47923 Based on interview and record review, the facility failed to notify the physician of a significant weight loss (a weight loss greater than 5% in one month, greater than 7.5% in three months and greater than 10% in 6 months) of 18 pounds ([lbs.] unit for measuring weight) 11.8 percent [%] in three months (Resident 24), and failed to notify the physician of a resident's swollen ankles for two of two sampled residents (Resident 24 and Resident 39). This deficient practice had the potential to place Resident 24 at risk for further weight loss, and placed Resident 39 at risk for further complications of ankle swelling. Cross reference F656. Findings: a. During a review of Resident 24's Admission Record, the Admission Record indicated, Resident 24 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity), urinary tract infection ([UTI] an infection in the bladder/urinary tract), and cerebral infarction (loss of blood flow to a part of the brain) with left hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and dysphagia (difficulty of swallowing). During a review of Resident 24's History and Physical (H&P), dated 7/12/2024, the H&P indicated, Resident 24 had the capacity to understand and make decisions. During a review of Resident 24's Minimum Data Set ([MDS] a federally mandated resident assessment tool), dated 9/12/2024, the MDS indicated, Resident 24's cognitive (ability to think and reason) skills for daily decision making was intact. The MDS also indicated Resident 24, needed supervision (helper provides verbal cues) to staff in eating, oral hygiene, and toileting hygiene. During a review of Resident 24's Weights and Vitals Summary from 6/3/2024 to 9/5/2024, the Weights and Vitals Summary indicated the following: 1. On 6/3/2024 - 153 pounds (lbs., unit for measuring weight) 2. On 7/2/204 - 139 lbs. 3. On 8/5/2024 - 138 lbs. 4. On 9/5/2024 - 135 lbs. (18 lbs. [11.8%] weight loss in 3 months) (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 10/3/2024 at 9:58 a.m. with the Director of Nursing (DON), Resident 24's clinical records were reviewed. The DON stated when Resident 24 had a significant weight loss of 18 pounds from 6/3/2024 to 9/5/2024, a Situation, Background, Assessment, Recommendation ([SBAR] a communication tool used by healthcare worker when there is a change of condition among the residents) should have been done. The DON stated there was no documentation indicating the physician was notified of Resident 24's significant weight loss of 18 pounds/11.8% in 3 months. The DON stated it was the licensed nurses responsibility to ensure Resident 24's significant weight loss was communicated to the physician in order to assess his medical condition and implement nutritional interventions to prevent further weight loss. The DON stated it was an oversight on her part by not addressing Resident 24's significant weight loss. The DON stated further weight loss could have negative outcome such as dehydration (a condition that occurs when the body loss too much water and other fluids that it needs to work normally) and sepsis (a life-threatening infection). During a review of the facility's policy and procedure (P&P) titled, Physician Notification, dated 2/2024, the P&P indicated, The nurse supervisor/charge nurse will notify the resident's attending physician or on-call physician when there has been a weight gain or weight loss of five pounds in a month or over a few months. 46144 b. During a review of Resident 39's Admission Record (Face Sheet), the Face Sheet indicated Resident 39 was admitted to the facility on [DATE]. Resident 39's diagnoses included gastrostomy ([G-tube] a surgical opening in the stomach for nutrition, hydration, and medication), Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), and atherosclerotic heart disease (a chronic inflammatory disease that causes plaque buildup in the walls of arteries, narrowing them and restricting blood flow). During a review of Resident 39's History and Physical (H&P), dated 11/20/2023, the H&P indicated Resident 39 did not have the capacity to understand and make decisions. During a review of Resident 39's Minimum Data Set ([MDS] a federally mandated assessment tool), dated 7/8/2024 the MDS indicated, Resident 39's cognition (ability to learn, reason, remember, understand, and make decisions) severely impaired. The MDS indicated Resident 39 required substantial assistance with staff for personal hygiene, showering, and dressing. The MDS indicated Resident 39 was dependent on staff for chair/bed to chair transfer. During an observation on 10/2/2024 at 12:30 p.m., in Resident 39's room, Resident 39 was observed sitting in a wheelchair. Resident 39's ankles and lower legs were swollen and had redness. During a concurrent observation and interview on 10/2/2024 at 3:49 p.m. with Licensed Vocational Nurse (LVN) 5, in Resident 39's room, Resident 39's ankles and legs were observed. LVN 5 stated Resident 39's ankles were not as swollen when he was lying in the bed. LVN 5 stated when Resident 39 was in the wheelchair the resident tended to have swollen ankles and slight redness. LVN 5 stated Resident 39's swollen ankles were a new finding. LVN 5 stated when there was a new finding the physician should be called. LVN 5 stated the physician needed to be notified to prevent any further complications of the swollen ankles. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 10/3/2024 at 3:18 p.m. with Director of Nursing (DON), the DON stated there was no records of Resident 39 having swelling. The DON stated when Resident 39 had swollen ankles with redness the physician should have been notified. The DON stated once the physician was called this allowed the physician to put interventions in place to eliminate the swelling for Resident 39. During a review of the facility's policy and procedure (P&P) titled, Change in Resident's Condition or Status, dated 3/2024, the P&P indicated, Our facility shall notify the resident, his or her attending physician, and responsible party of changes in the resident's medical conditions. The P&P indicated a significant change of condition is a decline or improvement in the resident's status. The P&P indicated swelling or discoloration was a change of condition.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47923 Based on interview and record review, the facility failed to ensure an accurate Minimum Data Set ([MDS] a federally mandated resident assessment tool) was completed accurately for two of 30 sampled residents (Resident 14 and Resident 81) by failing to: 1. Ensure Resident 14's mental illness diagnosis was reflected in the MDS assessment under Section A (Level II Preadmission Screening and Resident Review [PASRR] a tool to determine if the person had or was suspected of having a mental illness or intellectual disability) conditions. 2. Ensure Resident 81's Minimum Data Set [MDS] a federally mandated assessment tool) was updated quarterly. These deficient practices resulted in incorrect data transmitted to Center for Medicare and Medicaid Services (CMS) and had the potential to result inaccurate care and services for Residents 14 and 81. Findings: a. During a review of Resident 14's Admission Record, the Admission Record indicated, Resident 14 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including schizophrenia (a mental illness that can affect thoughts, mood, and behavior) and dementia (a progressive state of decline in mental abilities). During a review of Resident 14's History and Physical (H&P), dated 12/1/2023, the H&P indicated, Resident 14 did not have the capacity to understand and make decisions. During a review of Resident 14's Minimum Data Set ([MDS] a federally mandated resident assessment tool), dated 7/1/2024, the MDS indicated, Resident 14's cognitive (ability to think and reason) skills for daily decision making was severely impaired. During a concurrent interview and record review on 10/4/2024 at 9:53 a.m. with the Minimum Data Set Nurse (MDS Nurse), Resident 14's MDS annual assessment dated [DATE] was reviewed. The MDS nurse stated the MDS annual assessment was completed inaccurately. The MDS nurse stated there was a wrong entry on the MDS section A1510 (Level 11 PASRR Conditions). The MDS nurse stated Resident 14 had a diagnosis of schizophrenia which is considered as a serious mental illness and was not checked in the MDS assessment under section A. The MDS nurse stated accuracy of assessment in the MDS was essential because it involves the condition of resident and for facility reimbursement. 46144 b. During a review of Resident 81's Admission Record (Face Sheet), the Face Sheet indicated Resident 81 was initially admitted to the facility on [DATE] and last readmitted on [DATE]. Resident 81's diagnoses included dementia (a progressive state of decline in mental abilities), chronic obstructive pulmonary disease ([COPD] a chronic lung disease causing difficulty breathing), and anxiety (an excessive persistent feelings of fear and worry). (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 81's History and Physical (H&P), dated 10/10/2023, the H&P indicated Resident 81 did not have the capacity to understand and make decisions. During a review of Resident 81's Minimum Data Set ([MDS] a federally mandated assessment tool), dated 6/14/2024 the MDS indicated, Resident 81's cognition (ability to learn, reason, remember, understand, and make decisions) was severely impaired. The MDS indicated Resident 81 was dependent on staff for personal hygiene, showering, and dressing. During a review of Resident 81's MDS, dated [DATE], the MDS indicated Resident 81's MDS was not updated quarterly. During a concurrent interview and record review on 10/3/2024 at 11:51 a.m. with Minimum Data Set Nurse (MDS Nurse), Resident 81's MDS, dated [DATE] was reviewed. The MDS Nurse stated the MDS should be updated upon admission, quarterly, and annually. The MDS Nurse stated the staff would know what was going on with the resident. The MDS Nurse stated she reviewed the resident's MDS daily to check when they were due. The MDS Nurse stated Resident 81's MDS was late and sometimes she could not complete them on time when other things were happening such as meetings or other documents to update. The MDS Nurse stated it was important to have the MDS up to date to ensure improved care for Resident 81. During a concurrent interview and record review on 10/3/2024 at 3:50 p.m. with the Director of Nursing (DON), Resident 81's MDS, dated [DATE] was reviewed. The DON stated the MDS was a tool and gave a total visual of what was going on with the residents. The DON stated the MDS should be updated quarterly to ensure the staff could continue the residents plan of care. The DON stated the MDS was used to make sure the residents were getting the services needed to check for improvement or decline of the residents. The DON stated if the MDS was not up to date the staff was not able to catch any needed issues to be corrected. During a review of facility's policy and procedure (P&P) titled, Accuracy of Assessment, dated 3/2024, the P&P indicated, Any person completing a portion of the Minimum Data Set/MDS (Resident Assessment Instrument) must sign and certify the accuracy of that portion of the assessment. The P&P indicated a comprehensive assessment of a resident's needs done quarterly. The P&P indicated the purpose of the assessment is to describe the resident's capability to perform daily life functions.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47923 Based on interview and record review, the facility failed to correctly fill out the Preadmission Screening and Resident Review ([PASRR] a tool to determine if the person had, or was suspected of having a mental illness, intellectual disability or related condition) level one screening and refer one of three sampled residents (Resident 14) who had a diagnosis of schizophrenia (a mental illness that can affect thoughts, mood, and behavior) to the appropriate state-designated authority for PASSR level two evaluation and determination. This deficient practice had the potential to result in Resident 14 not receiving appropriate treatment recommendations for schizophrenia. Cross Reference F641. Findings: During a review of Resident 14's Admission Record, the Admission Record indicated, Resident 14 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including schizophrenia (a mental illness that can affect thoughts, mood, and behavior) and dementia (a progressive state of decline in mental abilities). During a review of Resident 14's History and Physical (H&P), dated 12/1/2023, the H&P indicated, Resident 14 did not have the capacity to understand and make decisions. During a review of Resident 14's Minimum Data Set ([MDS] a federally mandated resident assessment tool), dated 7/1/2024, the MDS indicated Resident 14's cognitive (ability to think and reason) skills for daily decision making was severely impaired. The MDS also indicated, Resident 14 was totally dependent (helper does all of the effort) to staff in oral hygiene, toileting hygiene, and personal hygiene. During a concurrent interview and record review on 10/4/2024 at 9:53 a.m. with the MDS nurse, Resident 14's PASRR level 1 Screening completed on 12/1/2023 was reviewed. The PASRR Level 1 Screening indicated, Resident 14 had no serious mental illness diagnosis and not receiving psychotropic medications (any drug that affects brain activities associated with mental processes and behavior) for mental illness. The PASRR Level 1 Screening also indicated, Resident 14's case was closed, and a PASRR Level 11 mental health evaluation and determination was not required. The MDS nurse stated the PASRR level 1 was not completed accurately because Resident 14 had a diagnosis of schizophrenia which is considered as a serious mental illness. The MDS nurse stated the facility should have completed and resubmitted a new PASRR level 1 to indicate the diagnosis of mental illness and should have referred Resident 14 for mental health evaluation to the State PASRR agency to avail treatment recommendation for her schizophrenia. During a review of the facility's policy and procedure (P&P) titled, PASRR, dated 2/2024, the P&P indicated, It is the policy of the facility to complete PASRR upon admission, annually and when significant change in physical or mental condition occurs. The P&P also indicated the new diagnosis of mental disorder from the physician will be written on the telephone order and a new PASRR will be completed to include the newly diagnosed mental health disorder.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49131 Based on interview and record review, the facility failed to develop an individualized person-centered plan of care with measurable objectives, timeframe, and interventions to meet the resident's needs for three out of four sampled residents (Residents 19, 24, and 39) by failing to: 1. Address Resident 19's need for a one to one (1:1, close supervision) sitter. This deficient practice had the potential to result in a lack of meeting necessary care goals and addressing medical needs for Resident 19. 2. Develop a care plan for significant weight loss for Resident 24. This deficient practice had the potential to place Resident 24 at risk for further weight loss related to not having nutritional interventions. 3. Ensure a care plan with interventions for swollen ankles was in place for Resident 39. This deficient practice of not having a care plan with interventions for swollen ankles for Resident 39 had the potential for worsening condition. Findings: 1. During a concurrent observation and interview on 10/2/2024 at 4:20 PM, with Resident 19's 1:1 Sitter (OS 1), OS 1 stated she was Resident 19's sitter due to the resident's history of falls. OS 1 stated her duties included staying close by to ensure Resident 19 did not fall. During a review of Resident 19's Admission Record (Face Sheet), the Admission Record indicated Resident 19 was readmitted to the facility on [DATE]. Resident 19's diagnoses included muscle weakness, lack of coordination, and dementia (a progressive state of decline in mental abilities). During a review of Resident 19's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 8/26/2024, the MDS indicated Resident 19 was not cognitively intact (ability to think and reason). During a concurrent interview and record review on 10/2/2024 at 4:45 p.m. with Licensed Vocational Nurse (LVN) 3, Resident 19's medical chart was reviewed. LVN 3 stated that residents with a sitter needed to have a care plan in place so staff would know if the resident met their goals. LVN 3 stated there was no physician order or a care plan for the use of a sitter after reviewing Resident 19's medical chart. 47923 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During a review of Resident 24's Admission Record, the Admission Record indicated, Resident 24 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity), urinary tract infection ([UTI] an infection in the bladder/urinary tract), and cerebral infarction (loss of blood flow to a part of the brain) with left hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and dysphagia (difficulty of swallowing). During a review of Resident 24's History and Physical (H&P), dated 7/12/2024, the H&P indicated, Resident 24 had the capacity to understand and make decisions. During a review of Resident 24's MDS dated [DATE], the MDS indicated Resident 24's cognitive skills for daily decision making was intact. The MDS also indicated, Resident 24 needed supervision (helper provides verbal cues) to staff in eating, oral hygiene, and toileting hygiene. During a review of Resident 24's Weights and Vitals Summary from 6/3/2024 to 9/5/2024, the Weights and Vitals Summary indicated the following: 1. On 6/3/2024 - 153 pounds (lbs., unit of measurement for weight). 2. On 7/2/204 - 139 lbs. 3. On 8/5/2024 - 138 lbs. 4. On 9/5/2024 - 135 lbs. (18 lbs. [11.8%] weight loss in 3 months) During a concurrent interview and record review on 10/3/2024 at 9:58 a.m. with the Director of Nursing (DON), Resident 24's clinical records were reviewed. The DON stated Resident 24 had a significant weight loss of 18 pounds from 6/3/2024 to 9/5/2024 and the facility did not formulate a care plan to address his significant weight loss. The DON stated the interdisciplinary team ([IDT] a group of healthcare professionals working together to plan the care needed for each residents) were responsible in creating a care plan. The DON stated care planning was a guide for facility staff to follow the interventions that were planned for the resident. The DON stated if there was no care plan then the specific needs of resident would not be met. 46144 3. During a review of Resident 39's Admission Record (Face Sheet), the Face Sheet indicated Resident 39 was admitted to the facility on [DATE]. Resident 39's diagnoses included gastrostomy ([G-tube] a surgical opening in the stomach for nutrition, hydration, and medication), Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), and atherosclerotic heart disease (a chronic inflammatory disease that causes plaque buildup in the walls of arteries, narrowing them and restricting blood flow). During a review of Resident 39's History and Physical (H&P), dated 11/20/2023, the H&P indicated Resident 39 did not have the capacity to understand and make decisions. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 39's MDS, dated [DATE] the MDS indicated, Resident 39's cognition was severely impaired. The MDS indicated Resident 39 required substantial assistance with staff for personal hygiene, showering, and dressing. The MDS indicated Resident 39 was dependent on staff for chair/bed to chair transfer. During an observation on 10/1/2024 at 12:30 p.m., in Resident 39's room, Resident 39 was observed sitting on a wheelchair. Resident 39's ankles and lower legs were swollen and had redness. During an observation on 10/2/2024 at 11:00 a.m., in Resident 39's room, Resident 39 was observed sitting on a wheelchair. Resident 39's ankles and lower legs were swollen and had redness. During an interview on 10/2/2024 at 3:29 p.m. with LVN 5, LVN 5 stated Resident 39 had swollen feet and ankles, and redness. LVN 5 stated a physician order was not needed to develop a care plan. LVN 5 stated a care plan should have been developed to address Resident 39's swollen feet. LVN 5 stated the development of a care plan was important so the nurses would know what was going on with Resident 39. LVN 5 stated developing a care plan would help prevent Resident 39's condition from worsening. During an interview on 10/3/2024 at 3:18 p.m. with the DON, the DON stated once something was identified such as Resident 39's swollen feet and ankles, staff needed to put interventions in place to make sure the resident's swelling was eliminated. The DON stated the swelling could cause discomfort for Resident 39. The DON stated once the interventions were in place, staff should do a follow-up to ensure the plan of care was improving the resident's condition. The DON stated the interventions were to be reviewed and checked if changes were needed to help Resident 39 feel more comfortable. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, dated 3/2024, the P&P indicated, a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The P&P indicated identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident. The P&P indicated the resident's physician is integral to this process.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46144 Based on interview and record review, the facility failed to ensure one out of eight sampled Residents (Resident 47) was taken outside for a garden stroll. This deficient practice of not taking Resident 47 outside for a garden stroll had the potential to negatively affect the resident's mental and emotional well-being. Findings: During a review of Resident 47's Admission Record (Face Sheet), the Face Sheet indicated Resident 47 initially admitted to the facility on [DATE] and last readmitted on [DATE]. Resident 47's diagnoses included gastrostomy ([G-tube] a surgical opening in the stomach for nutrition, hydration, and medication), epilepsy (a chronic brain disorder that causes a person to have two or more unprovoked [seizures]-uncontrolled, abnormal electrical activity of the brain that may cause changes in the level of consciousness, behavior, memory or feelings), chronic kidney disease (a long-term condition where the kidneys are damaged and can't filter blood properly), and benign prostatic hyperplasia (BPH - non-cancerous condition that occurs when the prostate gland. During a review of Resident 47's History and Physical (H&P), dated 3/16/2024, the H&P indicated Resident 47 did not have the capacity to understand and make decisions. During a review of Resident 47's Minimum Data Set ([MDS] a federally mandated assessment tool), dated 8/28/2024 the MDS indicated, Resident 47's cognition (ability to learn, reason, remember, understand, and make decisions) was severely impaired. The MDS indicated Resident 47 was dependent on staff for personal hygiene, showering, and dressing. The MDS indicated it was very important to Resident 47 to go outside to get fresh air when the weather was good. During a review of Resident 47's Activities Review Record dated 8/28/2024, the Activities Review Record indicated Resident 47 preferred activities related to sensory stimulation and garden strolls. During a review of Resident 47's Activity Attendance Record, dated 9/2024, the Activity Attendance Record indicated there no documentation that Resident 47 was taken outside for a stroll through the garden. During an interview on 10/3/2024 at 11:15 a.m. with Activity Assistant (AA) 1, AA 1 stated she mostly visited Resident 47 in the resident's room and had no specific scheduled visits. AA 1 stated when she visited, Resident 47 was in the bed, and she had not seen Resident 47 go outside for strolls through the garden. AA 1 stated it was important for Resident 47 to be escorted outside to help with the resident's mental health ([emotional psychological], and social well-being, and stress. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/3/2024 at 11:26 a.m. with Licensed Vocational Nurse (LVN) 6, LVN 6 stated she had not seen Resident 47 taken outside for a garden stroll. LVN 6 stated there was no set schedule when Resident 47 was to go outside. LVN 6 stated it was important for Resident 47 to go outside for a garden stroll to help him with sensory stimuli (physical energy such as light, sound, heat, or touch). LVN 6 stated it could make Resident 47 depressed (can cause a person to feel sad, irritable, or empty, and lose interest in activities) if he did not go outside. During an interview on 10/3/2024 at 3:50 p.m. with the Director of Nursing (DON), the DON stated the staff should offer and take Resident 47 outside daily when the weather was good. The DON stated the staff should use nonverbal cues to indicate if the resident would like to go outside. The DON stated it was important to fully accommodate Resident 47's needs so the resident would not display frustration and become unhappy. During a review of the facility's policy and procedure (P&P) titled, Quality of Life for Skilled Nursing Facility, dated 3/2024, the P&P indicated, the purpose of the policy is to ensure that all residents of the skilled nursing facility (SNF) experience a high quality of life and maintain the well-being of residents. The P&P indicated the SNF is committed to individualized care, respect for personal choices, and encouragement of social interaction and engagement in meaningful activities. The P&P indicated the facility will provide a variety of social, recreational, and cultural activities that cater to the interest and preferences of residents. The P&P indicated activities will be scheduled regularly, with input from residents to ensure relevance and engagement.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47923 Based on interview and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice, by failing to check pacemaker (a small battery-powered device that monitors and regulates the heart's rhythm and rate) for one of one sampled resident (Resident 63). This deficient practice had the potential to result in pacemaker failure possibly leading to medical complications requiring hospitalization . Findings: During a review of Resident 63's Admission Record, the Admission Record indicated, Resident 63 was admitted to the facility on [DATE] with diagnoses including acute on chronic congestive heart failure (a type of heart failure that occurs when the heart tries to compensate for a loss of function that has developed over time) and hypertensive heart disease (group of heart conditions that develop over time due to chronic high blood pressure). During a review of Resident 63's History and Physical (H&P), dated 8/19/2023, the H&P indicated, Resident 63 had the capacity to understand and make decisions. During a review of Resident 63's Minimum Data Set ([MDS] a federally mandated resident assessment tool), dated 8/6/2024, the MDS indicated, Resident 63's cognitive (ability to think and reason) skills for daily decision making was intact. The MDS also indicated, Resident 63 needed moderate assistance (helper does less than half the effort) in toileting hygiene, upper and lower body dressing, and personal hygiene. During a review of Resident 63's Order Summary Report (a document containing active orders), dated 10/3/2024, the Order Summary Report indicated, Resident 63 had a Boston Scientific (manufacturer of pacemaker) pacemaker implanted on 5/1/2017. During a review of Resident 63's care plan titled Resident with pacemaker dated 6/14/2023, indicated goal of Resident 63 will be free from signs and symptoms of pacemaker malfunction daily in 3 months. The care plan indicated intervention for pacemaker evaluation as ordered. During an interview on 10/1/2024 at 10:58 a.m. with Resident 63 at his room, Resident 63 stated that he had a pacemaker and had not been checked since he was admitted to the facility. During a concurrent interview and record review on 10/3/2024 at 1:13 p.m. with the Director of Nursing (DON), Resident 63's clinical records were reviewed. The DON stated Resident 63's pacemaker evaluation on 8/7/2023 was cancelled. The DON stated there was no documentation indicating the facility rescheduled Resident 63's appointment for pacemaker check. The DON stated Resident 63's pacemaker was not checked for four years. The DON stated it was a standard of practice to check resident with pacemaker at least every 3 months or yearly since it is an implanted device that could malfunction anytime. The DON stated failure to monitor pacemaker could result in pacemaker failure or malfunction such as slow irregular heartbeat that could lead to death of resident. (continued on next page)

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F 0684 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, Care of Permanent Pacemaker, dated 4/2013, the P&P indicated, Check pacemaker every 3 months if newly inserted or every month in an older model using the telephone and the appropriate device. During a review of facility's P&P titled, Quality of Care Policy for Skilled Nursing Facility, dated 3/2024, the P&P indicated To ensure that all residents receive the highest quality of care in accordance with regulatory standards, best practices, and individualized care plans, promoting their physical, emotional, and social well-being.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41379 Based on observation, interview, and record review, the facility failed to provide appropriate services to decline in joint range of motion (ROM, full movement potential of a joint) for three out of 12 sampled residents (Residents 64, 14, and 15) who had limited ROM or were assessed at risk for decline in joint ROM, as indicated in the resident's care plans. The facility failed to: 1. Ensure Resident 64 received timely quarterly rehabilitation joint mobility screens to monitor changes in joint range of motion. 2. Ensure Resident 14 received timely quarterly rehabilitation joint mobility screens to monitor changes in joint range of motion. 3. Ensure Resident 15 received timely quarterly rehabilitation joint mobility screens to monitor changes in joint range of motion. These deficient practices had the potential to cause further decline in Residents 64, 14, and 15's ROM and overall quality of life. Findings: 1. During a concurrent observation and interview on 10/2/2024 at 8:24 AM in Resident 64's room, Resident 64 was observed sitting up on a wheelchair with a bedside table in front of the resident. Resident 64 was able to hold a drink container in the left hand to drink after set-up assist from staff. During a review of Resident 64's Admission Record, the Admission Record indicated Resident 64 admitted to the facility on [DATE]. Resident 64's diagnoses included dementia (a progressive state of decline in mental abilities) and cerebral infarction (blockage of the flow of blood brain, causing or resulting in brain tissue death). During a review of Resident 64's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 7/12/2024, the MDS indicated Resident 64 had severe cognitive impairment (sufficient judgement, planning, organization to manage average demands in one's environment). The MDS indicated Resident 64 required supervision with eating and dependent assistance with oral hygiene, toileting hygiene, upper body dressing, lower body dressing, and chair to bed transfers. The MDS also indicated Resident 64 had impairment in functional limitation in ROM on both sides of the upper extremities (UE, shoulder, elbow, wrist, hand) and both sides of the lower extremities (LE, hip, knee, ankle, foot). During a review of Resident 64's care plan initiated 2/10/2022, the care plan indicated Resident 64 had functional limitations to both sides of the upper extremities at the shoulders and was at risk for further decline in joint mobility. The care plan goal indicated Resident 64 will maintain current joint mobility ROM daily and review every three months. The care [;am interventions indicated for restorative nursing services (RNA - nursing assistant who has additional training in rehabilitation technique) exercises as ordered and for quarter assessment of joint mobility or as needed. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 10/2/2024 at 3:38 PM, with the Assistant Director of Rehabilitation (ADOR), Resident 64's Joint Mobility Assessments (JMA) were reviewed. The ADOR stated JMAs were completed by the rehabilitation department and were completed on admission, quarterly (every three months), and as needed for all residents. After review of Resident 64's joint mobility assessments in the medical record, the ADOR stated Resident 64 had a joint mobility assessment completed on 1/15/2024 and 5/21/2024. The ADOR stated there was no JMA completed after 5/21/2024 and it should have been completed by the end of August 2024 and was late. The ADOR also stated the JMA completed 5/21/2024 was late and should have been completed by the end of April 2024. The ADOR stated the purpose of completing joint mobility assessments was to monitor a resident's joint ROM and act accordingly, such as if a resident was getting worse with their ROM, then the resident could be a candidate for therapy services. The ADOR stated the facility did not want to see any deterioration of a resident's physical capabilities, so it was important to monitor the resident's joint mobility. During an interview on 10/3/2024 at 2:11 PM with the Director of Nursing (DON), the DON stated rehabilitation staff was responsible for completing JMAs for all residents upon admission, quarterly, or as needed such as a decline in function. The DON stated it was important to complete the JMAs timely so that the facility could notice any decline in limbs and joints, because a decline in ROM could negatively affect the resident's balance, ability to hold items to feed themselves, and ability to walk. During a review of the facility's policy and procedure (P&P) dated 3/2024, titled, Joint Mobility Assessment, the P&P indicated the facility will identify the resident's current range of motion of his or her joints and limitations in movement or mobility. 2. During an observation on 10/2/2024 at 8:34 AM, in Resident 14's room during Resident 14's Restorative Nursing Aide program (nursing aide program that help residents to maintain their function and joint mobility) treatment session, Resident 14 was observed lying in bed. Resident 14 was able to move the right arm up and down past shoulder level, straighten the right elbow and open the right hand. Resident 14 was able to move the left shoulder to less than shoulder level and straighten the left elbow. Resident 14 did not want to move both legs. Resident 14's right leg was in a straight position and the left knee was straight and rotated away from the body. During a review of Resident 14's Admission Record, the Admission Record indicated Resident 14 originally admitted to the facility on [DATE], and readmitted on [DATE]. Resident 14's diagnoses included displaced (out of alignment) comminuted (broken into more than two pieced) fracture (broken bone) of shaft of left femur (long portion of thigh bone), hemiplegia (weakness to one side of the body) and hemiparesis (inability to move one side of the body) following cerebral infarction (blockage of the flow of blood brain, causing or resulting in brain tissue death) affecting the left dominant side. During a review of Resident 14's MDS dated [DATE], the MDS indicated Resident 14 had severe cognitive impairment. The MDS also indicated Resident 14 had functional limitation in ROM impairment on one side of the upper extremity and on one side of the lower extremity. The MDS also indicated Resident 14 required dependent assistance with oral hygiene, upper body dressing, lower body dressing, and bed to chair transfers. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 14's care plan initiated 2/11/2022, the care plan indicated Resident 14 had functional limitations and impairment to both upper and both lower extremities and was at risk for further decline in joint mobility and injury. The care plan goal indicated Resident 14 will maintain current joint mobility ROM. The care plan intervention indicated RNA exercises as ordered and quarterly assessment of joint mobility or as needed. During a concurrent interview and record review on 10/2/2024 at 3:38 PM, with the Assistant Director of Rehabilitation (ADOR), Resident 14's Joint Mobility Assessments (JMA) was reviewed. The ADOR stated JMAs were completed by the rehabilitation department and were completed on admission, quarterly (every three months), and as needed for all residents. After review of Resident 14's joint mobility assessments in the medical record, the ADOR stated Resident 14 had a joint mobility assessment completed on 3/25/2024 and 6/17/2024. The ADOR stated there was no JMA completed after 6/17/2024 and it should have been completed by the end of September 2024 and was late. The ADOR stated the purpose of completing joint mobility assessments was to monitor a resident's joint ROM and act accordingly, such as if a resident was getting worse with their ROM, then the resident could be a candidate for therapy services. The ADOR stated the facility did not want to see any deterioration of a resident's physical capabilities, so it was important to monitor. During an interview on 10/3/2024 at 2:11 PM with the Director of Nursing (DON), the DON stated rehabilitation staff was responsible for completing JMAs for all residents upon admission, quarterly, or as needed such as a decline in function. The DON stated it was important to complete the JMAs timely so that the facility could notice any decline in limbs and joints, because a decline in ROM could negatively affect the resident's balance, ability to hold items to feed themselves, and ability to walk. During a review of the facility's P&P dated 3/2024, titled, Joint Mobility Assessment, the P&P indicated the facility will identify the resident's current range of motion of his or her joints and limitations in movement or mobility. 50961 3. During a concurrent observation and interview on 10/1/2024 at 9:26 AM in Resident 15's room, Resident 15 was observed in bed and able to move the left shoulder up and down, straighten the left elbow, and open the left hand. Resident 15 was able to move right shoulder to less than shoulder level, straighten the right elbow, and open the right hand. Resident 15 stated she could move her legs a little and could not walk. During a review of Resident 15's Admission Record, the Admission Record indicated Resident 15 admitted to the facility on [DATE]. Resident 15's diagnoses included dementia (a progressive state of decline in mental abilities) and unspecified osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage). During a review of Resident 15's MDS dated [DATE], the MDS indicated Resident 15 had severe cognitive impairment. The MDS indicated Resident 15 required dependent assistance with lower body dressing, and chair to bed transfers. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 15's care plan initiated on 4/17/2024, the care plan indicated an order for RNA for active assistive range of motion (AAROM, use of muscles surrounding the joint to perform the exercise but required some help from a person or equipment) to both upper extremities five days a week as tolerated. The care plan also indicated an order for RNA for AAROM to both lower extremities five days a week as tolerated. The care plan goal indicated Resident 15 will maintain current joint range of motion. The care plan interventions indicated to observe Resident 15 for changes in ROM or pain. During a concurrent interview and record review on 10/2/2024 at 3:38 PM, with the ADOR, Resident 15's JMA was reviewed. The ADOR stated JMAs were completed by the rehabilitation department and were completed on admission, quarterly, and as needed for all residents. After review of Resident 15's JMA in the medical record, the ADOR stated Resident 15 had a JMA completed on 4/29/2024 and 8/28/2024. The ADOR stated the JMA completed 8/28/2024 was late and should have been completed by the end of July 2024. The ADOR stated the purpose of completing joint mobility assessments was to monitor a resident's joint ROM and act accordingly, such as if a resident was getting worse with their ROM, then the resident could be a candidate for therapy services. The ADOR stated the facility did not want to see any deterioration of a resident's physical capabilities, so it was important to monitor the resident's joint mobility. During an interview on 10/3/24 at 2:11 PM with the DON, the DON stated rehabilitation staff was responsible for completing JMAs for all residents upon admission, quarterly, or as needed such as a decline in function. The DON stated it was important to complete the JMAs timely so that the facility could notice any decline in limbs and joints, because a decline in ROM could negatively affect the resident's balance, ability to hold items to feed themselves, and ability to walk. During a review of the facility's P&P dated 3/2024, titled, Joint Mobility Assessment, the P&P indicated the facility will identify the resident's current range of motion of his or her joints and limitations in movement or mobility.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46144 Based on observation, interview, and record review, the facility failed to ensure: 1. Ensure Resident 81 had floor mats at bedside to prevent injury from a fall. This deficient practice of not placing floor mats at the Resident 81's bedside had the potential for injury if Resident 81 was to have a fall. 2. The sharps container (a puncture-proof container used to contain used and discarded needles and other sharp tools for patient care) in rooms 221, 321 and 333 were replaced with a new one when it was at least 75 percent (%) full. This deficient practice had the potential for staff or resident to sustain an injury with a full sharps container. Findings: 1. During a review of Resident 81's Admission Record (Face Sheet), the Face Sheet indicated Resident 81 initially admitted to the facility on [DATE] and last readmitted on [DATE]. Resident 81's diagnoses included dementia (a progressive state of decline in mental abilities), chronic obstructive pulmonary disease ([COPD] a chronic lung disease causing difficulty breathing), and anxiety (an excessive persistent feelings of fear and worry). During a review of Resident 81's History and Physical (H&P), dated 10/10/2023, the H&P indicated Resident 81 did not have the capacity to understand and make decisions. During a review of Resident 81's Minimum Data Set ([MDS] a federally mandated assessment tool), dated 6/14/2024 the MDS indicated, Resident 81's cognition (ability to learn, reason, remember, understand, and make decisions) was severely impaired. The MDS indicated Resident 81 was dependent on staff for personal hygiene, showering, and dressing. During a review of Resident 81's Order Summary Report, dated 10/1/2022, the Order Summary Report indicated, Resident 81 was to have floor mats at the side of the bed to prevent injury. During a review of Resident 81's Multidisciplinary Care Conference record dated 3/28/2024, the Multidisciplinary Care Conference record indicated, Resident 81 was to have floor mats at the side of the bed to prevent injury. During a review of Resident 81's Fall Risk Evaluation, dated 4/22/2024, the Fall Risk Evaluation indicated, Resident 81 was a high risk of falls. During an observation on 10/1/2024 at 12:45 p.m., in Resident 81's room, there were no floor mats observed on the floor. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 10/2/2024 at 3:00 p.m., in Resident 81's room, there were no floor mats observed on the floor. During a concurrent observation and interview on 10/2/2024 at 3:15 p.m. with Licensed Vocational Nurse (LVN) 5, in Resident 81's room, Resident 81 did not have floor mats observed on the side of the bed. LVN 5 stated Resident 81 was at high risk for falls. LVN 5 stated the floor mats were used as a cushion and to prevent serious injuries after a fall. LVN 5 stated if the floor mats were not placed at the bedside, Resident 81 was at risk for injury. During a concurrent interview and record review on 10/4/2024 at 1:57 p.m. with the Director of Nursing (DON), Resident 81's Fall Risk Evaluation, dated 4/22/2024 was reviewed. The Fall Risk Evaluation indicated, Resident 81 was a high risk of falls. The DON stated the floor mats were the tool used to reduce injuries after a fall. The DON stated if the floor mats were not placed at the bedside, it would place Resident 81 at a greater risk for injuries such as a fracture (a break in the bone). During a review of the facility's policy and procedure (P&P) titled, Fall/Accidents, dated 2/2024, the P&P indicated, the purpose of this procedure is to provide guidelines for assessing a resident. The P&P indicated identify fall a resident's risk and assemble the equipment and supplies needed. The P&P indicated the DON should consult with the attending physician or medical director to confirm specific causes from among multiple possibilities to prevent falls. During a review of the facility's policy and procedure (P&P) titled, Quality of Care dated 3/2024, the P&P indicated, residents are provided with a safe, clean, and comfortable environment that is free of accident hazards, and are adequately supervised. 49131 2. During a concurrent observation on 10/4/2024 at 1:51 PM with Licensed Vocational Nurse (LVN) 8, the sharps container in room [ROOM NUMBER] had sharps object and was just past the fill line on the container. LVN 8 stated when the sharps container is full, it needed to be replaced with a new one. LVN 8 stated she is unsure of who changes the sharps container. During a concurrent observation and interview on 10/4/2024 at 2:00 PM with LVN 8, the sharps container in room [ROOM NUMBER] was observed to be full and past the fill line. LVN 8 stated it was important for sharps containers to be changed when it is at least 75% full to avoid any possible needlestick injuries. During a concurrent observation and interview on 10/4/2024 at 2:15 PM with Registered Nurse (RN)1, the sharps container in room [ROOM NUMBER] was observed to be filled with sharps. The sharps container was filled to the top and a shaving razor can be seen protruding out from behind the container lid, there were also cotton gauze that can be seen around the used razor. RN 1 stated sharps container need to be changed out when you see the disposed items in the sharp container reach the fill line or when it is about 75% full to prevent needlestick injuries. RN 1 stated it is the responsibility of all the nurses to change out the sharps container. During a review of the policy and procedure titled, Sharps Disposal, dated 02/2024, it indicated to seal and replace containers when they are 75% to 80% full.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47923 Based on observation, interview, and record review, the facility failed to ensure oxygen (air) tubing and humidifier (a device that humidifies oxygen for patients undergoing oxygen therapy) were dated, labeled, and changed every seven days in accordance with facility's policy and procedure for one of five sampled residents (Resident 23). This deficient practice had the potential to cause respiratory infection for residents on oxygen therapy. Findings: During a review of Resident 23's Admission Record, the Admission Record indicated, Resident 23 was initially admitted to the facility on [DATE] and was readmitted on [DATE], with diagnoses including acute respiratory failure with hypoxia (a condition where the body doesn't have enough oxygen in the tissues and the respiratory system can't absorb enough oxygen) and obstructive sleep apnea (a condition where sleep is interrupted by abnormal breathing). During a review of 23s History and Physical (H&P), dated 4/19/2024, the H&P indicated, Resident 23 had the capacity to understand and make decisions. During a review of Resident 23's Minimum Data Set ([MDS] a federally mandated resident assessment tool), dated 8/7/2024, the MDS indicated, Resident 23's cognitive (ability to think and reason) skills for daily decision making was intact. The MDS also indicated, Resident 23 was independent (resident completes the activity by themself with no assistance from the helper) in eating and oral hygiene. During a review of Resident 23's Order Summary report (a document containing active physician orders), dated 10/3/2024, the Order Summary report indicated, Resident 23 has an active order of Bilevel positive Airway Pressure ([BIPAP] type of device that helps with breathing) at 2 liters (metric unit of measurement for volume) per nasal cannula (flexible tube that has two prongs that sit inside the nostrils used to deliver oxygen) every night and to change the oxygen tubing weekly on Sunday. During a concurrent observation and interview on 10/1/2024 at 10:16 a.m. in Resident 23's room with Licensed Vocational Nurse 2 (LVN 2), the oxygen tubing and humidifier was observed not dated and labeled. LVN 2 can't verify when was the oxygen tubing and humidifier was changed because it was not dated and labeled. LVN 2 stated it was the responsibility of the licensed nurse to label the oxygen tubing and put the date on humidifier upon opening. LVN 2 stated the oxygen tubing should be changed once a week on Sunday. LVN 2 stated if the oxygen tubing was not changed within the timeframe, it can cause bacterial growth that could lead to respiratory infection. During an interview on 10/2/2024 at 1:43 p.m. with the Director of Nursing (DON), the DON stated it was essential to date the humidifier and change the oxygen tubing once a week for infection control and to check the patency because a clogged tubing could not deliver the right amount of oxygen concentration that would result in shortness of breath of resident. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of facility's policy and procedure (P&P) titled, Respiratory Services/Oxygen, dated 2/2024, the P&P indicated, Change the oxygen canula and tubing every seven days, or as needed. The P&P also indicated to mark the humidifier bottle with date and initials upon opening.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46144 Based on observation, interview, and record review, the facility failed to ensure the physician signed an order for a one to one (1:1, close supervision) sitter for one out of eight sampled residents (Resident 19). This deficient practice had the potential for poor continuity of care and follow-up on the resident's status for each physician visit. Findings: During a concurrent observation and interview on 10/2/2024 at 4:20 p.m., in Resident 19's room, Resident 19 was observed to have a staff member sitting within arm's reach off to the side of him. The staff member stated she was Resident 19's 1:1 Sitter (OS 1). OS 1 stated she was the sitter for Resident 19 due to a history of falls and her duties included staying close by to ensure the resident did not fall. During a review of Resident 19's Admission Record (Face Sheet), the Admission Record indicated Resident 19 was readmitted to the facility on [DATE]. Resident 19's diagnoses included muscle weakness, lack of coordination, and dementia (a progressive state of decline in mental abilities). During a review of Resident 19's Minimum Data Set ([MDS]- a federally mandated assessment tool), dated 8/26/2024, the MDS indicated Resident 19 was not cognitively intact (ability to reason, understand, remember, judge, and learn). During a concurrent interview and record review on 10/2/2024 at 4:45 p.m. with Licensed Vocational Nurse (LVN) 3, Resident 19's medical chart was reviewed. LVN 3 stated residents with a sitter need to have a physician's order. LVN 3 stated after looking at Resident 19's medical chart, she (LVN 3) did not see a physician's order for Resident 19 to have a sitter. During a review of the facility's policy and procedure (P&P) titled, Sitters, dated 3/2024, the P&P indicated the use of sitters will be permitted when approved by the resident's Attending Physician. 49131

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 47923 Based on interview and record review, the facility failed to ensure a competency assessment skill (a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics in performing that an individual need to perform work roles or occupational functions successfully) checks performed annually for four out of five randomly selected staff. This deficient practice had the potential for the facility not be able to assess the skills necessary to provide nursing services to assure resident safety and to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident will not be performed within the acceptable standards of practice. Findings: During a concurrent interview and record review on 10/2/2024 at 10:00 a.m. with Licensed Vocational Nurse 7 (LVN 7), five random employees file were reviewed. LVN 6 stated the Director of Nursing (DON) was responsible for completing the annual competency assessment skills for licensed nursing staff and Certified Nurse Assistant (CNA). LVN 7 verified the employee records revealed the following: 1. Licensed Vocational Nurse 1 (LVN 1) was hired on 8/23/2021 and did not have an annual competency assessment skill on file. 2. Certified Nurse Assistant (CNA 1) was hired on 5/20/2015 and did not have an annual competency assessment skill on file. 3. Certified Nurse Assistant (CNA 3) was hired on 9/6/2023 and did not have an annual competency assessment skill on file. 4. Certified Nurse Assistant (CNA 4) was hired on 7/20/1999 and did not have an annual competency assessment skill on file. During an interview on 10/2/2024 at 11:10 a.m. with the Director of Nursing (DON), the DON stated competency assessment skills check must be done upon hire and annually. The DON stated licensed nursing staff and CNA's cannot work on the floor without completing and passed a competency assessment skill. The DON stated it was not fair on her part to complete an annual competency assessment skill for LVN 1, CNA 1, CNA 3, and CNA 4 since she was hired recently as DON. The DON stated it was important for the licensed nurse staff and CNA's to complete a competency assessment skill to validate that they can perform the skills they were expected to do for resident safety and to be in compliance with the requirement by the state licensing agency. During a review of the facility's policy and procedure (P&P) titled, Competency of Nursing Staff, dated 3/2024, the P&P indicated, Facility and resident-specific competency evaluations will be conducted upon hire, annually and as deemed necessary based on the facility assessment.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50961 Based on observation, interview, and record review, the facility failed to indicate the opened date on the label for medications (to be administered Residents 124, 131, 98, 7, and 23) stored in two of four sampled medication carts. This deficient practice had the potential for residents to experience adverse effects from the administration of expired medication. Findings: During a review of Resident 124's Admission Record, the Admission Record indicated Resident 124 was admitted on [DATE] with the following diagnoses, but not limited to, epilepsy (a condition with sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), difficulty in walking, testicular hypofunction (a condition where the testicles are unable to produce enough testosterone [a hormone that helps to develop and maintain many bodily functions including male sex characteristics]), hypopituitarism (a condition that occurs when the pituitary gland [a pea-sized organ in the brain] does not produce enough of one or more of its hormones). During a review of Minimum Data Set (MDS - a federally mandated resident assessment tool), dated [DATE], the MDS indicated Resident 124's cognitive function (mental processes that enable people to think, understand, make decisions, and complete tasks) was severely impaired. During a review of Resident 124's Order Summary Report, dated, [DATE], the Order Summary Report indicated Resident 124 was prescribed testosterone cypionate (a medication to treat males whose bodies do not make enough natural testosterone) 200 milligram (mg- metric unit of measurement, used for medication dosage and/or amount) /milliliter (ml-metric unit of measurement for volume). Resident 124 will receive 0.4ml via injection on Wednesday morning every 2 weeks. During a review of Resident 131's Admission Record, the Admission Record indicated Resident 131 was admitted on [DATE] with the following diagnoses, but not limited to, diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), encephalopathy (a condition that affects the brain and may lead to confusion and personality and behavioral changes), osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), anemia (a condition where the body does not have enough healthy red blood cells), hypertension (high blood pressure). During a review of Minimum Data Set (MDS, a federally mandated resident assessment tool), dated [DATE], the MDS indicated Resident 131's cognitive function was intact. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 131's Order Summary Report, dated [DATE], the Order Summary Report indicated Resident 131 was prescribed ipratropium-albuterol inhalation solution (a medication that relaxes and opens the air passages to the lungs to make breathing easier) 0XXX,d+[DATE].5mg/3ml. Resident 131 will receive 3ml via nebulizer (a small machine that turns liquid medication into a mist that can be inhaled) every eight hours as needed. During a review of Resident 98's Admission Record, the Admission Record indicated Resident 98 was admitted on [DATE] with the following diagnoses, but not limited to, diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), difficulty in walking, lack of coordination, hypertension (HTN-high blood pressure), asthma (a lung disease that narrows airways and causes difficulty breathing). During a review of Minimum Data Set (MDS, a federally mandated resident assessment tool), dated [DATE], the MDS indicated Resident 98's cognitive functioning was intact. During a review of Resident 98's Order Summary Report, dated [DATE], the Order Summary Report indicated Resident 98 was prescribed Phenergan/codeine oral syrup (a combination of medications used to relieve cough, runny or stuffy nose, sneezing or other symptoms caused by allergies or the common cold) 6XXX,d+[DATE]mg/5ml. Resident 98 will receive 5ml by mouth as needed three times daily. During a review of Resident 7"s Admission Record, the Admission Record indicated Resident 7 was admitted on [DATE] with the following diagnoses, but not limited to, end stage renal disease (ESRD-irreversible kidney failure), dependent on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage). During a review of Minimum Data Set (MDS, a federally mandated resident assessment tool), dated [DATE], the MDS indicated Resident 7's cognitive functioning was intact. During a review of Resident 7's Order Summary Report, dated [DATE], the Order Summary Report indicated Resident 7 was prescribed Nitro-Bid transdermal ointment 2% (a medication used to relax and increases the diameter of peripheral vessels increasing the blood flow) to apply 1 inch (unit of measure for distance) on both legs daily. During a review of Resident 23's Admission Record, the Admission Record indicated Resident 23 was admitted on [DATE] with the following diagnoses, but not limited to, unspecified asthma (a lung disease that narrows airways and causes difficulty breathing), diabetes mellitus ((DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), difficulty walking, neuropathy ((disease or dysfunction of one or more nerves, typically causing numbness or weakness in the hands and feet), hypertension (HTN-high blood pressure). During a review of Minimum Data Set (MDS, a federally mandated resident assessment tool), dated [DATE], the MDS indicated Resident 23's cognitive functioning was intact. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 23's Order Summary Report, dated [DATE], the Order Summary Report indicated Resident 23 was prescribed estradiol vaginal cream (a medication to treat irritation and dryness of the vaginal area) 0.01% to be applied vaginally at bedtime every Monday, Wednesday, and Friday. During a concurrent observation and interview on [DATE], at 12:08 p.m., with Licensed Vocational Nurse (LVN) 7, in the second-floor hallway, Medication Cart 1 had an open vial of testosterone cypionate intramuscular kit 200mg/ml for Resident 124 and an open box of ipratropium-albuterol inhalation solution 0XXX,d+[DATE].5mg/3ml for Resident 131that were not labeled with an open date. LVN 7 stated if the opened date is not noted on the medication, then the medication might be expired, and it might not be effective for the residents. During a concurrent observation and interview on [DATE], at 12:35 p.m., with LVN 6, in the second-floor hallway, Medication Cart 2 had an opened bottle of Phenergan/codeine Oral 6XXX,d+[DATE]mg/5ml for Resident 98, an opened tube of Nitro-Bid transdermal ointment 2% for Resident 7, and an opened tube of estradiol vaginal cream 0.1mg/gm for Resident 23 that were not labeled with an open date. LVN 6 stated when medications are not labeled with an open date there is a risk a resident will receive an expired medication that might not be effective and harm the resident. During an interview on [DATE], at 1:29 p.m., with Director of Nursing (DON), DON stated it is important to label the date medication is opened to make sure residents don't receive expired medication and experience adverse effects. During a review of the facility's policy and procedure (P & P) titled, Medication Labeling, dated [DATE], the P & P indicated, All medications maintained in the facility are properly labeled in accordance with current state and federal guidelines and regulations.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46144 Based on observation, interview, and record review, the facility failed to ensure food items were discarded after the use by date. The following items were as follows: 1 Baking Soda Powder dated [DATE] and use by date [DATE]. 2. Colander Seeds dated [DATE]. 3. Red Food coloring opened date [DATE] with no use by date. 4. Package of breadcrumbs open date [DATE] and use by date [DATE]. This deficient practice of having expired dry food items had the potential to result in harmful bacteria growth that could lead to foodborne illness for residents who received food and drinks from the kitchen. Findings: During a concurrent observation and interview on [DATE] at 9:25 a.m. with the Dietary Procurement Personnel (DP 1), in the dry storage room, the following expired dry food items were observed: 1. Expired Baking Soda Powder dated [DATE], and a use by date [DATE]. 2. Expired Colander Seeds dated [DATE]. 3. Red Food coloring container opened date [DATE], with no use by date. 4. Breadcrumbs opened date [DATE], and a use by date [DATE]. DP 1 stated when a food item was opened, kitchen staff put the remaining item in a closed container. DP 1 stated the remaining food item should labeled with the name, have an opened date, and use by date. DP 1 stated it was important to keep track of the dates for safety. DP 1 stated when the food item was expired it should be tossed. DP 1 stated if the food items were served to the residents, it placed the resident at risk of getting sick. During an interview on [DATE] at 9:40 a.m. with the Dietary Manager, in the dry storage room, the Dietary Manager stated when the food items were expired after the use by date the food items could lose their flavor. The Dietary Manager stated the process was to label the food items when opened and put a use by date. The Dietary Manager stated when the food item was passed the use by date the food needed to be tossed, including the food items without a date. The Dietary Manager stated it was important to not have any expired food stored so the kitchen staff did not serve the food to the residents. The Dietary Manager stated if the residents were served the expired food, they could eat it and become sick. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the facility's undated policy and procedure (P&P) titled, Food Storage, the P&P indicated, the Nutrition Services Manager is responsible for proper storage of nutrition services food and supplies. The P&P indicated to date all opened items and partially used foods shall be dated, labeled, and sealed before being returned to the storage area.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41379 Based on observation, interview, and record review, the facility failed to provide physical therapy (PT, a rehabilitation profession that restores, maintains, and promotes optimal physical function) services with an active physician's order for one of 12 sampled residents (Resident 64) when no PT services were provided after a physician's order dated 4/9/2024 for PT evaluation and treatment. This deficient practice had the potential for Resident 64 to have a decline in functional mobility without PT services. Findings: During a concurrent observation and interview on 10/2/2024 at 8:24 a.m., in Resident 64's room, Resident 64 was observed sitting up on a wheelchair with a bedside table in front of the resident. Resident 64 was able to hold a drink container in the left hand to drink after set-up assist from staff. During a review of Resident 64's Admission Record, the Admission Record indicated Resident 64 admitted to the facility on [DATE]. Resident 64's diagnoses included dementia (a progressive state of decline in mental abilities) and cerebral infarction (blockage of the flow of blood brain, causing or resulting in brain tissue death). During a review of Resident 64's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 7/12/2024, the MDS indicated Resident 64 had severe cognitive impairment (sufficient judgement, planning, organization to manage average demands in one's environment). The MDS indicated Resident 64 required supervision with eating and was dependent in assistance with oral hygiene, toileting hygiene, upper body dressing, lower body dressing, and chair to bed transfers. The MDS indicated Resident 64 had impairment in functional limitation in range in motion (ROM) on both sides of the upper extremity (UE, shoulder, elbow, wrist, hand) and both sides of the lower extremity (LE, hip, knee, ankle, foot). During a review of Resident 64's physician Order Summary Report, the order summary report indicated an order dated 4/5/2024 for PT evaluation and treatment as indicated. During a concurrent interview and record review on 10/2/2024 at 3:38 PM, with the Assistant Director of Rehabilitation (ADOR), Resident 64's physician's orders were reviewed. The ADOR stated Resident 64 had an order dated 4/5/2024 for PT evaluation and treatment as indicated. The ADOR stated if there was an order for PT evaluation and treatment as indicated, then there should be a PT evaluation completed. The ADOR reviewed Resident 64's therapy documentation and resident medical records and stated, there was not a physical therapy evaluation completed or PT documentation indicating why there was no PT evaluation completed for the PT evaluation and treatment order dated 4/5/2024. The ADOR stated if there was an order for therapy, then the rehabilitation department would see the resident within 24 hours and complete an evaluation. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/3/24 at 2:11 PM with the Director of Nursing (DON), the DON stated if there was a physician's order for physical therapy evaluation and treatment, then the order needed to be carried out and a PT evaluation completed. The DON stated the nurse receiving the order should communicate to rehabilitation department to carry out the order. The DON stated if the resident required PT and did not receive it, then the resident could get worse and cause more problems. During a review of the facility's policy and procedure (P&P) dated 2/2024, titled, Specialized Rehabilitation Services, the P&P indicated our facility will provide rehabilitative services to residents by qualified professional personnel only upon the written order of the resident's attending physician.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41379 Based on interview and record review, the facility failed to maintain timely resident medical records for one of twelve sampled residents (Resident 63) when Resident 63's Joint Mobility Assessment (JMA) dated 11/20/2023 was not documented until 10/3/2024. This deficient practice had the potential for inaccurate medical documentation and cause a delay in provision of appropriate interventions for Resident 63. Findings: During a record review of Resident 63's Admission Record, the Admission Record indicated Resident 63 was admitted to the facility on [DATE]. Resident 63's diagnoses included Parkinson's Disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements) without dyskinesia (involuntary movements of extremities) and cerebral infarction (blockage of the flow of blood brain, causing or resulting in brain tissue death). During a record review of Resident 63's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 8/6/2024, the MDS indicated Resident 63 was cognitively intact (sufficient judgement, planning, organization to manage average demands in one's environment). The MDS indicated Resident 63 had functional limitation impairments in range of motion (ROM, full movement potential of a joint) on one side of the upper extremity (shoulder, elbow, wrist, hand) and no functional limitation impairments in ROM on either side of the lower extremity (hip, knee, ankle, foot). The MDS indicated Resident 63 required set-up or clean-up assistance for eating, oral hygiene, and partial/moderate assistance (helper does less than half the effort) with toileting hygiene, upper body dressing, lower body dressing. The MDS indicated Resident 64 required supervision or touching assistance (helper provides verbal cues or touching/steadying assistance as needed) with sit to lying, lying to sitting, bed to chair transfers, and walking 10 feet. During a record review of Resident 63's JMA dated 11/20/2023 on 10/1/2024 at 1:31 PM, the JMA dated 11/20/2023 was blank and indicated NOT COMPLETED. During a concurrent interview and record review on 10/3/2024 at 1:43 PM with the Assistant Director of Rehabilitation (ADOR), Resident 63's JMA dated 11/20/2023 was reviewed. The JMA dated 11/20/2023 indicated an effective date of 11/20/2023 and was signed on 10/3/2024. The ADOR stated the JMA dated effective 11/20/2023 was signed very late and almost a year after the effective date. The ADOR stated he was not sure what happened and that the therapist who signed the document was not at the facility that day (10/3/2024). The ADOR stated all medical documents and therapy records should be documented and signed right after the completion of the service to ensure continuity of care, accuracy of the document, and timeliness, because the documents reflected the care the resident was receiving and could affect how the facility determined what interventions to take with the resident. The ADOR stated that documenting 11 months after the effective date was not considered professional standards. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/3/2024 at 2:11 PM with the Director of Nursing (DON), the DON stated it was important for all medical records to be documented timely and accurately. The DON stated if the service was completed, it needed to be documented so that the next person knows what happened and for follow up and care for the resident. The DON stated documentation reflected what the facility was providing for the resident, and it needed to be accurate and completed timely. The DON stated it the documentation was completed late, then it should be a late entry and indicate the actual date it was completed or updated. During a review of the facility's policy and procedure (P&P) dated 3/2024, titled, Charting and Documentation, the P&P indicated all services provided to the resident shall be documented in the resident's medical record. Documentation in the medical record will be objective, complete, and accurate.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49131 Based on interview and record review, the facility failed to ensure one of three sampled resident's (Resident 17) representative (FM 1) understood the facility's arbitration agreement (a document that settles any disputes between two parties through binding arbitration [a dispute resolution outside of the legal court system]). This deficient practice resulted in FM 1 entering into an agreement for binding arbitration without fully understanding what they were signing. Findings: During a review of Resident 17's Admission Record (Face Sheet), the Admission Record indicated Resident 17 was admitted to the facility on [DATE]. Resident 17's diagnoses included hypertension (high blood pressure) and a history of falling. During a review of Resident 17's Minimum Data Set ([MDS]- a federally mandated assessment tool), dated 8/15/2024, the MDS indicated Resident 17 was not cognitively intact (ability to reason, understand, remember, judge, and learn). During a review of Resident 17's Resident-Facility Arbitration Agreement, dated 4/24/2024, the Resident-Facility Arbitration Agreement indicated Resident 17's representative (FM 1) signed the arbitration. During an interview on 10/4/2024 at 11:30 a.m. with the Admissions Coordinator (AC), the AC stated the Resident-Facility Arbitration Agreement form was part of the admissions packet which was given to the resident or their responsible party to sign. The AC stated if the resident or their responsible party had any questions regarding any of the paperwork in the admission packet including the Resident-Facility Arbitration Agreement form, she(AC) would answer their questions. The AC stated when the Resident-Facility Arbitration Agreement form was signed, the party waives their right to a trial in front of a juror in the legal system and instead use an arbitrator to resolve any issues. During an interview on 10/4/2024 at 3:30 PM, with FM 1, FM 1 stated she remembered signing the Resident-Facility Arbitration Agreement form after Resident 17 was admitted to the facility. FM 1 stated no one from the facility explained to her what the form was about and tried to figure out for herself what she was signing by finding information online. During an interview on 10/4/2024 at 3:44 p.m., the AC stated she did not speak with FM 1 regarding the Resident-Facility Arbitration Agreement form. (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/4/2024 at 1:30 PM with the Patient Care Coordinator (PCC) and Licensed Vocational Nurse (LVN) 3, the PCC and LVN 3 stated the facility did not have a policy on Arbitration, only Arbitration Mediation Policy which speaks to the process once the resident or resident representative once they want to start the arbitration process. The PCC and LVN 3 stated they confirmed this after speaking with the Director of Nursing (DON), the AC, and staff members from the business office.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47923 Based on interview and record review, the facility failed to ensure that the hospice (compassionate care for people who are near the end of life provided at the person's home or within a health care setting) services meet professional standards for one of two sampled residents (Resident 122) by failing to: 1. Ensure hospice representative participates with facility interdisciplinary team ([IDT] team members from different disciplines who come together to discuss resident care) care conference meeting. 2. Ensure to have a hospice calendar with the scheduled visits for the hospice team. 3. Ensure current physician's certification for hospice benefit (a confirmation that a patient is terminally ill and has a prognosis of six months or less to live) was available in the resident's medical record. These deficient practices had the potential to result in a delay or lack of coordination in delivery of hospice care and services to Resident 122. Findings: During a review of Resident 122's Admission Record, the Admission Record indicated, Resident122 was initially admitted to the facility on [DATE] and was readmitted on [DATE], with diagnoses including Alzheimer's Disease ([AD] a disease characterized by a progressive decline in mental abilities) and hypertension ([HTN] high blood pressure). During a review of Resident's 122 History and Physical (H&P), dated 2/13/2024, the H&P indicated, Resident 122 did not have the capacity to understand and make decisions. During a review of Resident 122's Minimum Data Set ([MDS] a federally mandated resident assessment tool), dated 8/19/2024, the MDS indicated, Resident 122's cognitive (ability to think and reason) skills for daily decision making was severely impaired. The MDS also indicated, Resident 122 was totally dependent (helper does all of the effort) to staff in eating, oral hygiene, toileting hygiene, and personal hygiene. During a review of Resident 122's Order Summary Report (a document containing active physician order), dated 10/3/2024, the Order Summary Report indicated, Resident 122 was admitted to hospice care on 2/12/2024. During a review of Resident 122's care plan titled Resident with terminal prognosis (an advanced stage of a medical condition for which a physician gave a prognosis of eventual or inevitable death or hospice care was received) related to AD dated 2/12/2024, indicated goal of Resident 122 to maintain comfort daily. The care plan indicated intervention to work cooperatively with hospice team to ensure resident's spiritual, emotional, intellectual, physical and social needs are met. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 10/3/2024 at 12:41 p.m. with the Social Services Director (SSD), Resident 122's Multidisciplinary Care Conference record, dated 2/15/2024, was reviewed. The SSD stated the Multidisciplinary Care Conference record did not indicate a hospice representative was among the members attended the meeting. The SSD stated it was important for the facility staff to coordinate with the hospice team the condition of Resident 122 so there would be no breakdown in the continuity of care. During a concurrent interview and record review on 10/3/2024 at 12:57 p.m. with Registered Nurse 1 (RN 1), Resident 122's medical records were reviewed. RN 1 stated the hospice calendar for the month of September and October were missing and physician's certification for hospice benefit was not updated and available. RN 1 stated the hospice calendar would indicate when the hospice team would be in the facility and what type of care they would be providing. RN 1 stated by not having the hospice calendar, Resident 122's care would be neglected, and her needs would not be met by facility staff and hospice team. RN 1 stated Resident 122 was no longer under hospice care based on the last physician certification for hospice benefit available in the chart that ended on 8/24/2024. During a review of the facility's policy and procedure (P&P) titled, Hospice, dated 3/2024, the P&P indicated, When a resident participates in the hospice program, a coordinated care plan between the facility, hospice agency and resident/family will develop and shall include directives for managing pain and other uncomfortable symptoms. The P&P also indicated the hospice agency retains overall professional management responsibility of directing the implementation of the care plan related to the terminal illness and related conditions which include the provision of substantially all core services (physician, nursing, medical social work and counselling services) that must be routinely provided directly by the hospice employees and cannot be delegated to the facility as outlined in current hospice regulations at 418.80.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49131 Based on observation, interview, and record review, the facility failed to implement appropriate infection control practices when: 1. The facility did not follow their policy and procedure (P&P) for washing the laundry in the correct temperature range. 2. In the rehabilitation office, two resident reusable cold modality packs and two staff food containers in the refrigerator were stored in the same combination freezer/refrigerator. 3. Restorative Nursing Aide (RNA 1) did not properly disinfect a cloth gait belt (an assistive device that is secured around a person's waist to allow a caregiver to grasp the belt and assist in lifting or moving a person) during a treatment session with Resident 63. These deficient practices have the potential to spread infections among residents, staff, and visitors. Findings: 1. During a concurrent observation and interview on 10/3/2024 at 7:15 a.m. with Laundry Aide (LA) 1, in the laundry room, LA 1 stated the laundry was washed in temperatures ranging from 140 degrees Fahrenheit ([F]- unit of measurement for temperature) -145 F. LA 1 stated this was the temperature based on a signage that was on the washing machine that tells the laundry staff WARNING HOT WATER 140-145 DEGREE HOT WATER. During a concurrent interview and record review on 10/3/2024 at 8:30 a.m., the temperature logs for the water temperature log dated October 2024 was reviewed. LA 1 stated each washing machine has its own temperature log and once a day the laundry staff would record the temperature of the washing machine while it was running and write the temperature down on the log. LA 1 stated all recorded temperatures for all 3 washing machines had a temperature of 140 F during the month of October 2024. During an interview on 10/4/2024 at 9:45 a.m. with the Maintenance Supervisor (MS) and the Maintenance Lead (ML), the MS stated the laundry was washed in temperatures from 140 F - 145 F as it was stated on the signage posted on the washing machine. The MS and ML stated they did not know where the temperature recommendation came from, but the staff had been following the temperature posted on the signage. The ML stated it was important to have the laundry be washed at a certain temperature to ensure it killed all the germs. During a concurrent interview and record review on 10/4/2024 at 10:00 a.m. with the MS and ML, the facility's policy and procedure (P&P) titled Laundry Services, dated 3/2024 was reviewed. The P&P indicated to launder soiled linen using hot water 158-176 F. The MS and ML stated they were not aware of this temperature range, and they would have to adjust the temperature to ensure the laundry was being washed at the appropriate temperature. 41379 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. During a concurrent observation and interview on 10/2/2024 at 9:21 AM, in the rehabilitation department office, there was a small combination freezer and refrigerator in the corner. The Assistant Director of Rehabilitation (ADOR) stated the facility used cold packs for cold therapy on residents on therapy as needed. The ADOR proceeded to show the combination freezer/refrigerator. On the upper part of the unit, there was a small section with ice buildup around the area and there were two blue reusable cold ice packs. Underneath in the refrigerator section was two shelves and one shelf had two food containers. The ADOR stated the food containers were staff food and that staff used the refrigerator to store personal food. ADOR confirmed the freezer section contained reusable cold ice packs for resident use in therapy treatment in the same freezer/refrigerator unit used for staff personal food storage. During an interview on 10/3/2024 at 11:03 AM with the Infection Preventionist (IP), the IP stated equipment used for residents should not be stored in the refrigerator as staff food, because of infection control. The IP stated there was a separate refrigerator for staff in the downstairs staff lounge. The IP stated if equipment used for residents were stored in the same refrigerator as staff food, there was a potential for contamination of bacteria from the food. During an interview on 10/3/2024 at 2:11 PM with the Director of Nursing (DON), the DON stated reusable resident equipment should not be combined and stored in same refrigerator as staff food for infection control. The DON stated staff food and resident equipment could contaminate each other and bacteria could grow even in cold temperatures. During a review of the facility's policy and procedures (P&P) effective 7/1/09, titled, Rehabilitation Services Policies and Procedures, indicated the therapy department will possess an infection control program designed to provide a safe, sanitary, and comfortable environment for residents and staff to help prevent the development and transmission of disease and infection. 50961 3. During a review of Resident 63's Admission Record , the Admission Record indicated Resident 63 was admitted on [DATE] with diagnoses including, but not limited to, congestive heart failure (a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), and diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 63's Order Summary Report, dated 10/3/2024, the Order Summary Report indicated an order dated 9/30/2024 for Restorative Nursing Aide program (RNA, nursing aide program that help residents to maintain their function and joint mobility) for ambulation with rolling walker (an assistive device designed to assist individuals with walking difficulties with wheels on all four legs) five days a week as tolerated. During an observation on 10/3/2024 at 9:29 AM, in Resident 63's room, RNA 1 took out a cloth gait belt from her pocket and placed the cloth gait belt around Resident 63's waist to assist with ambulation. After RNA 1 completed ambulation with Resident 63, RNA 1 removed the cloth gait belt from Resident 63's waist and exited the room with the cloth gait belt. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055253	A. Building B. Wing	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St. John of God Retirement	2468 South St Andrews Place Los Angeles, CA 90018

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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 - Many	During an interview on 10/3/2024 at 09:47 AM, with RNA 1, RNA 1 stated the cloth gait belt was used with resident and RNA 1 cleaned the cloth gait belt with disinfecting wipes. RNA 1 showed a bottle of disinfecting wipes with a purple cap used to clean the cloth gait belt. During an interview on 10/3/2024 at 10:14 AM, with the IP, the IP stated cloth gait belts must be washed to be properly disinfected after each use to prevent contamination. The IP stated cloth gait belts were considered a porous material and disinfecting wipes could not properly disinfect porous materials. The IP stated disinfecting wipes could only be used with non-porous materials like plastic gait belts. The IP stated staff should be using plastic gait belts, which were non-porous, in order to be properly disinfected between resident use. During an interview on 10/3/2024, at 2:11 PM, with the DON, the DON stated cloth gait belts must be washed and stated disinfecting wipes could not properly disinfect cloth gait belts. The DON stated reusable resident equipment need to be disinfected to prevent the spread infection. During a review of the facility's P&P titled, Cleaning and Disinfection of Resident-Care Items and Equipment, revised 10/18, the P&P indicated, reusable items are cleaned and disinfected between residents and reusable resident care equipment will be decontaminated and/or sterilized between residents according to manufacturer's instructions.