STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055288	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Hills Health Care Center	430 N.Glendale Ave Glendale, CA 91206

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 46779 Based on observation, interview, and record review, the facility failed to ensure respect and dignity was provided for one of two sampled residents (Resident 12), by ensuring the Certified Nursing Assistant 2 (CNA 2) had eye contact while sitting and feeding the resident. This deficient practice had the potential to result in feelings of decreased self-esteem and self-worth to Residents 12. Findings: During a review of Resident 12's Admission Record indicated the facility originally admitted Resident 12 on 1/22/21 and readmitted her on 2/23/24 with diagnoses that included dementia (a general term for the impaired ability to remember, think, or make decisions that interferes with doing everyday activities) and hypertension (high blood pressure). During a review of Resident 12's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 10/6/23, indicated Resident 12 had severely impaired memory and cognition (ability to think and reasonably) impairment. The MDS indicated Resident 12 required supervision or touching assistance with eating, partial/moderate assistance with oral hygiene, personal hygiene, and dependent with lower body dressing, toilet hygiene, shower/bathe self, and chair/bed-to-chair transfer. During an observation on 6/3/24 at 12:50 PM, Resident 12 was observed sitting on the bed in her room with a bedside tray table in front of her. A plate of beef soft taco in mechanical soft texture was on the bedside tray table. Resident 12 tried to use a spoon to scoop the beef, but she could not scoop up any food. CNA 2 walked into the room and stood on the left side of the bed. CNA 2 used another spoon on the lunch tray and scooped up a spoonful of ground beef, then, she fed it to Resident 12. CNA 2 continued to spoon feed Resident 12 while standing. CNA 2 was not at eye-level with Resident 12. During an interview on 6/3/24 at 12:55 PM with CNA 2, CNA 2 stated she should have respected Resident 12's right to be treated with respect and dignity by sitting down next to the resident at the resident's eye level when assisting her with eating. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/5/24 at 10:45 AM with the Director of Nursing (DON), the DON stated the staff should be sitting down next to the resident at the resident's eye level to ensure the resident was treated with dignity and respect. During a review of the facility's policy and procedure titled, Assisting the Resident to Eat, dated 7/13/23, indicated Assist the resident as necessary. If the resident needs to be fed: sit at eye level in front of the resident. During a review of the updated facility's policy and procedure titled, Quality of Life-Dignity, indicated Residents are treated with dignity and respect at all times.

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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. 36925 Based on observation, interview, and record review, the facility failed to ensure that one of two sampled resident's call light was within reach (Resident 25) during an observation conducted on 6/3/24 at 8:55 AM, inside the resident's room, in accordance with the facility's policy titled Call Lights-Answering Of. This deficient practice had the potential to harm Resident 25 (e.g., falling out of bed due to an unassisted transfer) by not being able to call for assistance when needed. Findings: A review of Resident 25's Admission Record indicated the facility initially admitted the resident on 10/7/22 and readmitted the resident on 4/12/24 with diagnoses including anxiety disorder (a mental health disorder characterized by feelings of fear that are strong enough to interfere with one's daily activities). A review of Resident 25's History and Physical assessment, dated 4/15/24, indicated that the resident did not have the capacity to understand and make decisions. A review of Resident 25's Minimum Data Set (MDS - a standardized assessment and screening tool), dated 4/16/24, indicated that the resident ' s cognition (mental action or process of acquiring knowledge and understanding through thought, experience, and senses) was severely impaired and the resident needed maximum assistance (the helper does more than half the effort; lifts or holds the trunk or limbs) to perform daily living activities such as rolling left and right in bed or sitting on the side of the bed to lying flat on the bed. During an observation in Resident 25's room, on 6/3/24 at 8:55 AM, Resident 25 was lying in bed with the call light hanging below the mattress and was not within the resident ' s reach. During a concurrent interview with the Social Services Director (SSD), the SSD stated that the resident's call light needs to be within reach at all times to enable the resident to call for help if needed. During an interview on 6/5/24 at 4:12 PM, Certified Nurse Assistant (CNA 1) stated that the call light is how the resident asks for assistance, and it should always be within the resident ' s reach. A review of the facility ' s policy titled, Call Lights-Answering Of, approved on 3/21/24, revision number 1.0, indicated that the facility would provide an environment that helps meet the resident ' s needs by ensuring that when leaving the room of the resident, the staff places the call light within the resident ' s reach to maintain safety.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44429 Based on interview and record review, the facility failed to complete Physician Orders for Life-Sustaining Treatment (POLST) for four of four sampled residents (Resident 91, 59, 79, and 82) and ensure residents' medical records were updated to show documentation that advance directives (written statement of a person's wishes regarding medical treatment made to ensure those wishes are carried out should the person be unable to communicate them to a doctor) were discussed and written information were provided to the residents and/or responsible parties. These deficient practices violated the residents' and/or the responsible party (RP)'s right to be fully informed of the option to formulate their advance directives (AD) and had the potential to cause conflict with the residents' wishes regarding health care. Findings: 1. During a review of Resident 82's Face Sheet indicated the facility admitted Resident 82 on 11/26/2022 with diagnoses that included dementia (a general term to describe a group of symptoms related to loss of memory and judgment) and hypertension (high blood pressure). During a review of Resident 82's History and Physical Examination, dated 11/7/23, indicated Resident 82 did not have the capacity to understand and make decisions. During a review of Resident 82's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 5/17/24, indicated Resident 82 had a severe cognitive (ability to think and reason) impairment for daily decision making. During a concurrent interview and record review on 6/4/24 at 3:51PM with Director of Nursing (DON), Resident 82 ' s clinical record indicated the POLST, dated 11/6/23 was signed by the physician and the DON stated the physician signed Resident 82 ' s POLST but did indicate what he discussed with the responsible party, and no boxes were marked in section D of the POLST. The DON stated the physician should have indicated what was discussed with the responsible party and what the responsible party ' s wishes for Resident 82. DON stated that Resident 82 chart did not have an Advance Directive Notification form. The DON stated by not having a completed AD form it could delay care for Resident 82 in the event of an emergency. 46779 2. During a review of Resident 91's Face Sheet indicated the facility admitted Resident 91 on 5/13/24 with diagnoses that included dementia and hypertension. During a review of Resident 91's History and Physical Examination (H&P), dated 5/13/24, indicated Resident 91 have the capacity to understand and make decisions. During a review of Resident 91's MDS, dated [DATE], indicated Resident 91 had intact cognitive skills for daily decision making. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 6/4/24 at 10:13 AM with Registered Nurse (RN) 1, Resident 91's POLST, dated 5/16/24, and Resident 91's clinical charts were reviewed, RN 1 stated the physician signed Resident 91's POLST but did not put the date on the order. RN 1 stated the physician should sign and date the POLST. RN 1 stated Resident's POLST indicated Resident 91 did not have an AD, RN 1 stated she did not know if Resident 91 was informed about her rights to formulate an AD because there was no documentation in Resident 91's clinical chart that indicated that the AD was offered or assisted the resident to formulate and AD. RN 1 stated POLST was the only documentation regarding AD that was kept in the resident's chart. 3. During a review of Resident 59's Face Sheet indicated the facility admitted Resident 59 on 1/3/24 with diagnoses that included dementia and hypertension. During a review of Resident 59's, MDS, dated [DATE], indicated Resident 59 had severely impaired cognitive skills for daily decision making. During a concurrent interview and record review on 6/4/24 at 10:15 AM with Registered Nurse (RN) 1, Resident 59's POLST, dated 1/3/24, and Resident 59's clinical chart were reviewed, RN 1 stated Resident 59's POLST was prepared on 1/3/24 and was signed by the RP on 4/2/24, but the physician had not sign and date the POLST yet. RN 1 stated the physician should sign and date the POLST when the RP signed it. RN 1 stated Resident ' s POLST indicated Resident 59 did not have an AD, but she did not know if Resident's RP was informed about the right to formulate the AD for Resident 59 because there was no documentation in Resident 59 ' s clinical chart indicated that this information was provided to the resident. RN 1 stated POLST was the only documentation regarding AD that was kept in the resident's chart, and she did not know where else to look for AD information and documents. During an interview on 6/4/24 at 10:22 AM with the Social Service Director (SSD), the SSD stated when the facility admitted a resident, she would invite the resident and the RPs to the Interdisciplinary Team Meeting (IDT) and she would provide advance directive information to them, then, she would document it on Social Services Assessment (SSA) form in the electronic medical records (EMR). During an observation on 6/4/24 at 10:23 AM, the SSD logged into her assess and looked through the SSA forms in Resident 59's EMR. The SSD opened one file, read it and stated this was not the one. Then, she closed the current file, and continued to look through the files. During an observation on 6/4/24 at 10:24 AM, the SSD opened another Resident 59's file on EMR, read it, and was able to locate the documentation indicated she provided the AD information to RPs. During an interview on 6/4/24 at 10: 25 AM, the SSD stated the documentation of the residents and their RPs acknowledging their rights to formulate AD should be kept in the residents ' clinical chart. The SSD stated in case of an emergency, the malfunction of hardware, and the downtime of electronic health record system, the facility nurses and other interdisciplinary providers could still have the immediate access to the AD information and provide care in accordance with the resident and the RP's wishes during emergency. During a review of the facility ' s policy and procedure titled, Physician Orders, dated 7/13/23, indicated the licensed nurse must verify to ensure the order is complete and that is includes physician signature and date. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility ' s policy and procedure titled, Advance Directive, dated 8/16/21, indicated the resident or representative is provided with written information concerning the right to formulate an AD if he or she chooses to do so, and the information about whether or not the resident has executed an AD is displayed prominently in the medical record in a section of the record that is retrievable by any staff. 50203 4. A review of Resident 79's Admission Record (Face Sheet), indicated the facility originally admitted Resident 79 on 7/6/2023 and readmitted on [DATE] with diagnoses that include metabolic encephalopathy (a chemical imbalance that affected the brain and made it harder to think clearly and remember things), upper gastrointestinal bleed (bleeding that occurs anywhere in the esophagus [a muscular tube that food passes from the throat to the stomach], stomach, or upper part of the small intestine [long tube organ that helps digest food from the stomach]), and unspecified dementia (a loss of memory, language, and problem solving that is severe enough to interfere with daily life). A review of Resident 79's History and Physical (H&P, a comprehensive physician ' s note regarding the assessment of the resident's health status), dated 2/24/2023 and 5/23/2024, indicated Resident 79 sometimes had the capacity to understand and make decisions, however, Resident 79 was only oriented to himself. A review of Resident 79's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 4/16/2024, indicated Resident 79's cognitive (the ability to think and process information) skills for daily decision making was severely impaired. Resident 79 required set-up and cleaning assistance with eating but required some staff supervision and assistance with other activities of daily living. A review of Resident 79's POLST date prepared 7/8/2023, indicated the medical interventions, artificially administered nutrition, and advance directive were blank. A review of Resident 79's POLST date prepared 2/10/2024 indicated the advance directive section was blank. A review of Resident 79's Social Services Assessment - Initial dated 7/13/2023, indicated Resident 79 des not have an advance directive available. The Social Services Assessment - Initial that indicated if information was provided to the Resident/Resident Representative on initiating an advance directive was blank. A review of Resident 79's Social Services Assessment - Quarterly, Annual, SCOCS, Discharge Notes 82023, dated 5/23/2024, indicated the facility offered Resident 79 and his responsible party information about initiating an advance directive, but both refused. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 6/4/2024 at 10:13AM with Registered Nurse Supervisor 1 (RN 1), Resident 79's POLST, dated 2/10/2024, was reviewed. RN 1 stated the POLST did not indicate if there was an advance directive available or discussed with the resident or representative party. RN 1 stated the POLST form in the resident ' s physical medical chart (a thorough record of resident ' s medical history and clinical data) should indicate whether there was an advance directive available or discussed with the resident or responsible party. RN 1 stated the licensed and medical staff need quick access to what treatments the residents and responsible party desire in an event of a medical emergency (an acute illness or injury that poses an immediate risk to a person's health or long-term health). RN 1 stated that it was the Social Services Director's (SSD) responsibility to ensure the physician, resident or responsible party signed and dated the POLST. During a concurrent interview and record review on 6/4/2024 at 10:22AM with the SSD, Social Services Assessment - Quarterly, Annual, SCOS, Discharge Notes_082023, dated 5/23/2024, was reviewed. The SSD stated the facility asked the resident or the responsible party to fill out the POLST. The SSD stated she documented Resident 79 and his responsible party ' s refusal for an advance direction in the Electronic Medical Record (EMR, an electronic medical chart) but did not indicate it in the physical medical chart. The SSD stated she should have put it in the physical medical chart so the licensed staff can quickly access the information in case of an emergency. During an interview on 6/4/2024 at 12:00PM with the Administrator (ADM), the ADM stated the licensed nurses give the POLST to the resident or the responsible party to sign on admission. The ADM stated the physician should check off the sections and sign the POLST. The ADM stated the SSD was responsible for double checking that the physician, resident, or responsible party filled out the POLST completely. During a review of the facility ' s policies and procedures (P&P), titled Physician ' s Orders for Life Sustaining Treatment (POLST), dated 7/18/2023, the P&P indicated a completed POLST form reflects the process of careful decision making by the resident or the legally recognized responsible party in consultation with the Physician about the resident ' s medical condition and known treatment preferences. The P&P indicated the licensed nurses will review the POLST form for completeness on admission. The P&P indicated the social worker will conduct an initial review of the POLST for completeness with the resident or the responsible party. The P&P indicated if the POLST is incomplete, the social worker should refer the omissions to the attending physician.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50203 Based on observation and interview, the facility failed to ensure that one of three sampled residents (Resident 79) was free of involuntary physical restraints (methods to purposefully limit or obstruct a person's freedom of movement) by failing to remove the overbed (an adjustable table designed to roll over a bed and provide a flat and stable surface with lockable wheels) table over the Resident 79 after breakfast. This failure resulted in Resident 79 restrained in his bed and unable to have freedom of movement with his overbed table over him. Findings: A review of Resident 79's Admission Record (Face Sheet), indicated the facility originally admitted Resident 79 on 7/6/2023 and readmitted on [DATE] with diagnoses that include metabolic encephalopathy (a chemical imbalance that affected the brain and made it harder to think clearly and remember things), upper gastrointestinal bleed (bleeding that occurs anywhere in the esophagus [a muscular tube that food passes from the throat to the stomach], stomach, or upper part of the small intestine [long tube organ that helps digest food from the stomach]), and unspecified dementia (a loss of memory, language, and problem solving that is severe enough to interfere with daily life). A review of Resident 79's History and Physical (H&P, a comprehensive physician ' s note regarding the assessment of the resident ' s health status), dated 2/24/2023 and 5/23/2024, indicated Resident 79 sometimes had the capacity to understand and make decisions, however, Resident 79 was only oriented to himself. A review of Resident 79's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 4/16/2024, indicated Resident 79's cognitive (the ability to think and process information) skills for daily decision making was severely impaired. Resident 79 required set-up and cleaning assistance with eating but required some staff supervision and assistance with other activities of daily living. Resident 79's MDS indicated no methods of physical restraints used. A review of Resident 79's Physician Order Report (instructions that communicated the medical care that the resident received while in the facility), indicated a start date of 2/29/2024 for a low bed with floor mattress. A review of Resident 79's care plan titled Actual Fall from Bed, dated 2/29/2024, the care plan ' s interventions indicated Resident 79's interventions include low bed with floor mattress. The Physician Order Report indicated a start date of 7/13/2023 for Resident 79's left and right half side rails up when in bed to enable independent repositioning and transfers, but released during care, individual visits, meals, and monitored activities. The Physician Order Report indicated a start date of 5/9/2024 for Resident 79 ' s preference for his bed to be against the wall. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 79's care plan titled Side rails (non-restraint) dated 7/6/2023, the care plan ' s interventions indicated Resident 79's preference to have his bed against the wall. The care plan ' s intervention indicated for both half side rails (bed rails half the size of the bed) on side of the bed while in bed, but the half side rails to be released during care, one to one visit, meals, and some activities. The care plan interventions indicated to ensure the half side rails do not hinder the resident's freedom of movement to get in and out of bed. A review of Resident 79's Facility Verification of Informed Consent to Psychotherapeutic Drugs, dated 7/7/2023 indicated the physician obtained informed consent for Resident 79 ' s left and right half side rails to be up when in bed to enable independent repositioning and transfer, but released during care, individual visits, meals, and monitored activities. A review of Resident 79's Facility Verification of Informed Consent to Psychotherapeutic Drugs, Physical Restraints, and/or Prolonged use of Device, dated 5/23/2024, indicated the physician obtained informed consent for Resident 79 ' s preference to have his bed against the wall. There were no informed consents for any other form of physical restraints found in the resident ' s records. During an observation and interview on 6/4/2023 at 8:38 AM in Resident 79's room, the overbed table was over Resident 79 who laid in bed. The left side of Resident 79's bed was against the wall, and the right half side rail was up with the floor mattress on by Resident 79's bed. The overbed table ' s wheels were on top of the floor mattress. Resident 79 shook the overbed table, tried to push the overbed table away, grabbed the bedside controls, and started moving the bed into a lower position. The Licensed Vocational Nurse 1 (LVN 1) stated that Resident 79 was shaking the overbed table and unable to push the table away from him. LVN 1 stated the overbed table should not be on top of the floor mattress. LVN 1 stated the overbed table over Resident 79 looked like a form of restraints because Resident 79 is unable to move freely. During an interview on 6/4/2023 at 8:55PM with the Certified Nursing Assistant 1 (CNA 1), CNA 1 stated she sets up Resident 79 ' s overbed table for breakfast. CNA 1 stated that her normal process for meal set-up included pulling Resident 79 up in bed and setting up his breakfast tray by putting the overbed table on top of the floor mattress so he may reach his breakfast. CNA 1 stated after breakfast she should move the overbed table away from the resident and place to the side of the bed, remove the overbed table over the resident, remove the overbed table from the floor mattress, and putting it off to the side of the resident ' s bed. CNA 1 stated it is important to remove the overbed table so the resident may move independently, or it may restrict the resident's movement. During an interview on 6/4/2024 at 9:15AM with Registered Nurse Supervisor 1 (RN1), RN 1 stated the resident's overbed table should not be over the resident except for meal set-up. RN 1 stated that leaving the overbed table over the resident could be a form of restraints because Resident 79 was unable to move freely or independently. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/5/2024 at 10:45 AM with the Director of Nursing (DON), the DON stated Resident 79 had a floor mattress by his bed because the resident may slide down in his bed. The DON stated there was a care plan and the physician gave informed consent to Resident 79 ' s responsible party for the resident ' s bed to be placed against the wall and the bilateral half side rails up while in bed. The DON stated the overbed table should not be on top of the floor mattress because Resident 79 would not be able to push the bedside table way from him. The DON stated the overbed table ' s wheels cannot easily roll over a floor mattress compared to the floor. The DON stated the overbed table should not be over the resident in bed or on top of the floor mattress when not in use. The DON stated it can be a form of restraining the resident because it may be seen as a restriction of the freedom of movement. A review of the facility ' s policies and procedures (P&P) titled Physical Restraints Management, last dated 8/29/2023, indicated a restraint was any mechanical device or equipment attached to or adjacent to the resident ' s body that restricted freedom of movement or access to one ' s body. The P&P indicated if the resident cannot remove the device in the same manner the staff applied it and it limited their typical ability to change position or place, the device was a restraint.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47882 Based on observation, interview, and record review, the facility failed to implement interventions to prevent development of new pressure ulcer (skin injury due to prolonged unrelieved pressure or skin friction) or worsening of existing pressure ulcer for two of five sampled residents (Resident 56, and 76) in consistent with professional standards of practice and facility's policy and procedure by failing to: 1. Set the Alternating Pressure Mattress (APM) (mattress that provides pressure redistribution by filling and un-filling air cells within the mattress so that contact points with the body are reduced) according to the resident's weight as indicated in the manufacturer ' s recommendation for Resident 56. 2. Provide a heel protector (a device to minimize the risk of pressure damage to heels by off-loading) to Resident 76 who had a physician order to apply heel protector to both heels to high risk for pressure ulcer. This deficient practice had the potential for Resident's 56 and 76 to develop, worsened or new pressure ulcer or injury and/or delay the resident's wound to heal. Findings: 1. A review of Residents 56's Admission Record indicated the resident was originally admitted , on 4/11/2022 and readmitted [DATE], with diagnoses that included Diabetes (lifelong condition that causes a person's blood sugar level to become too high), protein calorie malnutrition (poor nutrition) and atherosclerotic heart disease (the buildup of fats, cholesterol, and other substances in and on the artery walls. A review of Resident 56's History and Physical (H&P) dated 12/11/2023 indicated Resident 56 does not have the capacity to understand and make decisions. A review of Resident 56's Minimum Data Set (MDS- a standardized assessment and screening tool), dated 4/12/2024, indicated Resident 56 mental status was severely impaired. The MDS indicated Resident 56 required substantial/maximal assist (helper does more than half the effort) with rolling left and right and dependent (helper does all the effort) with toileting, bathing, dressing, personal hygiene, sit to lying and lying to sitting on side of the bed. During a concurrent observation and interview on 6/3/2024 at 9:10 AM with Licensed Vocational Nurse (LVN) 2 in Resident 56's room, Resident 56 was observed lying in bed in a supine (lying horizontally with the face and torso facing up position) with the APM setting at 100 pounds. LVN 2 stated, the APM should be set according to Resident 56's weight. LVN 2 stated, Resident 56's current weight was 79.8 lbs., and she does not know why the MAP mattress was set for 100 lbs. person. LVN 2 stated, the APM mattress should always be in the correct setting based on the resident's weight to help Resident 56's wound to heal and prevent development of new pressure injury. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Hills Health Care Center	430 N.Glendale Ave Glendale, CA 91206

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/3/2024 at 10:10 AM with Treatment Nurse (TN) 1, TN 1 stated, she was responsible in making sure Resident 56 ' s APM mattress was setting set according to the resident ' s weight, and she does not know why it ' s not correctly set. TN 1 stated, it was important to set the APM at the right setting for wound management to prevent skin breakdown. A review of Resident 56's the Physician Order Report (POS), indicated the physician ordered on 11/7/2023, to provide Resident 56 with Low Air Loss mattress and to check placement and function Q (every) shift for skin maintenance. A review of Resident 56's facility document titled Care Plan (CP) revised on 11/7/2023, indicated Resident 56 was at risk for development of pressure ulcer/ skin breakdown. CP intervention included, use of pressure relieving device in bed: Low Air Loss mattress (LAL-a type of Alternating Pressure Mattress), check placement and function q shift for skin maintenance. A review of Resident 56 ' s facility document titled Care Plan (CP), revised 12/18/2023, indicated Resident 56 had sacral MASD (moisture associated skin damage), intervention includes low Air Loss mattress, check placement and function every shift for skin maintenance. A review of Resident 56 ' s facility document titled Braden Scale (BS) (assess a patient's risk of developing pressure ulcers), dated 5/28/2024, indicated Resident 56 was high risk in developing pressure ulcer. During an interview on 6/5/2024 at 10:07 AM with the Director of Nurses (DON), DON stated, Resident 56 ' s APM mattress should have been set according to Residents weight, because if it ' s not, it is not doing its job. DON stated, if the APM mattress is not in the right setting, it could prolong wound healing and potentially cause further skin breakdown. A review of manufactures guidelines for Med-Aire 8 Alternating pressure mattress replacement system with Low Air Loss indicated Product function-analog pressure dial adjust the dial to correspond to the patient ' s appropriate weight setting. A review of the facility ' s policy and procedure (P&P) titled, Pressure Ulcer and Skin care Management, dated 12/22/2023, indicated; a) the nursing staff reviews the pressure ulcer prevention and treatment procedure with the resident physicians, b) select the treatment procedures appropriate for the resident and the type of pressure ulcer or wound, and c) the licensed nurse implements the wound care treatment procedures in accordance with current standard of practice. 2) A review of Residents 76 ' s Admission Record indicated the resident was originally admitted on [DATE] and readmitted [DATE], with diagnoses that included Diabetes, muscle weakness, and adult failure to thrive (happens when an older adult has a loss of appetite, eats and drinks less than usual, loses weight, and is less active than normal). A review of Resident 76 ' s Minimum Data Set (MDS- a standardized assessment and screening tool), dated 3/19/2024, indicated Resident 76 mental status was severely impaired. The MDS indicated Resident 76 required partial/moderate assistance (helper does less than half the effort) with personal hygiene, required substantial/maximal assist (helper does more than half the effort) with rolling left to right, sit to lying, lying to sitting, and dependent (helper does all the effort) with toileting, bathing, and dressing. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 76's facility document titled Braden Scale (BS), dated 5/31/2024, indicated Resident 76 was high risk in developing pressure sore. A review of Resident 76's facility document Physician Order Report (POS), indicated the physician ordered on 5/31/2024 to apply heel protectors at all times. A review of Resident 76's facility document titled Care Plan (CP), dated 5/31/2024, indicated Resident 76 had risk for development of pressure ulcer/skin breakdown. The CP intervention included apply heel protectors at all times. During an observation on 6/3/2024 at 9:47 AM in Resident 76's room, Resident in bed in a supine position noted to not have a heel protector. During a concurrent observation and interview on 6/3/2024 at 12:05 PM with TN 1 in Resident 76 ' s room, Resident 76 remained with no heel protector both heels noted to have redness. TN 1 stated, Resident 76 should have heel protectors as ordered to prevent skin breakdown, she was not sure why Resident 76 does not have one. TN 1 stated, she will go to the central supply room to get heel protectors since it is not in Resident 76 ' s closet. During an interview on 6/3/2024 at 12:30 PM with Registered Nurse (RN) 3, RN 3 stated, Resident 76 ' s heel protectors should be on at all times as ordered, for skin management and prevent skin breakdown since resident 76 has limited mobility. During an interview on 6/5/2024 at 10:10 AM with the DON, DON stated, Resident 76 ' s heel protectors should be applied at all times as ordered to prevent skin breakdown, especially for a resident with fragile skin. A review of the facility's policy and procedure (P&P) titled, Pressure Ulcer and Skin care Management, dated 12/22/2023, indicated; a) the nursing staff reviews the pressure ulcer prevention and treatment procedure with the resident physicians, b) select the treatment procedures appropriate for the resident and the type of pressure ulcer or wound, and c)the licensed nurse implements the wound care treatment procedures in accordance with current standard of practice.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47882 Based on observation, interview and record review, the facility failed to ensure a resident maintained an acceptable parameters of nutritional status for one of two sampled residents (Resident 56) by failing to address and implement care plan interventions to monitor resident's food intake and hydration due to resident's significant weight loss of more than 5% in 30 days and monitor food intake for the month of May 2024. Resident 56's weights on April 2024 was 84.4 pounds and on May 2024 the resident's weight was 79.8 pounds a total of 4.6 pounds in a month. This deficient practice had the potential for Resident 56 to continue to lose weight that could result in medical complications such as tissue and organ failure. Findings: A review of Residents 56's Admission Record indicated the resident was originally admitted , on 4/11/2022 and readmitted on [DATE], with diagnoses that included diabetes (lifelong condition that causes a person's blood sugar level to become too high), protein calorie malnutrition (poor nutrition) and dementia (a group of related symptoms associated with an ongoing decline of the brain and its abilities). A review of Resident 56's History and Physical (H&P) dated 12/11/2023, indicated Resident 56 dis not have the capacity to understand and make decisions. A review of Resident 56's Minimum Data Set (MDS- a standardized assessment and screening tool), dated 4/12/2024, indicated Resident 56 mental status was severely impaired. The MDS indicated Resident 56 required substantial/maximal assist (helper does more than half the effort) with eating, rolling left and right and dependent (helper does all the effort) with toileting, bathing, dressing, personal hygiene, sit to lying and lying to sitting on side of the bed. A review of Resident 56's facility document titled Care Plan (CP) dated 4/13/2022 indicated Resident had nutritional risk due to loss of appetite, intervention included to monitor for undesirable weight changes. A review of Resident 56's facility document titled Care Plan (CP) dated 8/8/2023 indicated the resident had risk for dehydration, fluid and electrolyte imbalance with intervention that included to monitor weights as needed. A review of Resident 56's facility document titled Interdisciplinary Team Care Conference Notes (IDTN) dated 4/3/2024 indicated on dietary notes Resident 56 had a poor intake, continue to monitor weight and intake. A review of Resident 56's facility document titled Nutritional Assessment (NA) dated 4/23/2024, indicated Resident 56's current weight was 84.4 pounds, underweight, goals of stable weight and monitor weight and PO (oral) intakes. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Monthly Weight Logs dated 4/30/2024, indicated Resident 56's weights in May 2024 was 79.8 pounds and 84.4 pounds in the previous month of April 2024. A review of Resident 56's Diet oral intake for the month of May 2024 indicated the following entries: -5/2/2024 no documentation for lunch -5/3/2024 no documentation for breakfast -5/6/2024 no documentation for breakfast and lunch -5/7/2024 no documentation for breakfast and lunch -5/8/2024 no documentation for breakfast and lunch -5/9/2024 no documentation for breakfast and lunch -5/11/2024 no documentation for breakfast and lunch -5/13/2024 no documentation for lunch -5/14/2024 no documentation for breakfast and lunch -5/15/2024 no documentation for breakfast and lunch -5/16/2024 no documentation for breakfast -5/17/2024 no documentation for breakfast and lunch -5/18/2024 no documentation for breakfast and lunch -5/19/2024 no documentation for breakfast and lunch -5/22/2024 no documentation for breakfast and lunch -5/23/2024 no documentation for lunch -5/25/2024 no documentation for breakfast and lunch -5/26/2024 no documentation for breakfast and lunch -5/27/2024 no documentation for breakfast and lunch -5/28/2024 no documentation for breakfast and lunch -5/29/2024 no documentation for breakfast and lunch (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-5/30/2024 no documentation for breakfast -5/31/2024 no documentation for breakfast During a concurrent observation and interview on 6/3/2024 at 9:10 AM with Licensed Vocational Nurse (LVN) 2 in Residents 56's room, Resident 56 was sleeping comfortably. LVN 2 stated, Resident 56 sleeps a lot, Resident 56 ' s current weight was 79.8 pounds. During an interview on 6/4/2024 at 10:35 AM with the Dietary Supervisor (DS), the DS stated, from April to May 2024 Resident 56 had a 4.6 lbs. weight loss and stated that she reported the weight loss to the dietician and the DON. The DS stated, Resident 56 had a poor diet intake. During a concurrent interview and record review on 6/4/2024 at 10:55 AM with the treatment nurse (TN 1), Resident 56's Diet oral intake for the month of May 2024 was reviewed and TN 1 stated, the facility hired a lot of registry certified nurse assistants (CNA) and maybe one of the reason, Resident 56 ' s diet oral intakes were not documented. TN 1 stated it was important to document the oral intake to ensure monitoring of Resident 56 ' s intake. During a concurrent interview and record review of the facility's Monthly Weight Logs dated on 6/4/2024 at 11 AM, the Director of Nurses (DON) stated that Resident 56 ' s weight in May 2024 was 79.8 pounds from 84.4 pounds, a weight loss of 4.6 pounds (5.5%) in 30 days. The DON stated, we missed it, it should have been addressed by herself and dietary. On 6/4/2024, at 11:10 AM, the facility document titled Risk Note Monthly significant weight change for May with recommendations dated 5/7/2024 was reviewed with the DON. The DON stated the Risk Note indicated Resident 56 was not on the list of residents with significant weight change. The DON stated, the dietary supervisor and DON missed Resident 56 ' s significant weight change that is why it was not addressed. The DON stated the facility should have done a weekly weight, instead of continuing the monthly weight, to monitor Resident 56 closely. During a concurrent interview and record review, on 6/4/2024, at 11:20 AM, Resident 56 ' s Diet oral intake for the month of May 2024 (5/2/24 to 5/31/24) was reviewed with the DON, the DON stated, Resident 56's diet oral intake was not monitored and documented consistently for May 2024. The DON stated that Resident 56 ' s oral intakes should be monitored and documented consistently for breakfast, lunch, and dinner. During an interview on 6/4/2024 at 4:20 PM with the Registered Dietician (RD), the RD stated, she always goes by significant weight loss of 5 pounds in a month as a significant weight loss thinking it was more aggressive. The RD stated she should have followed the facility policy of 5% weight loss as significant. The RD stated, hypothetically she would have started weekly weights for Resident 56 beginning of May 2024. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/5/2024 at 10:03 AM with the DON, the DON stated, it was her responsibility and the RD to address Resident 56 ' s significant weight loss. The DON stated that care plan interventions should have been initiated, such as weekly weights to ensure weights are being monitored. The DON also stated, her expectations with the nursing staff would be to document Resident 56's diet oral intake consistently to ensure oral intake are being monitored. The DON stated, not having care plan intervention for the significant weight loss and consistent documentation of Resident 56's oral intake had the potential for Resident 56 to lose more weight. A review of the facility ' s policy and procedure (P&P) titled Nutritional Assessment, (undated), indicated: a) each resident receives a comprehensive nutritional assessment upon admission, annually and whenever a resident is identified as having a significant change in status, b) the assessment of the overall nutritional status of the resident includes; indicate any significant weight changes and expand significant weight changes and percentages (5% in 30 days), c) for estimated intake, information should be determined through observation of meal trays and meal intake consumption records.

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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** 50203 Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 51) who required respiratory care and services was provided with the necessary respiratory care consistent with professional standards of practice by failing to: 1. Ensure the licensed nurses follow Resident 51 ' s physician order dated 5/5/2024, to administer oxygen of 3 liters per minute (LPM) as needed for shortness of breath and may titrate up to 5 LPM, and as indicated in the resident ' s plan of care titled At risk for decreased cardiac output. 2. Ensure Resident 51 ' s oxygen (odorless and colorless gas needed for animal and plant life) tubing was free of any obstruction to provide consistent oxygen therapy (treatment to provide a person with extra oxygen to treat or prevent the symptoms of hypoxia [decrease oxygen flow to the tissues]), in accordance with the facility ' s policy titled Oxygen Administration. These failures resulted in Resident 51 receiving less oxygen than required, experienced symptoms of shortness of breath (SOB, an intense feeling of tightness in the chest or breathlessness), increased work of breathing (an increased use of abdominal and accessory muscle use), and had the potential to cause respiratory decline, anxiety, and fear related to shortness of breath. Findings: A review of Resident 51 ' s Admission Record (Face sheet), indicated the facility originally admitted Resident 51 on 3/21/2019 and readmitted on [DATE] with diagnoses that include pneumonia (an infection of the lungs caused by bacteria, virus, or fungi), respiratory failure (a serious condition when the lungs cannot get enough oxygen into the blood, which prevented the body ' s organs from functioning properly), and chronic congestive heart failure (a condition where the heart cannot pump enough blood for the body ' s needs.) A review of Resident 51 ' s History and Physical (H&P, a comprehensive physician ' s note regarding the assessment of the resident ' s health status), dated 5/7/2024, indicated Resident 51 did not have the capacity to understand and make decisions. The H&P indicated Resident 51 ' s current diagnoses included chronic obstructive pulmonary disease (COPD) recovering from pneumonia. A review of Resident 51 ' s Physican Orders for Life-Sustaining Treatment (POLST, a portable medical order form that records patients ' treatment wishes so the emergency, taking the patient ' s current medical condition into consideration), dated 5/4/2024, the POLST indicated Resident 51 was to receive comfort focused treatments (treatments focused on relieving pain and suffering, use of oxygen, and use of suctioning) with a primary goal of maximizing comfort. The POLST indicated Resident 51 may use oxygen, suctioning, and manual treatment of airway obstruction. The POLST indicated additional orders of No Transfer. A review of Resident 51 ' s Physican Order Report (instructions that communicated the medical care that the resident received while in the facility) dated 5/3/2024, indicated Oxygen inhalation at 2 LPM via N/C [nasal cannula] PRN [as needed] for SOB [shortness of breath]. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 51 ' s Nursing Progress Notes (documentation kept in the medical record [history of a person ' s health] to keep track of the medication and care a resident received), dated 5/3/2024, indicated the facility admitted the resident from an acute general hospital with a diagnosis of pneumonia, and she received oxygen therapy at 2 liters per minute (LPM, a measurement of gas flow rate) through the nasal cannula (a device used to deliver supplemental oxygen directly in the resident ' s nostrils) with oxygen saturations (the amount of oxygen circulating in a person ' s blood with the normal range percentage above 95%) of 95%. A review of Resident 51 ' s Nursing Progress Notes, dated 5/5/2024 at 12:50 PM, indicated Resident 51 had an episode of desaturation (amount of oxygen circulating in a person ' s blood drops below the normal levels of 95% to 100%) between 84 to 86% while on 2 LPM through the nasal cannula. The progress notes indicated Resident 51 had increased work of breathing, confusion, and disorientation (a transient state of confusion especially to time, place, or person). The progress notes indicated Resident 51 ' s responsible party was present at bedside, and the licensed staff notified the physician. The progress notes indicated the physician added a new order to increase Furosemide (a water pill used to eliminate extra fluid from the body) to 80 milligrams (mg, a unit of mass) and to increase oxygen through the nasal cannula to 3LPM and may be titrated to 5LPM if needed. A review of Resident 51 ' s SBAR (Situation, Background, Assessment, Recommendation, verbal or written communication tool to provide essential and concise information in emergency situations)- General, dated 5/5/2024 at 1:54 PM, indicated Resident 51 had a desaturation of 86%. The SBAR indicated the physician ordered increase furosemide to 80mg and increase O2 [oxygen] to 3LPM; may titrate up to 5LPM. A review of Resident 51 ' s Physician ' s Order Report, indicated a physician order dated 5/5/2024 to administer Oxygen inhalation at 3 LPM via N/C [nasal cannula] PRN [as needed] for SOB [shortness of breath]. The physician order indicated May titrate to up to 5 LPM. Resident 51 ' s record did not indicate if the previous physician order dated 5/3/2024 for oxygen inhalation at 2 LPM PRN for SOB was discontinued. A review of Resident 51 ' s care plan titled At risk for decreased cardiac output dated 5/5/2024,indicated to monitor Resident 51 ' s oxygen saturation (the amount of oxygen circulating in a person ' s blood with the normal range percentage above 95%) every shift and to administer oxygen as prescribed: 3 LPM via NC; may titrate up to 5LPM. A review of Resident 51 ' s Nursing Progress Notes, dated 5/5/2024 at 10:45 PM, indicated Resident 51 experienced another episode of labored breathing and the oxygen therapy was increased to 4 LPM through the nasal cannula with oxygen saturations of 92%. A review of Resident 51 ' s Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 5/14/2024, indicated the resident ' s cognitive (the ability to think and process information) skills for daily decision making was severely impaired and required complete staff assistance and supervision for all activities of daily living. The MDS indicated Resident 51 experienced SOB while at rest and required oxygen therapy as a resident in the facility within the last 14 days. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 51 ' s Vitals Report from 5/20/2024 to 6/10/2024, indicated Resident 51 ' s recorded oxygen saturations. The Vitals Report from 5/20/2024 to 6/10/2024 indicated 31 entries that showed Resident 51 ' s oxygen saturations were measured with oxygen use at 2 LPM, instead of 3 LPM or titrated up to 5 LPM, as indicated in the physician ' s order. -5/21/2024 timed at 6:19 AM, O2 (oxygen) saturation at 96%, Oxygen Use at 2 liters -5/22/2024 timed at 1:11 AM, O2 (oxygen) saturation at 98%, Oxygen Use at 2 liters -5/22/2024 timed at 6:34 PM, O2 (oxygen) saturation at 97%, Oxygen Use at 2 liters -5/23/2024 timed at 12:51 AM, O2 (oxygen) saturation at 98%, Oxygen Use at 2 liters - 5/23/2024 timed at 6:08 PM, O2 (oxygen) saturation at 97%, Oxygen Use at 2 liters - 5/24/2024 timed at 1:07 AM, O2 (oxygen) saturation at 98%, Oxygen Use at 2 liters - 5/24/2024 timed at 5:32 PM, O2 (oxygen) saturation at 97%, Oxygen Use at 2 liters - 5/25/2024 timed at 1:51 AM, O2 (oxygen) saturation at 98%, Oxygen Use at 2 liters - 5/25/2024 timed at 1:55 PM, O2 (oxygen) saturation at 96%, Oxygen Use at 2 liters - 5/25/2024 timed at 5:36 PM, O2 (oxygen) saturation at 96%, Oxygen Use at 2 liters - 5/26/2024 timed at 11:31 AM, O2 (oxygen) saturation at 97%, Oxygen Use at 2 liters - 5/27/2024 timed at 12:21AM, O2 (oxygen) saturation at 97%, Oxygen Use at 2 liters - 5/27/2024 timed at 5:45 PM, O2 (oxygen) saturation at 96%, Oxygen Use at 2 liters - 5/28/2024 timed at 5:26 AM, O2 (oxygen) saturation at 96%, Oxygen use at 2 liters - 5/28/2024 timed at 5:40 PM, O2 (oxygen) saturation at 96%, Oxygen use at 2 liters - 5/29/2024 timed at 12:36 AM, O2 (oxygen) saturation at 98%, Oxygen use at 2 liters - 5/30/2024 timed at 5:53 PM, O2 (oxygen) saturation at 97%, Oxygen use at 2 liters - 5/31/2024 timed at 5:37 PM, O2 (oxygen) saturation at 96%, Oxygen use at 2 liters - 6/1/2024 timed at 11:16 AM, O2 (oxygen) saturation at 96%, Oxygen use at 2 liters - 6/2/2024 timed at 2:08 AM, O2 (oxygen) saturation at 96%, Oxygen use at 2 liters - 6/2/2024 timed at 11:04 AM, O2 (oxygen) saturation at 96%, Oxygen use at 2 liters - 6/3/2024 timed at 12:36 AM, O2 (oxygen) saturation at 96%, Oxygen use at 2 liters (continued on next page)

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 6/4/2024 timed at 6:15 PM, O2 (oxygen) saturation at 97%, Oxygen use at 2 liters - 6/5/2024 timed at 12:30 AM, O2 (oxygen) saturation at 98%, Oxygen use at 2 liters - 6/6/2024 timed at 5:06 PM, O2 (oxygen) saturation at 96%, Oxygen use at 2 liters - 6/7/2024 timed at 12:42 AM, O2 (oxygen) saturation at 98%, Oxygen use at 2 liters - 6/7/2024 timed at 3:16 PM, O2 (oxygen) saturation at 97%, Oxygen use at 2 liters - 6/7/2024 timed at 5:31 PM, O2 (oxygen) saturation at 96%, Oxygen use at 2 liters - 6/8/2024 timed at 2:15 PM, O2 (oxygen) saturation at 97%, Oxygen use at 2 liters - 6/9/2024 timed at 1:14 AM, O2 (oxygen) saturation at 96%, Oxygen use at 2 liters - 6/10/2024 timed at 12:44 AM, O2 (oxygen) saturation at 97%, Oxygen use at 2 liters During a concurrent observation and interview on 6/3/2024 at 9:20AM with Licensed Vocational Nurse 1 (LVN 1), in Resident 51 ' s room, Resident 51 slept on her back with increased work of breathing. The nasal cannula was in Resident 51 ' s nostrils and connected to the oxygen concentrator (a medical device that concentrated oxygen from environmental air and delivered it to the resident in need of supplement oxygen) with a flow rate of 4.5 LPM. The nasal cannula tubing appeared pinched and obstructed at the connecting site between the tubing and oxygen concentrator. LVN 1 stated Resident 51 had some increased work of breathing. LVN 1 stated the nasal cannula tubing should not pinched while in use. LVN 1 stated any oxygen therapy device tubing should be open and unobstructed. LVN 1 stated the negative impact of an obstructive nasal cannula tubing indicated the resident received the oxygen air flow she needed to breathe comfortably. During a concurrent observation and interview on 6/6/2024 at 10:45AM with Treatment Nurse 1 (TN 1), in Resident 51's room, Resident 51 slept on her back with increased work of breathing. Resident 51's oxygen tubing was noted to be pinched at the base of the oxygen concentrator and oxygen tubing with 4.5 LPM of continuous oxygen flowing through her nasal cannula. TN 1 stated the oxygen device tubing should be free of blockage. TN 1 stated the licensed staff was responsible for checking the patency of all tubing. TN 1 stated the negative impact of an obstructed oxygen tubing implied the resident did not receive the correct oxygen flow that she needed. During an interview on 6/6/2024 at 10:55AM with the Registered Nurse Supervisor 1 (RN 1), RN 1 stated that the licensed staff completed their rounds and assessed the residents at least twice a shift. RN 1 stated the negative sign and symptoms of an obstructed oxygen tubing included signs of respiratory distress (a serious lung condition that cases low blood oxygen levels in the body) or respiratory failure manifested by cyanosis (when the skin, lips, or nails turn blue due to the lack of oxygen in a person ' s blood), increased breathing rate, nasal flaring (openings of the nose spreading open while breathing), and increased abdominal and accessory muscle use as the body ' s way to bring in more air into the lungs. RN 1 stated the Certified Nursing Assistants (CNAs) and Licensed Vocational Nurses (LVNs) should check that the oxygen tubing was is free of obstructions especially after moving the resident and before leaving the room. (continued on next page)

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	055288	A. Building B. Wing	06/06/2024

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/6/2024 at 11:30 AM with the Director of Nursing (DON), the DON stated the licensed staff will assess the resident and determine if there was a change of condition that required additional supplemental oxygen. The DON stated the licensed staff would notify the physician and wait for an order. The DON stated if the resident experienced an emergency, the licensed staff would start oxygen therapy and follow up with the physician. The DON stated the oxygen tubing should be free of obstruction. The DON stated the negative impact of an obstructed oxygen tubing meant the resident cannot receive the supplemental oxygen therapy she may need to breath comfortable, and the resident may experience signs and symptoms of respiratory distress or respiratory failure. During a review of the facility's policies and procedures (P&P), titled Oxygen Administration, dated 12/18/2023, the P&P indicated the resident will need to start oxygen therapy when hypoxemia (low oxygen in blood) occurs. The P&P indicated Licensed Nurse or Respiratory Care Practitioner must secure and attach all connections of the oxygen unit and flow meter (an equipment used to control the oxygen flow delivery) to the oxygen delivery device correctly. The P&P indicated the Licensed Nurse or Respiratory Care Practitioner must turn on the unit to the desired flow rate and check the tubing for proper airflow and diffused bubbles in the humidified bottle. The P&P also indicated if there is no evidence of oxygen flow, the licensed staff must check the oxygen unit ' s connections and oxygen devices tubes for leaks.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36925 Based on interview, and record review, the facility failed to ensure that the Social Services Director (SSD) confirmed that the physician filled out the Physician Orders for Life-Sustaining Treatment (POLST, a form that communicates the individual's wishes regarding life-sustaining treatment and resuscitation) form completely for one of four sampled residents (Resident 46). This deficient practice had the potential for the facility not to fulfill the resident's end-of-life wishes when he stops breathing. Findings: A review of Resident 46's Admission Record indicated that the facility initially admitted the resident on [DATE] and readmitted the resident on [DATE] with diagnoses that included a history of traumatic brain injury (a brain dysfunction caused by an outside force, usually a violent blow to the head). A review of Resident 46's Minimum Data Set (MDS - a standardized assessment and screening tool), dated [DATE], indicated that the resident ' s cognition (mental action or process of acquiring knowledge and understanding through thought, experience, and senses) was severely impaired. A review of Resident 46's POLST, prepared by the facility on [DATE], indicated that the physician has not signed or has indicated in the form, the treatment the resident should receive when he stops breathing and/or has no more pulse. There is no documented evidence the resident ' s conservator (a guardian or protector) signed the form. During an interview on [DATE] at 11:18 AM, Registered Nurse 1 (RN 1) stated that the SSD is responsible for ensuring that the physician, resident, and/or responsible party fills out and signs the POLST form within a reasonable time after the facility admits the resident. During a concurrent interview with the SSD, she stated that the facility asks the resident to fill out the POLST form during admission. If the resident is unable to make decisions for himself, the facility asks the responsible party (RP) to fill out the form. If the RP is unreachable, the facility notifies the physician, and the resident becomes a Full Code (full support which includes cardiopulmonary resuscitation (CPR) if the patient has no heartbeat and is not breathing) by default. The SSD stated that she does not know who ensures that signatures from the resident and/or responsible party and the physician are present on the POLST form and filled out, after the facility admits the resident. During a concurrent interview with the Administrator, she stated that the SSD is responsible in making sure that the POLST is signed, dated, and complete. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the SSD's job description titled, Social Services Director - Hourly, Job Code 61, indicated that the SSD reports to the administrator and has essential duties and responsibilities including the completion of required forms and documents in accordance with company policy and state and/or federal regulations.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44429 Based on observation, interview and record review, the facility failed to ensure one kitchen staff was wearing a hair net prior to entering the kitchen and when properly storing foods in the refrigerator. 1. There were 26 applesauce containers not labeled or dated in the food storage. 2. There was one gallon of milk without a label on when it was opened. These deficient practices had the potential to result in food contamination (foods that are spoiled or tainted because of microorganisms, such as bacteria or parasites, or toxic substances that make them dangerous for consumption) and result in the resident to be exposed to food borne illnesses (an illnesses contracted from eating contaminated food or beverages). Findings: 1. During an initial kitchen tour on [DATE] at 8:23AM with the Dietary Supervisor (DS), Refrigerator 1 was observed to have prepared applesauce in a cups or bowl without labels or dates and one gallon of milk that was open and had no date on when it was opened. The DS stated that the applesauce should have been all labeled to identify the contents in the container and to identify if the food was expired. DS stated the milk container was opened and should have had a open date to indicate when the milk would expire. The DS stated dating and labeling food was important to ensure food were not expired, and to prevent residents from becoming sick. 2. During an observation of the kitchen on [DATE] at 8:50AM Kitchen Staff (KS 1) was observed entering the kitchen without a hair net. During an interview on [DATE] at 8:53AM, KS 1 stated he was in rush to get ice that he forgot his hair net was in his back pocket. KS 1 stated that he should have been wearing the hair net inside the kitchen to prevent his hair from contaminating the ice and that resident could get sick. During an interview on [DATE] at 8:55AM, DS stated that wearing a hair net is important to wear in the kitchen to prevent food & drink from being contaminated and residents getting sick, that hair net acts as a form of protection. A review of the facility ' s policy titled, Food Handling Practices dated [DATE], indicated food services employees comply with strict time and temperature requirements and use proper food handling techniques to prevent the occurrence of foodborne illness. The policy indicated practice good personal hygiene: restrain hair appropriately. The policy indicated store contents open cans in clean, approved containers in refrigerator units, cover, date and use within 48hrs.

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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** 44429 Based on interview, and record review, the facility failed to ensure the Hospice binder (a binder that contains the care and services provided and being provided to residents under hospice care [end of life care]) was completed by the hospice nurses and used to communicate with the facility staffs) was completed by the hospice nurses during their visits and reviewed by the facility staffs for 2 of 2 sampled residents (Resident 59 and Resident 77). The Hospice binder contains hospice nurse sign-in sheet, weekly calendar visits and hospice nurse ' s notes, care plans and treatment recommendations. This deficient practice had the potential for the residents not to receive appropriate hospice care which could negatively affect the delivery of care and services related to the resident ' s change of health (including but not limited to pain, shortness of breath, spiritual and psychosocial needs related to dying), and result in the resident ' s personal needs for the end of life issues not to be met. Findings: 1. During a review of Resident 77's Face Sheet indicated the facility admitted Resident 77 on 3/21/2022 with diagnoses that included dementia (a general term to describe a group of symptoms related to loss of memory and judgment) and heart failure (when the heart doesn ' t pump enough blood for the body's needs). During a review of Resident 77's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 4/30/2024, indicated Resident 77 had severely impaired cognitive (ability to think and reasonably) skills for daily decision making. The MDS indicated Resident 77 required dependent care for shower/bathe self and chair/bed-to-chair transfer. During an interview and record view on 6/5/2024 at 9:43AM with Registered Nurse (RN) 2, RN 2 stated Resident 77 ' s Hospice binder was reviewed. RN 2 stated that Resident 77 hospice binder did not contain any nursing notes, resident assessment, and no plan of care for Resident 77. RN 2 stated she would not know what care is being provide by the hospice nurse. During an interview and record review on 6/5/24 at 10:11 AM with the Director of Nursing (DON), Resident 77 ' s Hospice binder and medical records were reviewed, the DON stated Resident 77 ' s Hospice Binder did not have Resident 77 ' s hospice nurse notes, resident assessment, and no plan of care. DON stated the care plan and visiting notes from the hospice should be kept in Resident 77 ' s hospice binder and readily available for review to ensure the facility and the hospice staff maintain a good communication and collaborate effectively to deliver consistent comfort care for end of life. 46779 (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During a review of Resident 59's Face Sheet indicated the facility admitted Resident 59 on 1/3/24 with diagnoses that included dementia (a general term to describe a group of symptoms related to loss of memory and judgment) and hypertension (high blood pressure). During a review of Resident 59's MDS, dated [DATE], indicated Resident 59 had severely impaired cognitive skills for daily decision making. The MDS indicated Resident 59 required substantial/maximal assistance with eating, oral hygiene, and personal hygiene, and dependent with toileting hygiene, shower/bathe self and chair/bed-to-chair transfer. During a review of Resident 59's physician Order Report, dated 6/1/24 to 6/30/24, indicated to admit Resident 59 to receive hospice care on 1/3/24. During an interview and record review on 6/5/24 at 9:43 AM with Registered Nurse (RN) 2, Resident 59's Hospice Binder (a binder that contains the resident ' s progress notes and care plan used to communicate the residents care needs and progress) was reviewed. RN 2 stated the facility nurses and the hospice staff communicated about the resident's care through the hospice binder. RN 2 stated there was no care plan and consistent visiting notes from the hospice in Resident 59 ' s Hospice Binder. RN 2 stated she would not know what care the hospice staff will or provided to Resident 59. RN 2 stated the Hospice CP should be kept in the Hospice Binder to ensure Resident 59 receive consistent care from the facility and the hospice. During an interview and record review on 6/5/24 at 10:14 AM with the Director of Nursing (DON), Resident 59 ' s Hospice Binder and medical records were reviewed, the DON stated Resident 59 ' s Hospice Binder did not have Resident 59's care plan and hospice nurse notes did not indicate that the hospice nurse consistently visited from the hospice in Resident 59's Hospice Binder and her medical record. The DON stated the care plan and visiting notes from the hospice should be kept in Resident 59's Hospice Binder and readily available for review to ensure the facility and the hospice staff maintain a good communication and collaborate effectively to deliver consistent care to Resident 59. During a review of the facility's policy and procedure titled, Hospice Services Agreement, dated 5/3/19, indicated hospice and facility each shall maintain a copy of each Hospice Patient's POC (plan of Care) in the respective clinical records maintained by each Party. During a review of the updated facility's policy and procedure titled, Hospice Care, indicated When a resident participates in the hospice program, a coordinated plan of care between the Company, hospice agency and resident/family will be developed and shall include directives for managing pain and other uncomfortable symptoms. The care plan shall be revised and updated as necessary to reflect the resident ' s current status.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 44429 Based on observation and interview and record review, the facility staff failed to provide a safe environment for residents by leaving a Hoyer Lift (a device that allows a person to be lifted and transferred with minimum physical effort) unattended in the resident ' s room. This had the potential for residents to be placed at risk for accidents and injury. Additionally the staff will have limited space in the room to comfortably provide care to the residents. Findings: During an observation on 6/3/2024 at 10:01 AM, a Hoyer lift was left unattended near by a resident ' s bed. During an interview on 6/3/2024 at 10:05 AM with Certified Nursing Assistant (CNA 3) 3, CNA 3 stated that she had left the Hoyer lift unattended it in the resident ' s room while assisting a resident to get up to a wheelchair and taking the resident to the dining area. CNA 3 stated the Hoyer lift should not be left in the resident ' s room unattended because the residents in the room might trip over the device and get injured. CNA stated the Hoyer lifts had to be put in the proper storage area when not in use. During an interview on 6/3/2024 at 10:10AM with the Director of Nurses (DON), DON stated the Hoyer lift needs to be placed outside of the resident ' s room in the proper storage area so that residents in the room won ' t get injured. DON and she will educate the staff not to leave the Hoyer lift in the resident ' s room to prevent residents from getting injured. A review of the facility ' s policy titled, Safety Supervision of Residents dated 9/24/2023, indicated our company strives to make the environment as free from accidents hazards as possible. The policy indicated employee shall be trained on potential accident hazards and demonstrate competency on how to identify and report accidents hazard, and try to prevent