STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055262	A. Building B. Wing	11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lomita Post-Acute Care Center	1955 Lomita Blvd Lomita, CA 90717

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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 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** 49145 Based on observation, interview, and record review, the facility failed to ensure one of three residents (Resident 12) Minimum Data Set (MDS- a federally mandated resident assessment tool) was accurately documented to reflect Resident 12 hearing status. This deficient practice had the potential to negatively affect Resident 12's plan of care and delivery of necessary care and services. Findings: During a review of Resident 12's Admission Record, the Admission Record indicated Resident 12 was admitted to the facility on [DATE] with diagnoses including anxiety (a feeling of fear, dread, and uneasiness) and major depressive disorder (a mood disorder that can cause severe symptoms that affect a person's feelings, thoughts, and daily activities). During a review of Resident 12's MDS, the MDS indicated Resident 12 has adequate (normal) hearing. During a review of Resident 12's Care Plan titled, Resident 12 had a communication problem related to hard of hearing bilateral ear initiated on 1/30/2024, the Care Plan interventions for Resident 12 included validate message by repeating aloud and use touch, facial expression, tone, and body language to enhance communication. During an interview on 10/29/2024 at 10:19 a.m., with Resident 12, Resident 12 stated she is hard of hearing and would like to have hearing aids. During an interview on 10/31/2024 at 2:37 p.m., with Certified Nurse Assistant (CNA) 4, CNA 4 stated Resident 12 was hard of hearing and when speaking to her, you must get very close to her so she can hear. CNA 4 stated Resident 12 watches television with the volume high and would benefit from hearing aids. During an interview on 10/31/2024 at 3:30 p.m., with Registered Nurse Supervisor (RNS) 1, RNS 1 stated Resident 12 is hard of hearing. RNS 1 stated hearing aids would be helpful for Resident 12 because she enjoys watching the sports games and hearing aids would be good for Resident 12's overall health. (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 11/1/2024 at 12:23 p.m., with the Minimum Data Set Nurse (MDSN), MDSN stated Resident 12 is hard of hearing, but the MDS indicated her hearing was adequate which means there were no hearing issues. MDSN stated the MDS should state minimal rather than adequate for Resident 12's hearing assessment. MDSN stated MDS accuracy was important because it affects what necessary care and services Resident 12 needs. During a concurrent interview and record review on 11/1/2024 at 4:17 p.m., with the Director of Nursing (DON), the DON stated Resident 12's MDS for hearing should be marked as minimal and not adequate because Resident 12 is hard of hearing. During a review of the MDS Nurse Job Description, dated 4/12/2024, the job description indicated, Assist with MDS completion with the Interdisciplinary team in timely completion of the assessments. Monitors overall the documentation in the medical record to validate that it supports MDS coding.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 45269 Based on interview and record review, the facility failed to ensure three of 20 sampled residents (Resident 22, 24 and 13) had a Preadmission Screening and Resident Review (PASARR-a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care) assessment done when diagnosed with a mental illness prior to admission. This failure had the potential to result in Resident 22, 24 and 13 not receiving the necessary services and appropriate psychiatric level of treatment and evaluation in the facility. Findings: a. During a review of Resident 22's Admission Record, the Admission Record indicated Resident 22 was admitted to the facility on [DATE] with diagnoses including major depressive disorder(a mood disorder that causes a persistent feeling of sadness and loss of interest),paraplegia (loss of movement and/or sensation, to some degree, of the legs) and acute transverse myelitis of central nervous system(brief but intense inflammation of the spinal cord which caused damage to the protective covering of nerve fibers). During a review of Resident 22's History & Physical (H&P) dated 10/17/2024, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 22's Minimum Data Set (MDS- a federally mandated resident assessment tool) dated 10/20/2024, the MDS indicated Resident 22 had moderately impaired cognitive (ability to think, understand, learn, and remember) skills and was dependent on staff with bathing, toileting hygiene and dressing. During a review of Resident 22's Physician Order Summary Report, the Order Summary Report indicated an order on 10/14/2024 for Abilify (medicine that helps treat several kinds of mental health conditions) five (5)milligrams (mg- unit of measurement) one tablet by mouth one time a day for psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) manifested by inability to relax /anxiety. During a review of Resident 22's Physician Order Summary Report, Physician Order Summary Report indicated an order on 10/12/2024 for Fluoxetine Hydrochloride (medicine used to treat depression) 40 mgs, give one capsule by mouth one time a day for depression manifested by irritability. During a review of Resident 22's Physician Order Summary Report, the Physician Order Summary Report indicated an order on 10/18/2024 for Quetiapine Fumarate (medicine that treats depression, schizophrenia [a mental illness that is characterized by disturbances in thought], and bipolar disease {sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs}) give 25 mgs. by mouth at bedtime for psychosis manifested by agitation (a state of anxiety or nervous excitement). (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 22's Interdisciplinary Team Interdisciplinary (IDT- group of professional and direct care staff that have primary responsibility for the development of a plan for the care of a resident) Care Plan Review, dated 10/25/2024, the IDT Care Plan Review indicated PASSAR Level 1 assessment was not reviewed or addressed. During a concurrent interview and record review on 10/31/2024, at 4:17 p.m. with the Director of Nursing (DON), reviewed Resident 22's PASSR Level 1. The DON stated Resident 22's PASSR Form was not accurately filled up because resident was on three psychotropic medications and had a diagnosis of mental illness, but the form dated 10/10/2024 indicated Resident was not on any psychotropic medications and had no mental illness. The DON stated she was the primary responsible for residents' PASSAR Forms and the facility supposed to double check if the form was accurate from general acute hospital (GACH). The DON stated not screening accurately for PASSR could affect residents' care, could cause delay in treatment and services related to mental illness and missed interventions for specific diagnosis. b. During a review of Resident 24's Admission Record, the Admission Record indicated Resident 24 was originally admitted to the facility on [DATE] with diagnoses including major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), bipolar (sometimes called manic-depressive disorder, mood swings that range from the lows of depression to elevated periods of emotional highs) and anxiety. During a review of Resident 24's History and Physical (H&P), dated 12/4/23, 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 9/5/2024, the MDS indicated Resident 24 needed setup or clean-up assistance with eating. The MDS indicated Resident 24 needed substantial to maximal assistance with oral hygiene. The MDS indicated Resident 24 was dependent on staff for toileting, showering, dressing, putting on and taking off shoes, transferring and rolling from left to right, and sitting to lying. During a concurrent interview and record review on 10/31/2024 at 1:47 pm with the Director of Nursing (DON), Resident 24's PASARR, dated 11/09/2019 was reviewed. The PASARR indicated the level one screening was negative and did not need a PASARR level two evaluation due to no diagnosis of a mental illness. The DON stated Resident 24 has anxiety and the level one PASARR was documented incorrectly. The DON stated she was responsible for reviewing and completing the PASARR. The DON stated she will update and make a new PASARR for Resident 24. The DON stated if the PASARR was not documented correctly there will be a missed plan of care for Resident 24 and a delay in treatment and services for mental illness. c. During a review of Resident 13's Admission Record, the Admission Record indicated Resident 13 was admitted to the facility on [DATE] with diagnoses including diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality). (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 13's MDS dated [DATE], the MDS indicated Resident 13 had a psychotic disorder (a severe mental illness that causes a person to lose touch with reality and have difficulty relating to others). The MDS indicated Resident 13 had moderate cognitive (ability to think, understand, learn, and remember) impairment. During a review of Resident 13's Physician Order Summary Report, the Physician Order Summary Report indicated an order was placed 10/30/2024 for Olanzapine (medication to treat psychosis). The Physician Order Summary Report indicated an order was placed on 10/30/2024 for monitoring for psychotic behaviors every shift. During a review of Resident 13's Care Plan titled Resident 13 had a potential for a behavior problem related to psychosis initiated 10/18/2024, with goals for Resident 13 to not have behavior problems. The Care Plan interventions including approaching her in a calm manner. During a review of Resident 13's PASARR completed on 10/15/2024, the PASARR indicated a negative Level 1 screening. PASARR did not indicate that Resident 13 was diagnosed with psychosis but did indicate she was on psychotropic medications (medication to treat mental health disorders). During a concurrent interview and record review on 10/31/2024 at 1:47 p.m., with the DON, the DON stated she was responsible to ensure the PASAAR was completed accurately. The DON stated Resident 13's PASARR was done incorrectly because Resident 13 has a diagnosis of psychosis. The DON stated it was important that the PASARR was accurately completed because it can affect the residents care and result in a delay in treatment. During a review of the facility's policy and procedure (P&P) titled Resident Assessment/PASARR, dated revised 7/2022, the P&P indicated It is the policy of this facility to ensure that each resident is properly screened using the PASARR specified by the State.

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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** 49145 Based on interview and record review, the facility failed to implement care plan interventions for one of three residents (Resident 51) who received anti-coagulant therapy (a medication that prevents or treats blood clots in the heart and blood vessels). This failure had the potential to result in complications from the use of anti-coagulant therapy including bruising and bleeding. Findings: During a review of Resident 51's Admission Record, the Admission Record indicated Resident 51 was admitted to the facility on [DATE] with diagnoses including venous thrombosis (a condition where a blood clot forms in a vein and blocks blood flow) and embolism (blood clots in the veins) and renal dialysis (a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly). During a review of Resident 51's Minimum Data Set (MDS- a federally mandated assessment tool) dated 10/17/2024, the MDS indicated Resident 51 had moderate cognitive (ability to think, understand, learn, and remember) impairment. During a review of Resident 51's Physician Order Summary Report, the Physician Order Summary Report indicated on order was placed on 8/8/2024 for Eliquis (a blood thinner medicine that reduces blood clotting). During a review of Resident 51's Care Plan titled Resident 51 was on anticoagulant therapy initiated 4/15/2024, the care plan interventions for Resident 51 included monitoring, documenting, and reporting signs and symptoms of anticoagulant complications: blood in urine, black tarry stools (bleeding in the upper gastrointestinal tract), blood in stool, bruising, and bleeding. During a concurrent interview and record review on 10/30/2024 at 2:30 p.m., with Licensed Vocational Nurse (LVN) 3, LVN 3 stated Resident 51 is currently taking Eliquis for venous thrombosis. LVN 3 stated there was a care plan for Eliquis and to monitor for bleeding, but LVN 3 was unable to locate documentation for monitoring for bleeding. LVN 3 stated they are not following the care plan but should be because if Resident 51 was not monitored for bleeding, Resident 51 could go into shock (a life-threatening condition that occurs when the body is not getting enough blood flow), develop internal bleeding (bleeding that occurs within the body), and possibly die. (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 concurrent interview and record review, on 10/30/2024, at 3:53 p.m., with Registered Nurse Supervisor (RNS) 1, RNS 1 stated Resident 51 is taking Eliquis for venous thrombosis and there should be monitoring for bleeding because Resident 51 is on renal dialysis and is at risk for bleeding. Reviewed Resident 51's medical record, RNS 1 stated there was no documentation on monitoring for signs and symptoms of bleeding. RNS 1 stated there was a care plan for Eliquis to monitor for signs and symptoms of bleeding but was not implemented. RNS 1 stated Resident 51's care plan was not followed. During an interview with the Director of Nursing (DON), on 11/1/2024 at 4:17 p.m., the DON stated it was important to follow the Eliquis plan of care for Resident 51 monitoring for signs and symptoms of bleeding. The DON stated Resident 51 could develop internal bleeding and signs and symptoms of bleeding could be missed. During a review of the facility's policy and procedure (P&P) titled General Anticoagulation Management, undated, the P&P indicated, Evaluation of bleeding may include the assessment for the following signs/symptoms, as reported by the patient's nurse/charge nurse: excessive bleeding/bruising, petechiae, nose bleed, gingival (gums) bleeding, hematuria (blood in urine), blood in stools, hemorrhoidal bleeding, persistent oozing from superficial injuries, severe, acute abdominal or back pain.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45269 Based on interview and record review, the facility failed to ensure one of six sampled residents (Resident 163) was helped with activities of daily living (ADL- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) when Resident 163 requested to have a shower. This failure resulted in Resident 163 feeling abandoned and neglected. Findings: During a review of Resident 163's Admission Record, the Admission Record indicated Resident 163 was admitted to the facility on [DATE] with diagnoses including displaced intertrochanteric fracture of left femur (hip breaks between the bumpy parts at the top of the thigh bone), history of falling, polymyalgia rheumatica (inflammatory disorder that causes muscle pain and stiffness especially in the shoulders and hips) and presence of left artificial knee joint. During a review of Minimum Data Set (MDS- a federally mandated resident assessment tool) dated 10/29/2024, the MDS indicated Resident 163 had an intact cognition (ability to think, understand, learn, and remember) and was dependent on staff with shower or bathing, and toileting hygiene. The MDS indicated Resident 163 had an impairment on one side of the body (hip, knee, ankle, and foot) and required substantial or maximal assistance (staff complete the activities for the resident) with bed mobility and lower dressing. The MDS indicated chair/bed to chair transfer was not attempted due to medical and safety concerns. During a review of Resident 163's Care Plan titled Resident had a left comminuted (bone is broken into more than two pieces) intertrochanteric hip fracture and intramedullary hip screw (use of internal devices like screw to stabilize broken bones) related to fall, care plan goal indicated surgical incision will heal without infection. The Care Plan interventions included anticipating and meeting resident's needs and ensuring call light was within reach and to respond promptly to all requests for assistance. During a review of Resident 163's Activities of Daily Living Task dated 10/28/2024 to 11/1/2024, the ADL Task indicated Resident 163 was dependent on staff with showering or bathing. During a review of Resident 163's ADL Task dated 10/28/2024, 10/30/2024, and 11/1/2024, the ADL Task indicated Resident 163 was dependent on staff with transfer to and from a bed to a chair or wheelchair. During an interview on 11/1/2024, at 12:05 p.m., with Resident 163, Resident 163 stated she used her call light because her diaper was wet and needed to be changed. Resident 163 stated Certified Nursing Assistant (CNA1) answered and offered a shower. Resident 163 stated CNA 1 had difficulty bringing her to the shower room because she could not bend her left leg while in the shower chair. Resident 163 stated CNA 1 returned her to the bed with another staff and told her she would be back to give her a bath. Resident 1 stated she fell asleep and woke up in tears and used the call light to get help. Resident 163 stated she felt abandoned and frustrated because CNA 1 did not return to help her. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/1/2024, at 12: 31 p.m. with CNA 1, CNA 1 stated Resident 163 required total assistance with personal care because of her legs. CNA 1 stated on 10/31/2024, at around 10:00 a.m., Resident 163 was requesting for a shower because she had not showered for a few days. CNA1 stated it was her first time to transfer Resident 163 by herself in a shower chair and noticed resident's left leg was unable to bend while in the shower chair. CNA 1 stated resident was able to sit on the shower chair but could not bend her leg, so she asked CNA 2 to help her get Resident 163 back to bed at around 11:00 a.m. CNA 1 stated she told Licensed Vocational Nurse (LVN 2) about Resident 163's complaint of pain and told the Resident 163 she will provide bed bath after lunch. CNA1 stated she did not provide bed bath due to Resident 163's pain and had left for lunch at 11:40 a.m., then came back to the unit at 12:10 p.m. CNA1 stated she should have found out more information on how to transfer and take care of Resident 163's needs or asked another CNA to help her move Resident 163 to the shower chair to assist Resident 163 with her ADLs. CNA 1 stated Resident 163 could feel ignored and frustrated when her needs were not met in a timely manner. During an interview on 11/1/2024, at 1:27 p.m., with CNA 2, CNA2 stated CNA 1 asked her to help with the transfer of Resident 163 from the shower chair to the bed. CNA 2 stated she would usually ask physical therapist on what kind of assistance would a resident need if they had hip surgery before transferring the resident to a chair to ensure patient's safety. During a telephone interview on 11/1/2024, at 1:27 p.m., with LVN 2, LVN 2 stated he could not remember CNA 1 notifying him about Resident 163's pain around 11:00 a.m. and did not administer any pain medication to Resident 163 yesterday (10/31/2024). During a review of Resident 163's Physician Order Summary Report, the Physician Order Summary Report dated 10/26/2024 indicated toe touch weight bearing (a weight bearing restriction that allows a person to touch the floor with their toes or foot for balance, but no weight should be placed on the affected leg) on left lower extremity (leg). During a concurrent interview and record review 11/1/2024, at 1:40 p.m. with Director of Nursing (DON), reviewed Resident 163's Medication Administration Record (MAR) dated 10/31/2024, the DON stated Resident 163 did not receive any as needed (prn) pain medication on 10/31/2024 except Duloxetine (medicine that treats pain and depression) administered on 10/31/2024 at 6:30 a.m. During an interview on 11/1/2023, at 2:26 p.m. with Physical Therapist (PT 1), PT 1 stated Resident 163 can have one person assist as long as the staff know what they are doing because of the toe touch weight bearing on the left leg. PT 1 stated the staff should transfer her on the good side because Resident 163 had a lot of stiffness and if it was a new resident, the staff should get another person to help transfer Resident 163 from bed to chair. During an interview on 11/1/2024, at 3:20 p.m. with RN Supervisor (RNS 1), RNS 1 stated Resident 163 should have two people assist with transfer to prevent an accident or fall. RNS 1 stated CNA 1 should have notified another staff that covers her while on lunch break about Resident 163's request to be bathe or showered. RNS 1 stated CNA 1 should have communicated Resident 163 that she would be taking her lunch break and there will be another staff covering her while at lunch break. RNS 1 stated Resident 163 would feel neglected, and her needs would not be met. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/1/2024, at 5:01 p.m., with the DON, the DON stated the incident should have been prevented by providing care in a timely manner. The DON stated Resident 163 would feel abandoned and neglected if her needs were not met. During a review of facility's policy and procedure(P&P) titled, Resident Rights, revised 12/2016, the P&P indicated employees shall treat all residents with kindness, respect, and dignity and these rights include the resident rights to be informed of and participate in her care planning and treatment. During a review of the facility's policy and procedure (P&P) titled, ADL Care revised 11/2021, the P&P indicated residents who are unable to carry out activities of daily living (ADL) will receive assistance as needed.

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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** 45269 Based on observation, interview and record review, the facility failed to ensure one of six sampled residents (Resident 32) received necessary care and services by failing to: 1.Follow up and ensure venous and arterial doppler (imaging test that uses sound waves test and help diagnose problems that affect the flow of blood) was done in a timely manner as ordered by the physician on 10/28/2024. 2. Monitor and assess the size of hematoma on Resident 32's left leg. This failure had the potential to cause delays in diagnosis, which could lead to delays in appropriate treatment for Resident 32. Findings: During a review of Resident 32's Admission Record, the Admission Record indicated Resident 32 was admitted to the facility on [DATE], and was readmitted on [DATE] with diagnoses including laceration of popliteal artery of the left leg(cut or tear of popliteal artery which is the main blood vessel that supplies blood for the lower leg and knee area), displaced bicondylar fracture of left tibia (severe injury that occurs when both upper and lower parts of shinbone are broken and displaced from their normal position), and heart failure (heart does not pump enough blood to meet body's needs). During a review of Resident 32's Minimum Data Set (MDS- a federally mandated resident assessment tool) dated 9/19/2024, the MDS indicated Resident 32 had moderately impaired cognitive skills (ability to think, understand, learn, and remember) and required partial/moderate assistance (helper does less than half the effort) with toileting hygiene, bathing, and lower body dressing. During a review of Resident 32's Physician Order dated 10/28/2024, the Physician's Order indicated a telephone order of venous and arterial doppler on left lower extremity (left leg) to check circulation, today (10/28/2024). The Physician Order indicated the test was for the pain/ swelling. During a review of Resident 32's Treatment Administration Record (TAR) dated from October 10 to October 31, 2024, the TAR indicated to apply ice packs to left knee for 15 to 20 minutes three times a day. During an observation and interview on 10/29/2024, at 11:38 a.m., with Resident 32, Resident 32 was lying in bed scratching her left leg. Observed a hematoma (a solid swelling of clotted blood within the tissues) on the left leg below the knee. Resident 32 stated she had swelling on her leg because it got broken into several pieces and was waiting for ultrasound test of her leg. (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 concurrent interview and record review on 10/30/2024, at 2:13 p.m. with Licensed Vocational Nurse (LVN 3), reviewed Resident 32's electronic health record, LVN 3 stated Resident 32 had a surgical incision and a hematoma on the left leg. LVN 3 confirmed the order of doppler of venous and arterial was ordered to be done on 10/28/2024 and was not done yet. LVN 3 stated the licensed nurses will fax the order and will follow up if the order for the test was received. LVN 3 stated if the venous and arterial doppler test was not done, the licensed nurse should notify the physician and the resident so they will know there was a delay. LVN 3 stated no documentation the physician was notified of the delay, or the test was followed up with the ultrasound company. During a concurrent interview and record review on 10/30/2024, at 3:24 p.m. with Registered Nurse Supervisor (RNS 1) reviewed Resident 32's Nurses Progress Notes, RNS 1 stated venous and arterial doppler was not done on 10/28/2024 because the x-ray technician was not available at that time. RNS 1 stated the facility should inform the physician when a test was not done. RNS 1 confirmed there was no documentation about notification of the physician that the test was not done on 10/28/2024 as ordered. RNS 1 stated not notifying the physician the venous and arterial doppler was not done as ordered could cause a delay of treatment or care to Resident 32. During an interview on 11/1/2024, at 4:34 p.m., with the Director of Nursing (DON), the DON stated Resident 32 had a history of ruptured popliteal artery which was treated in general acute care hospital (GACH). The DON stated facility staff should have followed up with ultrasound company and if there was a delay the physician should be notified. The DON stated Resident 32 could have a blood clot if not addressed right away which could lead to complications if the test was not done in a timely manner. 2. During a concurrent interview and record review on 10/31/2024, at 11:26 a.m., with Treatment Nurse (TN 1), reviewed Resident 32's electronic health record, TN 1 stated ice pack was applied on Resident 32's left knee swelling on 10/9/2024 up to the present (10/31/2024). TN 1 stated the hematoma below the left knee was first documented on 9/16/2024. TN 1 stated the hematoma was monitored through visual check and agreed it was not an accurate way of assessing if the size got bigger or had decreased. TN 1 stated resident complained of discomfort but no new increasing discomfort. During an interview on 10/30/2024, at 3:24 p.m. with RN Supervisor (RNS 1), RNS 1 the reason for the venous and arterial doppler test was because Resident 32 had pain and swelling on the left leg. RNS 1 stated she monitored the hematoma on the left leg by looking at it and the size had not changed. During an interview on 11/1/2024, at 4:34 p.m. with the DON, the DON stated assessment of hematoma should be specific and the licensed nurse should have measured the size to determine if it was getting bigger or smaller. The DON stated Resident 32 could be bleeding internally and could go unnoticed which could cause a delay in treatment and care. During a review of facility's Job Description of Registered Nurse (RN) dated 12/17/2021, the Job Description of Registered Nurse indicated The RN initiates requests for consultation or referral consult with physician concerning resident evaluation and determine when to refer the resident to the physician for evaluation, supervisions, and directions. (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 facility's policy and procedure (P&P) titled Change in a Resident's Condition or Status, undated, the P&P indicated The nurse supervisor will notify resident's attending physician when there is a need to alter the resident's treatment significantly or deemed necessary or appropriate in the best interest of the resident. The P&P indicated regardless of the resident's mental or physical or mental, nursing services will inform the resident of any changes in his or her medical care or nursing treatments.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49145 Based on observation, interview, and record review, the facility failed to ensure one of three residents (Resident 12) received access to hearing services. This failure resulted in Resident 12 having trouble hearing properly. Findings: During a review of Resident 12's Admission Record, the Admission Record indicated Resident 12 was admitted to the facility on [DATE] with diagnoses including anxiety (a feeling of fear, dread, and uneasiness) and major depressive disorder (a mood disorder that can cause severe symptoms that affect a person's feelings, thoughts, and daily activities). During a review of Resident 12's MDS, the MDS indicated Resident 12 has adequate (normal) hearing. During a review of Resident 12's Care Plan titled, Resident 12 had a communication problem related to hard of hearing bilateral ear initiated on 1/30/2024, the Care Plan interventions for Resident 12 included validate message by repeating aloud and use touch, facial expression, tone, and body language to enhance communication. During an interview on 10/29/2024 at 10:19 a.m., with Resident 12, Resident 12 stated she is hard of hearing and would like to have hearing aids. During an interview on 10/31/2024 at 2:37 p.m., with Certified Nurse Assistant (CNA) 4, CNA 4 stated Resident 12 was hard of hearing and when speaking to her, you must get very close to her so she can hear. CNA 4 stated Resident 12 watches television with the volume high and would benefit from hearing aids. During an interview on 10/31/2024 at 3:30 p.m., with Registered Nurse Supervisor (RNS) 1, RNS 1 stated Resident 12 is hard of hearing. RNS 1 stated hearing aids would be helpful for Resident 12 because she enjoys watching the sports games and hearing aids would be good for Resident 12's overall health. During an interview on 11/1/2024 at 4:17 p.m., with the Director of Nursing (DON), the DON stated Resident 12 is hard of hearing and it would be beneficial for her to have hearing aids so she could communicate better and understand more. During a review of the facility's policy and procedure (P&P) titled, Ancillary Services, undated, the P&P indicated, It is the policy of this facility to obtain dental, optometry, ophthalmology, podiatry, audiology (ENT), and psychosocial/psychiatric services for residents who present with or request a need for these ancillary services. Ancillary services help residents attain and maintain healthy psychosocial functioning through their ability to interact with their environment. All residents will be assessed for ancillary needs upon admission, and reassessed quarterly and as needed. Cross Reference F641

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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** 44898 Based on observation, interview, and record review, the facility failed to provide appropriate safety precautions to residents at risk for fall for one of 20 sampled residents (Resident 40). Facility failed to ensure: a. Resident 40, who was on fall risk precaution with landing pads placed on the side of the bed had no bedside table on top of the landing pads. This failure had the potential for injury when Residents 40 would fall out of bed and hit their head on the bedside table placed on top of the landing pads. Findings: During a review of Resident 40's Admission Record, the Admission Record, indicated Resident 40 was originally admitted to the facility on [DATE] with diagnoses including transient ischemic attack (TIA is a short period of symptoms similar to those of a stroke [(damage to the brain from interruption of its blood supply)]) , cardiac pacemaker (a small, battery-powered device that's surgically implanted in the chest or abdomen to regulate the heart's rhythm and rate) , dementia (a progressive state of decline in mental abilities), and anxiety (a feeling of fear, dread, and uneasiness). During a review of Resident 40's History and Physical (H&P), dated 6/12/2024, indicated Resident 40 could make needs known but could not make medical decisions. During a review of Resident 40's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 8/8/2024, the MDS indicated Resident 40 needed setup or clean-up assistance with eating and oral hygiene. The MDS indicated Resident 40 needed substantial to maximal assistance with showering, upper body dressing, personal hygiene, changing positions from left to right, sitting to lying and lying to sitting. The MDS indicated Resident 40 was dependent on staff for toileting, lower body dressing, putting on and taking off footwear and transferring. During a review of Resident 40's Physician Order Summary Report, dated 6/18/2024, the Physician Order Summary Report indicated Resident 40 had an order to have the bed low with landing pads (designed to provide a cushioned landing pad and reduce injuries) at bedside when Resident 40 is in bed to minimize impact and injury if Resident 40 rolls out of bed. During an observation on 10/29/2024 at 1:32 p.m., in Resident 40's room, Resident 40 had a landing pad on the floor next to the bed with a bedside table on top of the landing pad. During an interview on 10/30/2024 at 12:08 p.m., with Certified Nursing Assistant (CNA) 7, CNA 7 stated Resident 40 was a fall risk, and has landing pads on the floor. CNA 7 stated landing pads were used in case residents' fall so they do not hit the floor hard. CNA 7 stated the table was not supposed to be on top of the landing pad. CNA 7 stated if Resident 40 falls from the bed she could hit herself on the bedside table. (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 interview on 10/30/2024 at 3:54 p.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated landing pads were used to protect residents in the event of fall from the bed so it will provide a cushioned to prevent injury. LVN 1 stated Resident 40 was at risk for fall. LVN 1 stated any resident at risk for falls have landing pads. LVN 1 stated Resident 40 had a fall on 1/28/2024 without any injury. LVN 1 stated it was not okay for the bedside table to be on top of the landing pads. LVN 1 stated Resident 40 could be a risk for injury and hit her head on the bedside table. LVN 1 stated it was best to move the table out of the way. During an interview on 11/1/2024 at 3:36 p.m., with Registered Nurse Supervisor (RNS) 1, RNS 1 stated landing pads were used for residents at risk for fall. RNS 1 stated the landing pads are placed on the side of the bed and act as a cushion to prevent any injury. RNS 1 stated if the resident falls out of bed the fall will not be as hard. RNS 1 stated the bedside table on top of the landing pad could add more injury to the resident if the resident falls. During an interview on 11/1/2024 at 4:17 p.m., with the Director of Nursing (DON), the DON stated the landing pad was an intervention to prevent injury when resident fall from the bed. The DON stated the bedside table could present a hazard for the resident if the resident falls. During a review of the facility's policy and procedure (P&P) titled Falls-Clinical Protocol revised 3/2018, the P&P indicated, Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 49145 Based on interview and record review, the facility failed to ensure employee files were reviewed and kept up to date to ensure an at the time of hire and annual competency 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),Tuberculosis (TB-lung disease) testing, performance evaluation, annual health examinations and background checks were completed for seven employees. The facility failed to: 1.Ensure DSD, Registered Nurse Supervisor (RNS) 1, Licensed Vocational Nurse (LVN) 3, LVN 4, LVN 5, Certified Nurse Assistant (CNA) 5, and CNA 6 had a Tuberculosis (TB- a lung disease) test, (a skin test to check if you have been infected with Tuberculosis) upon hire and annually. 2.Ensure DSD, LVN 3, LVN 4, LVN 5, CNA 5, and CNA 6 had a skills competency checklist at the time of hire and annually. 3. Ensure DSD, LVN 3, LVN 4, LVN 5, CNA 5, and CNA 6 had annual performance evaluation. 4.Ensure health examinations were completed upon hire and annually. 5.Ensure background checks were completed prior to the hire date. These failures 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. Findings: During a concurrent interview and record review on 11/1/2024 at 3:49 p.m., with the Director of Staff Development (DSD), seven employee files were reviewed including DSD, Registered Nurse Supervisor (RNS) 1, Licensed Vocational Nurse (LVN) 3, LVN 4, LVN 5, Certified Nurse Assistant (CNA) 5, and CNA 6. DSD stated TB tests were not done for DSD, RNS 1, LVN 3, LVN 4, LVN 5, and CNA 5 upon hire and annually. DSD stated there were no background checks prior to hiring DSD, LVN 3, LVN 4, LVN 5, CNA 5, and CNA 6 and no annual competency skills. DSD stated, DSD, RNS 1, LVN 3, and LVN 4 had no annual health exams on file. DSD stated failure to assess staff competency and skills can directly affect the quality of care provided to residents and potentially compromise resident safety. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/1/2024 at 4:17 p.m., with the Director of Nursing (DON), the DON stated it was the responsibility of the DSD to review and maintain the employee files to ensure all necessary competency, performance evaluation and health records were up to date. The DON stated it was important and mandatory to keep employee files up to date to ensure staff had the skills and competency to perform their roles and addressed any skill gaps. The DON stated if the employee files were not up to date, it could affect the resident's care and safety. The DON stated no annual health exam including TB testing had the potential to expose residents and other staff to TB. During a review of the facility's Licensed Vocational Nurse and Registered Nurse Job Description dated 12/17/2021, the job descriptions indicated, Must provide evidence of being free of tuberculosis infection upon hire and as set forth by the policies of the facility.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44898 Based on interview and record review, the facility failed to ensure two of six sampled residents (Resident 8 and Resident 32) are free of unnecessary medicines. The facility failed to: a. Ensure Resident 8 was adequately monitor for the continued used of methenamine (medication used to treat bladder and kidney infections). This failure resulted in the prolonged use of methenamine that can lead to adverse reactions (undesirable harmful effect) including blood in the urine and skin rashes. b. Monitor adverse effects of Eliquis (anticoagulant- medicine used to treat and prevent blood clots in blood vessels and heart) for Resident 32. This failure had the potential to result in Resident 32 in developing an adverse reaction from the use of anticoagulant. Findings: a. During a review of Resident 8's Admission Record, the Admission Record, indicated Resident 8 was originally admitted to the facility on [DATE] with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), dementia (a progressive state of decline in mental abilities), and hypertension (HTN-high blood pressure). During a review of Resident 8's Physician Order Summary Report, dated 4/27/2023, the Physician Order Summary Report indicated, Resident 8 had an order for methenamine one gram given by mouth two times a day for urinary tract infection prophylaxis (action taken to prevent disease). During a review of Resident 8's History and Physical (H&P), dated 12/1/2023, the H&P indicated Resident 8 did not have the capacity to understand and make decisions. During a review of Resident 8's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 8/21/2024, the MDS indicated Resident 8 needed setup or clean-up assistance with oral hygiene. The MDS indicated Resident 8 needed supervision or touching assistance with eating. The MDS indicated Resident 8 needed substantial to maximal assistance with personal hygiene and rolling from left to right. The MDS indicated Resident 8 was dependent on nursing staff for toileting, showering, dressing, putting on and taking off footwear. The MDS indicated Resident 8 was dependent on nursing staff with changing positions from sitting to lying, sitting to standing, and transferring. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/01/2024 at 10:08 a.m., with the Infection Preventionist Nurse (IPN), IPN stated Resident 8 received methenamine an antibiotic prophylactically for a urinary tract infection (UTI- an infection in the bladder/urinary tract). IPN stated no labs were drawn, and urinalysis (a test that examines the contents of a urine sample to check for a variety of health conditions) with culture and sensitivity (helps diagnose an infection and determine the best treatment) was not done. IPN stated when the medication was ordered, a urinalysis with culture and sensitivity should have been done. IPN stated Resident 8 should have been monitored for dysuria (painful urination), hematuria (blood in the urine) and changes in urine pattern. IPN stated the results of urinalysis with culture and sensitivity will determine if the resident has a urinary tract infection. IPN stated culture and sensitivity determine what antibiotics can be used to treat the infection. IPN stated the Mc Greer's criteria (a set of guidelines used to identify infections in long-term care facilities) was not used. IPN stated Resident 8 had no history of urinary tract infection. IPN stated with prolonged use of this medication the resident could build up antibiotic resistance (the ability not to be affected by something, especially harmfully) to the medication and could cause harm to the resident. During an interview on 11/1/2024 at 4:28 pm with the Director of Nursing (DON), the DON stated it was unusual for a resident to be on antibiotics since 4/27/2023. The DON stated Resident 8 should not be on antibiotics. The DON stated Resident 8 could develop resistance to antibiotics and the antibiotic could kill normal flora (the microorganisms that are normally present in or on a healthy person and typically do not cause disease) or cause diarrhea (loose stool). During a review of the facility's policy and procedure (P&P) titled, Medication Regimen Review (Monthly Report) Unnecessary Medication, dated 8/2019, the P&P indicated, Each resident's medication regimen must be free from unnecessary drugs. An unnecessary drug is any drug used in excessive doses, including duplicate therapy; or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. During a review of the facility's policy and procedure (P&P) titled, Antibiotic Stewardship, dated 9/2017, the P&P indicated, It is the policy of this facility to implement an Antibiotic Stewardship Program (ASP) that is incorporated in the overall Infection Prevention and Control Program which will promote appropriate use of antibiotics while optimizing the treatment of infections, at the same time reducing the possible adverse events associated with antibiotic use. This policy has the potential to limit antibiotic resistance in the post-acute care setting, while improving treatment efficacy and resident safety, and reducing treatment-related cost. 45269 b. During a review of Resident 32's Admission Record, the Admission Record indicated Resident 32 was admitted to the facility on [DATE], and was readmitted on [DATE] with diagnoses including laceration of popliteal artery of the left leg(cut or tear of popliteal artery which is the main blood vessel that supplies blood for the lower leg and knee area), displaced bicondylar fracture of left tibia (severe injury that occurs when both upper and lower parts of shinbone are broken and displaced from their normal position), and heart failure (heart does not pump enough blood to meet body's needs). (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 32's Minimum Data Set (MDS- a federally mandated resident assessment tool) dated 9/19/2024, the MDS indicated Resident 32 had moderately impaired cognitive skills (ability to think, understand, learn, and remember) and required partial/moderate assistance (helper does less than half the effort) with toileting hygiene, bathing, and lower body dressing. During a review of Resident 32's Physician Order Summary Report, the Physician Order Summary Report dated 10/10/2024 indicated an order for Eliquis 10 milligrams (mgs.- unit of measurement) two times a day for deep vein thrombosis (DVT-occurs when a blood clot forms in one of the deep veins in the body usually the legs) prophylaxis (attempt to prevent occurrence of disease) for seven days and Eliquis 5 mgs. by mouth two times a day for DVT prophylaxis. During a review of Resident 32's Care Plan titled For anticoagulant therapy (Eliquis) related to DVT prophylaxis initiated on 10/30/2024, the Care Plan goal indicated the resident will be free from discomfort or adverse reactions related to anticoagulant use. The Care Plan's interventions included to monitor, document, report to the physician as needed for signs and symptoms of anticoagulant complications such as blood tinged or frank blood (blood that is bright red and visible) in urine, black tarry stools (comes from bleeding in your upper gastrointestinal (GI) tract), dark or bright red blood in stools, sudden severe headaches, nausea, vomiting and sudden change in mental status. During a concurrent interview and record review on 10/30/2024 with Licensed Vocational Nurse (LVN) 3, reviewed Resident 32's Medication Administration Record (MAR) and Physician's Order, LVN 3 stated there was no physician order to monitor for signs and symptoms of bleeding or documentation of monitoring the side effects for Eliquis in the Medication Administration Record for the month of October 2024. During an interview on 10/30/2024, at 3:24 p.m. with Registered Nurse Supervisor (RNS 1), RNS 1 stated Resident 32 was on Eliquis for DVT prophylaxis and the licensed nurses should be documenting monitoring for signs and symptoms of bleeding or potential side effects of Eliquis in the MAR. RNS 1 stated not monitoring for adverse reaction of Eliquis would place the resident at risk for bleeding and anemia (a condition where the body does not have enough healthy red blood cells) which is preventable if Resident 32 was monitored for adverse reaction of Eliquis. During an interview on 11/1/2024, at 4:34 p.m., with the Director of Nursing (DON), the DON stated Resident 32 would be at risk for bleeding if not monitored for adverse reaction of Eliquis. The DON stated the licensed staff should monitor for skin issues like discoloration, blood in the stool or urine, and vomiting of blood which could be a sign of internal bleeding (bleeding inside the body). During a review of facility's policy and procedure (P&P) titled, Medication Regimen Review Unnecessary Medications updated 8/2019, the P&P indicated Each resident's medication regimen must be free from unnecessary drugs and an unnecessary drug is any drug used without adequate monitoring, excessive durations or without adequate indication of its use.

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Lomita Post-Acute Care Center	1955 Lomita Blvd Lomita, CA 90717

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45269 Based on interview and record review, the facility failed to ensure two of six sampled residents (Resident 11 and Resident 22) were free of unnecessary psychotropic medications (any drug that affects brain activities associated with mental processes and behavior) by failing to: a. Ensure Resident 11 was provided with non- pharmacological interventions (intervention that does not primarily use medicine) before administering as needed (prn) psychotropic medication. b. Ensure Resident 22's psychotropic medications were reevaluated for appropriateness of medication. These failures placed Resident 11 and Resident 22 at risk for using psychotropic medicines for excessive duration and developing adverse effects from the medicines. Findings: During a review of Resident 11's Admission Record, the Admission Record indicated Resident 11 was admitted on the facility on 9/17/2024 with diagnoses including major depressive disorder (a serious mood disorder that affects how a person feels, thinks, and acts), cellulitis (skin infection) of right toe, and opioid (broad group of medicines used to relieve pain) dependence (addiction). During a review of Resident 11's History and Physical (H&P) dated 9/20/2024, the H&P indicated Resident 11 has the capacity to understand and make decisions. During a review of Resident 11's Minimum Data Set (MDS- a federally mandated resident assessment tool) dated 9/23/2024, the MDS indicated Resident 11 had an intact cognition (ability to think, understand, learn, and remember) and required partial/ moderate (helper does less than half the effort) with bed mobility, upper body dressing, and transfer to and from a bed to chair. During a review of Resident 11's Care Plan titled Resident is on Anti-anxiety medication related to Ativan (medication used to treat anxiety) use initiated 10/3/2024, the Care Plan goal indicated Resident 11 will be free from discomfort or adverse reactions related to ant-anxiety therapy. The Care Plan interventions included to monitor and document occurrence or episodes of target behavior symptoms and provide non-pharmacological interventions (healthcare treatments that are not primarily based on medication). During a review of Resident 11's Physician Order Summary Report dated 10/24/2024, the Physician Order Summary Report indicated an order of Ativan 0.5 milligram (mg.- unit of measurement) one tablet by mouth every 6 hours as needed for anxiety for 14 days manifested by inability to relax leading to shortness of breath (SOB- difficulty of breathing). During a review of Resident 11's Physician Order Summary Report dated 9/17/2024, the Physician Order Summary Report indicated an order for anti-anxiety - intervention codes: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1.one on one, 2. activity, 3. adjust room temperature, 4. backrub, 5.change position, 6.give fluids, 7. give food, 8. re-direct, 9. refer to nurses' notes, 10.remove resident from the environment, 11. return to room, 12. toilet, 13. Other as needed. During a review of Resident 11's Medication Administration Record (MAR) for the month of October 2024, the MAR indicated Ativan 0.5 mg. one tablet by mouth every six hours as needed for anxiety as manifested by inability to relax leading to SOB was ordered on 9/17/2024 and reordered on 10/3/2024 and 10/24/2024. During a review of Resident 11's MAR for 10/1/2024 to 10/31/2024, MAR indicated non- pharmacological interventions for anti-anxiety medications were not filled out by licensed staff. During a review of Resident 11's MAR dated October 2024, the MAR indicated on 10/4/2024, at 6:41 a.m., 10/5/2024, at 6:39 a.m. and at 11:33 p.m., on 10/6/2024, at 10:00 a.m. and 4:00 p.m., 10/9/2024, at 5:15 p.m. , 10/11/2024, at 7:37 a.m., and 9:36 p.m., 10/12/2023, at 3:22 p.m., 10/13/2024, at 3:06 p.m. and at 9:33 p.m. ,10/15/2024 at 1:03 p.m. and on 10/16/2024 at 6:10 p.m. Ativan was administered without providing nonpharmacological intervention. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 10/30/2024, at 2:35 p.m., with Licensed Vocational Nurse (LVN 3), reviewed Resident 11's Physician Order and MAR, LVN 3 stated Resident 11's MAR indicated resident was not manifesting any episodes of anxiety on some days when Ativan was administered to the resident on 10/4/ 2024, 10/5/2024, 10/9/2024,10/12/2024,10/13/2024, and 10/15/2024. LVN 3 stated Resident 11 usually liked to take the Ativan at bedtime, or when Resident 11 would ask for it or she would get restless. LVN 3 stated nonpharmacological interventions were not documented or provided to Resident 11 before Ativan was administered. LVN 3 stated not offering non-pharmacological interventions and not monitoring episodes of anxiety before administering Ativan can be considered unnecessary medications and could cause side effects like sleepiness leading to fall and weakness. During a concurrent interview and record review on 10/30/2024, at 3:57 p.m. with RN Supervisor (RNS 1) reviewed Resident 11's MAR, RNS 1 stated Resident 11 received Ativan on 10/4/2024 without documented episodes of anxiety. RNS 1 stated licensed staff should document episodes of anxiety was monitored and provide non-pharmacological interventions before administering Ativan to Resident 11. RNS 1 stated Resident 11 could be at risk for drug dependence, unnecessary medications, side effects like drowsiness, confusion and fall without proper assessment and monitoring of anxiety episodes. During an interview on 11/1/2024, at 4:52 p.m., with the Director of Nursing (DON), the DON stated when a resident is receiving as needed psychotropic medication, the licensed staff should use non-pharmacological interventions before administering the medication to prevent side effects like drowsiness, sedation, nausea, confusion, and vomiting. 2. During a review of Resident 22's Admission Record, the Admission Record indicated Resident 22 was admitted to the facility on [DATE] with diagnoses including major depressive disorder(a mood disorder that causes a persistent feeling of sadness and loss of interest),paraplegia (loss of movement and/or sensation, to some degree, of the legs) and acute transverse myelitis of central nervous system(brief but intense inflammation of the spinal cord which caused damage to the protective covering of nerve fibers). During a review of Resident 22's History & Physical (H&P) dated 10/17/2024, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 22's Minimum Data Set (MDS- a federally mandated resident assessment tool) dated 10/20/2024, the MDS indicated Resident 22 had moderately impaired cognitive (ability to think, understand, learn, and remember) skills and was dependent on staff with bathing, toileting hygiene and dressing. During a review of Resident 22's Physician Order Summary Report, the Order Summary Report indicated an order on 10/14/2024 for Abilify (medicine that helps treat several kinds of mental health conditions) five (5)milligrams (mg- unit of measurement) one tablet by mouth one time a day for psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) manifested by inability to relax /anxiety. During a review of Resident 22's Physician Order Summary Report, Physician Order Summary Report indicated an order on 10/12/2024 for Fluoxetine Hydrochloride (medicine used to treat depression) 40 mgs, give one capsule by mouth one time a day for depression manifested by irritability. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 22's Care Plan titled Resident was on antipsychotic medication (drugs that treat symptoms of psychosis) related to psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) initiated 10/15/2024, the Care Plan goals indicated Resident 22 will not have reactions related to the use of antipsychotic drug therapy. The Care plan interventions included administering Abilify by mouth 5 mgs and Quetiapine Fumarate 25 mgs. by mouth for psychosis and document episodes of behavior. During a review of Resident 22's Physician Order Summary Report, the Physician Order Summary Report indicated an order on 10/18/2024 for Quetiapine Fumarate (medicine that treats depression, schizophrenia [a mental illness that is characterized by disturbances in thought], and bipolar disease {sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs}) give 25 mgs. by mouth at bedtime for psychosis manifested by agitation (a state of anxiety or nervous excitement). During a review of Consultant's Pharmacist 's Medication Regimen Review (thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences associated with the medication) of Resident 22, the Consultant's Pharmacist Medication Regimen Review dated 10/18/2024 indicated to evaluate the use of Abilify 5 mgs. by mouth daily and Quetiapine Fumarate 25 mgs. by mouth at bedtime and recommending to maybe discontinued or increase the dose of the other medicine due to similarity of actions. During an interview and record review on 10/31/2024 at 12:26 p.m., with the Director of Nursing (DON) reviewed Resident 22's Medication Regimen Review for October 2024, the DON stated the pharmacist recommendations was not followed up and the psychiatrist referral was needed but was not called. The DON stated when a resident was newly admitted to the facility, licensed staff will review the medications with the physician. The DON stated she was waiting for the psychiatric team to come and there was a delay sometimes, but the psychiatrist should evaluate and assess the resident's condition and appropriateness of psychotropic medications. The DON stated Resident 22's medications might not be effective or not appropriate for the manifested behavior and could be an unnecessary medication if the psychiatrist's referral was not done. During a review of facility's policy and procedure (P &P) titled, Medication Regimen Review Unnecessary Medications updated on 8/2019, the P&P indicated indicators of unnecessary medications are two or more antipsychotic medicines and each resident's medication regimen must be free from unnecessary drugs. The P&P indicated an unnecessary drug is any drug used in excessive doses or duplicate therapy. During a review of facility's P&P titled Psychotropic Medications revised 12/2023, the P&P indicated residents do not receive psychotropic drugs pursuant to an as needed' (PRN)unless medication is necessary to treat a diagnosed specific condition that is documented in the clinical record. The P&P indicated psychotropic medications shall not be administered for the purpose of discipline or convenience and will be considered only after nonpharmacological interventions have been attempted and failed.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 45269 Based on observation, interview and record review, the facility failed to ensure medication cart was locked and secure and not left unattended during administration of resident's medication. This failure had the potential to place residents at risk for accidental ingestion of non-prescribed medicines and unauthorized access of the medication cart from anyone in the facility. Findings: During a concurrent observation of medication administration and interview on 10/31/2024, at 8:17 a.m., with Licensed Vocational Nurse (LVN 1), LVN 1 did not lock the cart when he performed handwashing in another room and left the medication cart unattended. Observed medication cart was not locked when LVN 1 entered a room to administer medications to a resident. LVN 1 stated he failed to lock the medication cart after preparation of medication and before administering the medication to residents. During an interview on 11/1/2024, at 3:42 p.m., with Registered Nurse Supervisor (RNS 1), RNS 1 stated medication cart should be locked when unattended to prevent other residents to have access to the medication cart and had the potential for accidental ingestion of non-prescribed medicines by residents who had poor cognition (had problems with a person's ability to think, learn, remember, use judgement, and make decisions) who could be roaming around the hallway and might accidentally remove or take medicines that are not prescribed for them. During an interview on 11/1/2024, at 5:25 p.m., with the Director of Nursing (DON), the DON stated failure to locked and secure the medication cart during medication pass could give anyone (residents) access to the medications inside the medication cart which could be unsafe for residents because the medicines could cause side effects. During a review of facility's policy and procedure(P&P) titled, Security of Medication Cart revised 4/2007, the P&P indicated the nurse must secure the medication cart during medication pass to prevent unauthorized entry and the cart must be locked before the nurse enters the resident's room or when out of nurses' view.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49145 Based on observation, interview, and record review, the facility failed to observe infection control measures for two of 10 sampled residents (Resident 17 and 168) by failing to: a.Ensure Resident 17's nasal cannula (a device used to deliver oxygen to a resident) was changed after seven days per facility's policy and procedure. b.Ensure Resident 168's nasal cannula was dated and labeled upon admission. These failures had the potential to result in the transmission of infectious microorganisms and increase the risk of respiratory infection for Residents 17 and 168. Findings: a.During a review of Resident 17's Admission Record, the Admission Record indicated Resident 17 was admitted to the facility on [DATE] with diagnoses including acute respiratory failure (difficult to breathe on your own) and atrial fibrillation (irregular and often rapid heart rate). During a review of Resident 17's Minimum Data Set (MDS- a federally mandated assessment tool), the MDS indicated Resident 17 had severe cognitive (ability to think, understand, learn, and remember) impairment. During a review of Resident 17's Physician Order Summary Report, the Order Summary Report indicated an order was placed on 9/19/2024 to change oxygen tubing every Saturday during night shift. During an observation on 10/29/2024 at 10:30 a.m., in Resident 17's room, Resident 17's nasal cannula tubing was dated 10/20/2024. During a concurrent observation and interview on 10/29/2024 at 10:36 a.m., with Licensed Vocational Nurse (LVN) 3, LVN 3 verbally confirmed the nasal cannula tubing was dated 10/20/2024 and LVN 3 stated the tubing was outdated and should have been changed. LVN 3 stated it was important to change the nasal cannula tubing to prevent infection and for safety concerns. 45269 b.During a review of Resident 168's Admission Record, the Admission Record indicated Resident 168 was admitted to the facility on [DATE] with diagnoses including displaced intertrochanteric fracture of left femur (broken left hip between the bumpy parts of the thigh bone) and traumatic subdural hemorrhage (bleeding in the area between the brain and skull) without loss of consciousness. During a review of Resident 168's History and Physical (H&P) dated 10/30/2024, the H&P indicated Resident 17 had fluctuating capacity to make decisions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 168's MDS dated [DATE], the MDS indicated the resident had moderately impaired cognition and required substantial (helper does more than half the effort) assistance with bed mobility, toileting hygiene and bathing. During a review of Resident 168's Physician Order Summary Report, the Physician Order Summary Report dated 10/28/2024 indicated to change oxygen tubing and humidifier (device used to humidify supplemental oxygen) every Saturday during night shift. During an observation on 10/29/2024, at 2:31 p.m., in Resident 168's room, Resident 168 was wearing a humidified nasal cannula. Observed both cannula and humidifier were not dated or labeled. During a concurrent interview and record review on 11/1/2024, at 3:10 p.m. with LVN 1, reviewed photograph of Resident 168's nasal cannula and humidifier, LVN 1 stated the staff members need to date and label the oxygen tubing and humidifier when Resident 168 was admitted because they need to know when to replace the oxygen tubing and humidifier to prevent infection. During an interview on 11/1/2024 at 9:20 a.m., with the Infection Prevention Nurse (IPN), the IPN stated the charge nurses were responsible for changing the oxygen tubing every Saturday. IPN stated it was important to change the nasal cannula tubing to prevent infection getting into the resident's lungs. During an interview on 11/1/2024 3:20 p.m., with the Registered Nurse Supervisor (RNS) 1, RNS 1 stated nasal cannula tubing should be changed weekly to prevent infection. RNS 1 stated nasal cannula and humidifier should be labeled with date it was changed. During an interview on 11/1/2024 at 4:17 p.m., with the Director of Nursing (DON), the DON stated the licensed nurses were responsible for changing the nasal cannula tubing once a week and as needed. The DON stated not changing the nasal cannula tubing can place the resident as risk for infection which could lead to pneumonia (infection of the lungs that may be caused by bacteria, viruses, and fungi) and possibly hospitalization . During a review of the facility's policy and procedure (P&P) titled, Use of Oxygen, revised 5/2021, the P&P indicated, The oxygen cannula or mask will be changed at least every 7 days, as well as the disposable humidifier.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 49145 Based on interview, and record review, the facility failed to have an Infection Preventionist (IP) on staff with required qualifications and completed specialized training in Infection Control and Prevention. This deficient practice had the potential for failure to monitor and implement Infection Control and Prevention in the facility. Findings: During a record review of the Infection Prevention Nurse (IPN) certification, dated 6/5/2018, the IPN certification indicated it was a 16-hour Boot Camp for Long Term Care Facilities certificate. During an interview on 11/1/2024 at 9:20 a.m., the IPN stated she did not have the correct certificate by the Center of Disease Control (CDC) for 19.75 hours. IPN stated she was unaware she needed a specific infection prevention certificate. During an interview on 11/1/2024 at 4:17 p.m., the DON stated the IPN did not have the correct IP certificate. No policy and procedure regarding what certificate was required for IP. During a review of facility's Infection Preventionist Job Description dated 12/17/202, the Infection Preventionist Job Description indicated Ensure that the facility is in compliance with current Centers for Disease Control and Prevention (CDC), Occupational Safety and Health Administration (OSHA), and local regulations concerning infection control universal precautions.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44898 Based on observation, and record review, the facility failed to ensure 12 residents rooms met the requirements of 80 square feet (sq. ft.) for each resident. Rooms 1, 2, 3, 5, 6, 7, 9, 12, 14, and 15, housed two residents per room and room [ROOM NUMBER] and 17 housed one resident per room. This deficient practice had the potential to result in an inadequate provision of safe nursing care, and privacy for the residents. Findings: During an observation 11/1/2024 at 2:04 p.m., rooms 1, 2, 3, 4, 5, 6, 7, 9, 12, 14, 15, and 17 did not meet the requirement of 80 square feet (sq ft-unit of measurement) per residents. During a review of Client Accommodations Analysis form, provided by the facility's Maintenance Supervisor (MS), the Client Accommodation Analysis indicated Rooms 1, 2, 3, 5, 6, 7, 9, 12, and 15, occupied by two residents each, ranged in total square feet measurement between 68.75 square feet to 77.6 square feet per resident and rooms [ROOM NUMBERS] occupied by one residents ranged in total square feet measurement between 149.5 square feet for rooms [ROOM NUMBERS].25 square feet for rooms 17. During a review of Room Waiver letter dated 10/19/2023 provided by the ADM, indicated, There were no residents who complained of available space in the room. As there has been no evidence presented to suggest that this variation in room size is not in accordance with special needs of the residents, is not in the best interest of the health and safety of residents, or adversely affecting residents' health and safety we request the room . The floor size of room [ROOM NUMBER] was 149.5 sq. ft, and room [ROOM NUMBER] was 155.25 sq. ft. This exceeds the required 80 sq. ft per bed requirement. During observations from 10/29/2024 to 11/1/2024, the residents residing in these rooms were observed with sufficient space to move around freely within the room, and the nursing staff had enough space to provide care. There was space for the beds, side tables, dressers, and resident care equipment. There were no adverse effects noted to the residents' privacy, health, and safety, which could have been compromised by the size of the rooms.