STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055297	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Springs Post-Acute	10625 Leffingwell Road Norwalk, CA 90650

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055 Based on observation, interview, and record review the facility failed to ensure three of four sampled residents (Residents 34, 45, and 82) call lights (device that allows residents to request assistance from nursing staff) were answered in a timely manner. This deficient practice resulted in a delay of care and services. Findings: During a review of Resident 34's Admission Record, the Admission Record indicated Resident 34 was admitted to the facility on [DATE] with diagnoses including polyneuropathy (malfunction of nerves in the body), muscle weakness, and paraplegia (inability to voluntarily move the lower parts of the body). During a review of Resident 34's Minimum data Set (MDS), a resident assessment tool, dated 2/3/2024, the MDS indicated Resident 34's cognition was intact. The MDS indicated Resident 34 needed partial assistance (helper does less than half the effort) with eating, oral hygiene, needed substantial assist (helper does more than half the effort) with personal hygiene, and was dependent (helper does all the effort) on staff with toileting hygiene and showering. During a review of Resident 34's care plan (untitled), initiated on 12/3/2024, the care plan indicated Resident 34 has Self-care deficit with ADLs. The care plan intervention indicated assist with ADLs as needed. During a review of Resident 45's Admission Record, the Admission Record indicated Resident 45 was admitted to the facility on [DATE] with diagnoses including Acquired absence of left leg below the knee, osteomyelitis (swelling of the bones), and reduced mobility. During a review of Resident 45's MDS, dated [DATE], the MDS indicated Resident 45's cognition was moderately impaired. The MDS indicated Resident 45 needed set up assistance with eating, needed partial assistance (helper does less than half the effort) with oral hygiene, toileting hygiene, needed substantial assist (helper does more than half the effort) with showering and personal hygiene. During a review of Resident 45's care plan (untitled), initiated on 8/27/2024, the care plan indicated Resident 45 has Self-care deficit with ADLs. The care plan intervention indicated assist with ADLs as needed. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055297	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER The Springs Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 10625 Leffingwell Road Norwalk, CA 90650	

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 82's Admission Record, the Admission Record indicated Resident 82 was admitted to the facility on [DATE] with diagnoses including cord compression (back injury), cervicalgia (neck injury or pain), muscle weakness, and reduced mobility. During a review of Resident 82s MDS, dated [DATE], the MDS indicated Resident 82's cognition was intact. The MDS indicated Resident 82 needed supervision (helper does verbal cues) with eating, partial assistance (helper does less than half the effort) with oral hygiene, toileting hygiene, needed substantial assist (helper does more than half the effort) with showering, and personal hygiene. During a review of Resident 82's care plan (untitled), initiated on 8/20/2024, the care plan indicated Resident 82 has Self-care deficit with ADLs. The care plan intervention indicated assist with ADLs as needed. During an interview on 2/4/2025 at 9:15 a.m. with Resident 45, Resident 45 stated call lights were not answered timely with the wait times of up to 15 minutes. During an interview on 2/4/2025 at 11:44 a.m. with Resident 34 and 82, Resident 82 stated call lights were not answered timely. Resident 34 stated nurse call light wait times were sometimes long. Resident 82 stated sometimes the nurse will answer the call light promise to come back but never do. During an interview and record review on 2/7/2025 at 8 a.m. with the Infection Prevention Nurse (IPN), The facility's Resident Council Minutes, 1/22/2025, was reviewed and the minutes indicated call lights were not answered in a timely manner. The minutes indicated Resident 82 stated call lights were not answered in a timely manner. The IPN stated call lights need to be answered timely to meet the needs of the residents. During an interview on 2/7/2025 at 5 p.m., with the Director of Nursing (DON), the DON stated all residents must have a call light to be able to verbalize the residents' needs. The DON stated call lights need to be answered immediately so staff can attend to the residents. During a review of the facility's policy and procedure (P&P) titled, Assistive Devices and Equipment, revised 1/2020, the P&P indicated certain devices and equipment that assist resident safety and independence are provided. During a review of the facility's policy and procedure (P&P) titled, Answering the Call Light, revised 9/2022, the P&P indicated call lights will be answered in a timely manner. The P&P indicated the resident call system will be answered immediately.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45777 Based on interview and record review, the facility failed to protect one of three sampled residents (Resident 50) from physical and verbal abuse, by not separating Resident 50 from Resident 197 after a verbal altercation and Resident 197 threw a box of tissues at Resident 50. This deficient practice placed Resident 50 at risk for further abuse and had the potential to cause feelings of intimidation, neglect and not feeling safe in the facility which was considered the Residents' home. Findings: During a review of Resident 50's Admission Record , the Admission Record indicated Resident 50 was admitted to the facility on [DATE], with diagnoses including cerebral infarction unspecified (a condition in which blood flow to the brain is interrupted, causing brain tissue to die without a specified identifiable cause), muscle weakness generalized, and legal blindness (a very limited visual field). During a review of Resident 50's History and Physical (H&P), dated 4/17/2024, the H&P indicated, Resident 50 had the capacity to understand and make decisions. During a review of Resident 50's Minimum Data Set (MDS a resident assessment tool) dated 12/13/2024, The MDS indicated, Resident 50 required partial/moderate assistance (helper does less than half the effort) with shower/bathe self, upper body dressing sit to stand , substantial /maximal assistance with lower body dressing. During a review of Resident 197's Admission Record, the Admission Record indicated Resident 197 was initially admitted to the facility on [DATE] with diagnoses including essential hypertension (high blood pressure), anxiety disorder (repeated episodes of sudden feelings of intense fear and terror that reach a peak within minutes) and muscle weakness. During a review of Resident 197's H&P, dated 1/24/2025, the H&P indicated, Resident 197 had decision making capacity. During a review of Resident 197's MDS, dated [DATE], the MDS indicated, Resident 197 was independent with self-care, ambulation and required supervision or touching assistance with toilet hygiene and lower body dressing. During record review of Resident 197 's care plan titled, Resident has verbal argument with roommate dated 1/24/2025, the care plan indicated Resident 197 refused to close the patio door despite freezing temperature and Resident 50 insisted on closing the patio door. The care plan indicated to monitor Resident 197's whereabouts/ activities for 72 hours room change if indicated and to separate from Resident 50 immediately. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/4/2025 at 9 a.m., with Resident 50, Resident 50 stated on 1/24/2025 at 7 a.m., when he (Resident 50) woke up Resident 197 was yelling that he (Resident 197) was going to knock him (Resident 50) out. Resident 50 stated the Registered Nurse 2 (RNS 2) came in and calmed the argument down. Resident 50 stated after RN 2 left the room, Resident 197 threw two tissue boxes at him then left the room. Resident 50 stated he felt his safety was at risk because Resident 197 was later moved to another room which shared a common patio with Resident 50. During an interview on 2/7/2025 at 9:44 a.m., with Registered Nurse 2 (RNS 2) , RN 2 stated he was sitting at the nurse's station on 1/24/2025 when he heard the verbal altercation between Resident 50 and Resident 197. RN 2 stated he went inside the residents' room to calm down Resident 50 and Resident 197. RN 2 stated he left the room and sat at the nurse's station next to the room and he (RN 2) saw Resident 197 leave the room and sit in the facility lobby. RN 2 stated he went to check on Resident 50, this is when Resident 50 stated Resident 197 threw a tissue box at him. During an interview on 2/ 7/2025 at 2:00 p.m., with Licensed Vocational Nurse 4 (LVN 4), LVN 4 stated when there is a resident-to-resident altercation we de-escalate the situation and move one of the residents to another location, so they are not close to each other. LVN 4 stated two residents that were in a verbal altercation should not be left together, because it could escalate and become physical. LVN 4 stated this was a resident safety issue. During an observation and interview on 2/7/2025 at 11:04 a.m., with the Director of Nursing (DON), the DON stated when there is a resident-to-resident altercation he would first investigate the reason for yelling and roommate incompatibility. The DON stated he would then make room changes as there is always a room available. The DON stated the facility always keep at least two rooms available. The DON stated Resident 197 was moved to room where the two residents Resident 50 and Resident 197 shared a patio. The DON stated staff should have ensured Resident 197 did not have access to Resident 50 by not putting Resident 1197 in a room that shared a patio with Resident 50. During a review of the facility's policy and procedure (P&P) titled, Resident- to- Resident Altercations, dated April 2021, the P&P indicated if two residents are involved in an altercation, staff : a. Separate the residents, and institute measures to calm the situation b. Identify what happened, including what might have led to aggressive conduct on the part of one or more of the individuals involved in the altercation. c. Make any necessary changes in the care plan approaches to any or all the involved individuals.

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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** 46537 Based on observation, interview, and record review, the facility failed to assess, monitor, and document the use of hand mittens (soft gloves that are designed to restrict the movement of one or both hands, and are used with patients who have removed essential lines or tubes on more than one occasion.) to prevent the residents from pulling out his gastrostomy tube ([G-tube]- a tube inserted through the abdomen that brings nutrition directly to the stomach) for one of six sampled residents (Resident 86). This failure had the potential to result in entrapment, skin injury, and compromised circulation for Resident 86's hands. Findings: During a review of Resident 86's Admission Record, the Admission Record indicated, Resident 86 was admitted to the facility on [DATE] with traumatic (physical injury of sudden onset) subarachnoid (tissue layer that protects the brain) hemorrhage (bleeding), hemiplegia of right side (total paralysis of the arm, leg, and trunk on the same side of the body), and generalized muscle weakness. During a review of Resident 86's History and Physical (H&P), dated 1/3/2025, the H&P indicated, Resident 86 had no capacity (ability) to understand and make decisions. During a review of Resident 86's Minimum Data Set (MDS - a resident assessment tool), dated 11/20/2025, the MDS indicated Resident 86 required dependent assistance (Helper does all of the effort) from two or more staff for dressing, hygiene, bed mobility, and transfer. The MDS indicated, Resident 86 had impairment (A loss of part or all of a physical or mental ability) on both upper extremity (shoulder, elbow, wrist, hand) and lower extremity (hip, knee, ankle, foot) for one side. During a review of Resident 86's Order Summary Report, dated 2/5/2025, the Order Summary Report, indicated, may apply hand mitten on the left-hand releasing for 15 minutes every two hours and check for skin breakdown was ordered on 10/19/2024. During a review of Resident 86's Care Plan, revised on 2/5/2025, the Care Plan Focus indicated, Resident 86 was pulling at life sustaining device (G-tube) and hand mitten was used to prevent pulling at life sustaining devices. The Care Plan Interventions indicated, apply hand mittens on the left-hand releasing for 15 minutes every two hours and check for skin breakdown. During a review of Resident 86's Informed Consent for Physical Restraint, Bed rails, and Others, dated 10/21/2024, the Informed Consent for Physical Restraint, Bed rails, and Others indicated, Informed Consent: 1. Proposed treatment: May apply hand mitten to left hand every two hours with release for 15 minutes and check for skin breakdown .3. The physician had disclosed the benefits, risks, and consequences related to the following proposed treatment/procedure: Physical restraint. (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 observation on 2/4/2025, at 10:05 a.m., in Resident 86's room, Resident 86 was sitting on a wheelchair and a hand mitten (type of physical restraint used to prevent patients from removing tubes and lines that are used for treatment) was on his left hand. Resident 86 was able to move his right thumb and index fingers slightly and tried to take off the left-hand mitten. Resident 86 was not able to take the mitten off. During a concurrent interview and record review on 2/6/2025, at 3:02 p.m., with Licensed Vocational Nurse (LVN) 3, Resident 86's Medication Administration Records (MAR), dated from 10/1/2024 to 2/4/2025 were reviewed. LVN 3 stated, there was no documentation regarding monitoring and assessment of Resident 86's left-hand mitten. LVN 3 stated, staff did not transcribe the physician order to MAR, and no one followed up. LVN 3 stated, Resident 86's restraints should be removed for 15 minutes every two hours, and Resident 86's skin integrity should be assessed and documented in the MAR. LVN 3 stated, it was important to assess and monitor restraints every two hour to prevent injury. During an interview on 2/6/2025, at 3:50 p.m., with Registered Nurse Supervisor (RNS) 2, RNS 2 stated, Resident 86's mittens were considered restraints, if the mitten was placed to restrict the resident's movement. RNS 2 stated, nursing staff should re-evaluate and assess the need for the restraints and use less restrictive measures to prevent Resident 86 from pulling out his GTube. RNS 2 stated, nursing staff should monitor Resident 86's mittens every two hours for pain, circulation, and skin breakdown to prevent unintentional injuries related to the restraint use. During an interview on 2/7/2025, at 4:57 p.m., with the Director of Nursing (DON), the DON stated, anything that restricted the resident's movement would be considered as restraint and the least restrictive measure should be tried first. The DON stated, restraints should be monitored as frequently as ordered to prevent injury and the monitoring should be documented. The DON stated, all orders should be transcribed to the MAR and carried out. The DON stated, assessment and monitoring order for the mitten was not carried out correctly. During a review of the facility's Policy and Procedure (P&P) titled, Use of Restraints, reviewed 4/2022, the P&P indicated, Policy Statement: Restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience, or for the prevention of falls. When the use of restraints is indicated, the least restrictive alternative will be used for the least amount of time necessary, and the ongoing re-evaluation for the need for restraints will be documented. Policy Interpretation and Implementation: 1. Physical Restraints are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body . 3. Examples of devices that are/may be considered physical restraints include leg restraints, arm restraints, hand mitts, soft ties or vest, wheelchair safety bars, geri-chairs, and lap cushions and trays that the resident cannot remove . 12. The following safety guidelines shall be implemented and documented while a resident is in restraints: c. A resident placed in a restraint will be observed at least every thirty (30) minutes by nursing personnel and an account of the resident's condition sha11 be recorded in the resident's medical record. d. The opportunity for motion and exercise is provided for a period of not less than ten (10) minutes during each two (2) hours in which restraints are employed. e. Restrained residents must be repositioned at least every two (2) hours on all shifts.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055 46537 49573 Based on observation, interview and record review the facility failed to ensure three of three resident's (Resident 80, 86, 296) Minimum data Set (MDS - a resident assessment tool), Section P - Restraints (any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body) and alarms, indicated Residents 80, 86, and 296 had restraints. This deficient practice resulted an inaccurate depiction of Resident 80, 86, and 296's current health status. Findings: a) During a review of Resident 80's Admission Record, the Admission Record indicated Resident 80 was originally admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (brain problem), seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), and Resident 80 had a gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems)tube. During a review of Resident 80's Minimum Data Set ([MDS], a resident assessment tool), dated 11/20/2024, the MDS indicated Resident 80 had severe cognitive (ability to make decisions of daily living) impairment and was dependent (helper does all the effort) with all activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS indicated Resident 80 did not have any restraints. During a review of Resident 80's Medication Administration Record (MAR) for 11/2024, the MAR indicated Resident 80 had mittens (type of physical restraint used to prevent patients from removing tubes and lines that are used for treatment) to the right hand from 11/1/2024 to 11/19/2024. During an interview and record review on 2/7/2025 at 1:00 p.m., with the MDS Coordinator, Resident 80's Medication Administration Record (MAR) for 11/2024 was reviewed. The MDS Coordinator stated Resident 80 had mittens in November 2024. During a concurrent interview and record review on 2/7/2025 at 1:05 p.m., with the MDS Coordinator, Resident 80's MDS dated [DATE] was reviewed. Resident 80's MDS did not indicate Resident 80 had any restraints. The MDS coordinator stated the MDS was not coded to indicate the resident had restraints or mitens. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. During a review of Resident 296's Admission Record, the Admission Record indicated Resident 296 was admitted to the facility on [DATE] with diagnoses including Parkinson disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), chronic respiratory failure with hypoxia (a condition in which the lungs are unable to adequately exchange oxygen and carbon dioxide over a prolonged period), tracheostomy (a surgical procedure that creates an opening in the trachea (windpipe) to provide an airway when the natural airway is blocked or compromised), and gastrostomy (a surgical procedure that creates an opening in the abdomen and inserts a tube directly into the stomach). During a review of Resident 296's history and physical (H/P) dated 10/25/2024, the H/P indicated refer to psychiatry (the branch of medicine concerned with the study, diagnosis, and treatment of mental illness) and neurology (the branch of medicine that deals with the diagnosis and treatment of disorders of the nervous system) as capacity was not able to be determined. During a review of Resident 296's MDS dated [DATE], the MDS indicated Resident 296 was rarely or never understood and was dependent (helper does all the effort, resident does none of the effort to complete the activity) with self-care abilities such as oral hygiene, toileting hygiene, shower/bathe, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene. The MDS indicated Resident 296 was dependent with mobility abilities such as rolling left and right, sit to lying position, and lying to sitting position. The MDS also indicated Resident 296 did not have any restraints used or on person. During a review of Resident 296's MAR for January 2025, the MAR indicated may apply hand mittens to both hands related to resident pulling at life sustaining devices. During an observation on 2/4/2025 at 10:23 a.m., of Resident 296 in his room, Resident 296 was resting in bed with his eyes closed. Resident 296 had hand mittens on both of his hands and he was moving his hands around in the air. During a concurrent interview and record review on 2/7/2025 at 9:20 a.m., with MDS Coordinator, the MDS dated [DATE] was reviewed. The MDS Coordinator stated restraints are any devices that restricts a resident's movement and the resident is not able to remove the device. The MDS Coordinator stated if residents have mittens, they cannot grab the medical devices as it would be harder for them to grab the medical devices. The MDSC stated hand mittens are considered physical restraints and the MDS should have been coded that mittens were a restraint used on the resident because hand mittens are considered restraints. c.During a review of Resident 86's Admission Record, the Admission Record indicated, Resident 86 was admitted to the facility on [DATE] with traumatic (physical injury of sudden onset) subarachnoid (tissue layer that protects the brain) hemorrhage (bleeding), hemiplegia of right side (total paralysis of the arm, leg, and trunk on the same side of the body), and generalized muscle weakness. During a review of Resident 86's H&P, dated 1/3/2025, the H&P indicated, Resident 86 had no capacity to understand and make decision. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 86's MDS, dated [DATE], the MDS indicated Resident 86 required dependent assistance from two or more staff for dressing, hygiene, bed mobility, and transfer. The MDS indicated, Resident 86 had impairment (a loss of part or all of a physical or mental ability) on both upper extremity (shoulder, elbow, wrist, hand) and lower extremity (hip, knee, ankle, foot) for one side. The MDS indicated, Resident 86 did not have any restraints or alarms. During an observation on 2/4/2025, at 10:05 a.m., in Resident 86's room, Resident 86 was sitting on wheelchair and a hand mitten was on his left hand. Resident 86 was able to move his right thumb and index fingers slightly and tried to take off the left-hand mitten. Resident 86 was not able to take the mitten off. During a concurrent interview and record review on 2/7/2025, at 9:40 a.m., with MDS Coordinator of Resident 86's Order Summary Report (OSR), dated 2/5/2025 was reviewed. The OSR indicated, may apply hand mitten on the left-hand releasing for 15 minutes every two hours and check for skin breakdown was ordered on 10/19/2024. The MDS Coordinator stated, that Resident 86 had the mitten on the left hand to prevent him from pulling his gastrostomy tube. The MDS Coordinator stated, she did not realize the hand mitten is considered a restraint. The MDS Coordintor stated, that was why she did not code the mitten as a restraint in MDS section P. During a concurrent interview and record review on 2/7/2025, at 9:45 a.m., with the MDS Coordinator, Resident 86's Informed Consent for Physical Restraint, Bed rails, and Others, dated 10/21/2024 was reviewed. The Informed Consent for Physical Restraint, Bed rails, and Others indicated, Informed Consent indicated: 1. Proposed treatment: May apply hand mitten to left hand every two hours with release for 15 minutes and check for skin breakdown .3. The physician had disclosed the benefits, risks, and consequences related to the following proposed treatment/procedure: Physical restraint. The MDS Coordinator stated, she understood that the mitten was considered a restraint after reviewing the consent form. The MDS Coordinator stated, it was important to assess and code accurately because incorrect coding could negatively affect the president's plan of care. MDSC stated, it could affect financially because government funding is based on service provided in some cases. During an interview on 2/7/2025 at 5 p.m. with the Director of Nursing (DON), the DON stated assessments should be accurate to get a clear representation of the resident. During a review of the facility's policy and procedure (P&P) titled, Resident Assessments, revised 3/2022, the P&P indicated comprehensive assessments will be conducted. The P&P indicated persons who completed the MDS must sign the form attesting to the accuracy of such information. During a review of Resident Assessment Instrument (RAI - a standardized evaluation that helps healthcare providers assess a resident's needs, strengths, and preferences) manual, Chapter 1, dated October 2019, the RAI indicated the assessment accurately reflects the resident's status. The RAI Section P indicated Bed rails used as positioning devices. If the use of bed rails (quarter-, half- or three quarter, one or both, etc.) meet the definition of a physical restraint even though they may improve the resident's mobility in bed, the nursing home must code their use as a restraint. The RAI indicated hand mittens are included in limb restraints category. Limb restraints include any manual method or physical or mechanical device, material or equipment that the resident cannot easily remove, that restricts movement of any part of an upper extremity (i.e., hand, arm, wrist) or lower extremity (i.e., foot, leg) that either restricts freedom of movement or access to his or her own body

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055 45777 Based on interview and record review the facility failed to ensure two of three sampled resident's (Resident 11 and 33) Preadmission Screening and Resident Review (PASARR - a federal assessment requirement to help ensure that individuals who have a mental disorder -MD- are placed in facilities that can provide the appropriate care) screening was accurate. This deficient practice had the potential to result in inappropriate placement and unidentified specialized services for Resident 11 and 33. Findings: a) During a review of Resident 11's Admission Record, the Admission Record indicated Resident 11 was admitted to the facility on [DATE] with diagnoses including schizophrenia, unspecified a mental illness that can affect thoughts, mood, and behavior), type 2 diabetes mellitus (a long -term condition in which the body has trouble controlling blood sugar and using it for energy) and essential hypertension (high blood pressure). During a review of Resident 11's Minimum Data Set (MDS - a resident assessment tool), dated 11/22/2024 the MDS indicated Resident 11's cognition was moderately impaired. The MDS indicated Resident 11 needs substantial/ maximal assistant (helper does more than half the effort) with toileting hygiene, lower body dressing, putting on taking off footwear and partial / moderate assistance with upper body dressing and personal hygiene. During an interview and record review on 2/7/2025 at 12:00p.m. with the MDS Coordinator, Resident 11's Admission Record and Resident 11's PASARR and Resident Review Level I Screening, dated 5/18/2024 was reviewed. The MDS coordinator stated Resident 11 had mental illness diagnosis of schizophrenia unspecified. The MDS Coordinator confirmed Resident 11's PASARR and Resident11's MDS were not accurate she stated when Resident 11 arrived at the facility someone should have reviewed and corrected the PASARR so the MDS can also be accurate. MDS Coordinator stated should have indicated Resident 1 had a diagnosed mental disorder. The form indicated Resident 11 did not have a mental disorder. The MDS coordinator stated because the PASRR was not filled out correctly we run a risk of patients not going into the correct facilities that could handle the patients. b) During a review of Resident 33's Admission Record, the Admission Record indicated Resident 33 was admitted to the facility on [DATE] with diagnoses including schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior) bipolar type (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs). During a review of Resident 33's MDS, dated [DATE], the MDS indicated Resident 55's cognition was severely impaired. The MDS indicated Resident 55 was dependent (helper does all the effort) on staff with all activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and record review on 2/6/2025 at 9:56 a.m. with the MDS Coordinator, Resident 33's Admission Record and Resident 33's PASARR and Resident Review Level I screening, dated 3/2/2022. The MDS coordinator stated Resident 33 had mental illness diagnosis of schizoaffective disorder bipolar type. The MDS Coordinator stated Resident 33's PASARR and Resident Review Level I Screening should have indicated Resident 1 had a diagnosed mental disorder. The form indicated that Resident 33 did not have a mental disorder. The MDS coordinator stated it was important to answer the screening correctly to be able to meet the needs of the resident. During an interview on 2/7/2024 at 1:00 p.m., the Director of Nursing (DON), the DON stated the PASARR should be accurate and completed as required by law. During a record review of the facility's policy and procedure (P&P) titled, Admission Criteria, revised 3/2019, the P&P indicated the facility conducts Level I PASRR screen for all admissions and readmissions. The P&P indicated all residents are screened for mental disorders per PASRR Process.

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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** 49573 Based on observation, interview and record review, the facility failed to implement a comprehensive care plan for one of two sampled residents (Resident 296) who had bilateral (both) hand mittens. This deficient practice had the potential to negatively affect the quality of life and wellbeing for Resident 296 to prevent him from achieving his highest practical well-being. Findings: During a review of Resident 296's Admission Record, the Admission Record indicated Resident 296 was admitted to the facility on [DATE] with diagnoses including chronic respiratory failure with hypoxia (inadequate levels of oxygen [life sustaining element of air] in the body), tracheostomy (a surgical procedure that creates an opening in the trachea (windpipe) to provide an airway when the natural airway is blocked or compromised), and gastrostomy (a surgical procedure that creates an opening in the abdomen and inserts a tube directly into the stomach). During a review of Resident 296's history and physical (H/P) dated 10/25/2024, the H/P indicated refer to psychiatry (the branch of medicine concerned with the study, diagnosis, and treatment of mental illness) and neurology (the branch of medicine that deals with the diagnosis and treatment of disorders of the nervous system) as capacity was not able to be determined. During a review of Resident 296's Minimum Data Set (MDS a resident assessment tool) dated 10/29/2024, the MDS indicated Resident 296 was rarely or never understood and was dependent (helper does all of the effort, resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity) with self-care abilities such as oral hygiene, toileting hygiene, shower/bathe, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene. The MDS also indicated Resident 296 was dependent with mobility abilities such as rolling left and right, sit to lying position, and lying to sitting position the sit to stand, bed to chair transfer, toilet transfer and shower transfer were not attempted due to resident's medical conditions or safety concerns. During a review of Resident 296's Order Summary Report, the Order Summary Report indicated, may apply hand mitten to both hands as indicated related to resident pulling at life sustaining devices. May check circulation every 2 hours with release for 15 minutes and check for skin breakdown dated 10/25/2024. During a review of Resident 296's comprehensive care plan dated 10/25/2024, the comprehensive care plan did not indicate a care plan addressing Resident 296's bilateral hand mittens for pulling at life sustaining devices. During an observation on 2/4/2025 at 10:23 a.m., of Resident 296, Resident 296 had hand mittens on both of his hands, and he was moving his hands around in the air. (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 2/7/2025 at 9:20 a.m., with the MDS Coordinator (MDSC), of Resident 296's comprehensive care plan dated 10/25/2024 was reviewed. The MDSC stated there should be a care plan for hand mittens. The MDSC stated the importance of a care plan was for the facility to be able to care for the residents according to their diagnoses, what the residents are at risk for so the facility can monitor and prevent any further complications. The MDSC stated if residents have a new order, the new orders are added to the care plan. During an interview on 2/7/2025 at 4:46 p.m., with the Director of Nursing (DON), the DON stated the care plan was a plan of care for residents and the importance of having a care plan was how to care for the residents, their needs and diagnosis. During a review of the facility's policy and procedure titled, Care Plans, Comprehensive Person-Centered, revised March 2022, indicated, a comprehensive, person-centered care plan includes measurable objectives and timeframes; describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment; includes the resident's stated goals upon admission and desired outcomes; builds on the resident's strengths; and reflects currently recognized standards of practice for problem areas and conditions

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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. 36943 Based on observation, interview, and record review, the facility failed to provide services to one of 13 sampled residents (Resident 76) with limited range of motion [(ROM) full movement potential of a joint (where two bones meet)] and mobility (ability to move) by failing to transfer Resident 76 out of the bed daily. This failure had the potential to result in Resident 76's decreased activity tolerance and to experience limited social interaction, affecting Resident 53's quality of life. Findings: During a review of Resident 76's General Acute Care Hospital (GACH) Documents Review Report, the GACH Documents Review Report indicted Resident 76 was admitted to the GACH on 3/27/2024 and found to have a meningioma (brain tumor). The GACH Documents Review Report indicated Resident 76 underwent surgical removal of the meningioma on 4/2/2024, partial removal of the skull on 4/3/2024, and placement of a tracheostomy tube (hole made through the front of the neck and into the windpipe [trachea]) for breathing on 4/13/2024. During a review of Resident 76's General Acute Care Hospital (GACH) Discharge Medication Orders, dated 4/25/2024, the GACH Discharge Orders included to discharge Resident 76 to a sub-acute (level of care that does not require hospitalization but requires more intensive skilled nursing care including medical equipment, supplies, and treatments such as ventilators [medical device to help support or replace breathing) with gastrostomy tube feeding [G-tube feeding, a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems]). The GACH Discharge Medication Orders indicated Resident 76 had a helmet. During a review of Resident 76's Admission Record, the Admission Record indicated the facility admitted Resident 76 on 4/25/2024 with diagnoses including severe hypoxic ischemic encephalopathy (brain injury that occurs when the brain does not receive enough oxygen [hypoxia] and blood flow [ischemia]), cerebral infarction (brain damage due to loss of oxygen to the area) of the right posterior cerebral artery ([PCA] blood vessel that supplies blood and oxygen to a portion of the brain), cerebral edema (swelling of brain tissue due to excessive fluid), and attention to the G-tube. During a review of Resident 76's care plan titled, Activites of Daily Living ([ADL] tasks related to personal care including bathing, dressing, hygiene, eating, and mobility) self-care performance deficit and is at risk for ADL decline, initiated on 4/27/2024, the care plan interventions indicated to assist Resident 76 during transfer using a mechanical lift (a device used to lift and/or transfer a person from one surface to another surface) with two to three persons assist. The care plan interventions included to dress Resident 76 appropriately when in a Geri chair (reclining chair that allows someone to get out of bed and sit comfortably in different positions while fully supported). The interventions, were initiated 11/22/2024, included to apply the helmet when Resident 76 was out of bed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 76's physician orders, dated 11/1/2024, the physician orders indicated Resident 76 may be up in a Geri chair as needed for comfort and postural (position of the body) support as Resident 76 was non-ambulatory (unable to walk) and may use mechanical lift with two to three persons assist during transfer. Another physician order, dated 11/22/2024, indicated to apply Resident 76's protective helmet when up in a Geri chair and during appointments. During a review of Resident 76's Minimum Data Set ([MDS] a resident assessment tool), dated 1/27/2025, the MDS indicated Resident 76 did not have any speech, rarely/never expressed ideas and wants, rarely/never understood verbal content, and was severely impaired for daily decision making. The MDS indicated Resident 76 did not have any ROM limitations in both arms and legs. The MDS indicated Resident 76 was dependent (helper does all of the effort or the assistance of two or more helpers is required for the resident to complete the activity) for oral hygiene, toileting, bathing, dressing, rolling to either side in bed, and chair/bed-to-chair transfers. During an observation on 2/4/2025 at 4:29 p.m., in Resident 76's room, Resident 76 was lying in bed with Family 1 standing on the right side of the bed. During an observation on 2/5/2024 at 8:01 a.m., in Resident 76's room, Resident 76 was lying in bed wearing a hospital gown while Restorative Nursing Aide 1 ([RNA] certified nursing aide program that helps residents to maintain their function and joint mobility) performed passive range of motion ([PROM] movement of joint through the ROM from an external force with no effort from the person) exercises to both arms and legs. During an observation on 2/5/2024 at 3:59 p.m., outside Resident 76's room, Resident 76 was lying in bed. During an observation on 2/6/2025 at 8:49 a.m., in Resident 76's room, Resident 76 was lying in bed while Physical Therapist 2 performed an assessment on both hands and both legs. During an observation on 2/7/2025 at 8:32 a.m., outside Resident 76's room, Resident 76 was lying in bed wearing a hospital gown. During a telephone interview on 2/7/2025 at 12:14 p.m., with Family 1, Family 1 stated the facility was supposed to apply the helmet when Resident 76 got out of bed and for medical appointments. Family 1 stated the facility transferred Resident 76 into a Geri chair once about two months ago. Family 1 stated the desire for Resident 76 to get out of bed daily. During an observation on 2/7/2025 at 12:54 p.m., in Resident 76's room, Resident 76 was awake while lying in bed wearing a hospital gown. During a concurrent interview and record review on 2/7/2025 at 1:11 p.m., with Certified Nursing Assistant 2 (CNA 2), Resident 76's care plans were reviewed. CNA 2 stated Resident 76 required a Hoyer lift for transfers and went to the shower room this morning (date of the interview). CNA 2 stated it would be good for Resident 76 to get out of bed into a Geri chair but the family wanted Resident 76 in bed. CNA 2 stated the family would call the facility to request Resident 76 to transfer into the Geri chair, which was part of Resident 76's care plans. CNA 2 reviewed Resident 76's care plans and stated the care plans did not include for Resident 76 to get out of bed only upon the family's request. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 2/7/2025 at 1:24 p.m., with Family 1, Family 1 stated the family never requested to maintain Resident 76 in bed and to transfer Resident 76 out of bed only when the family requested it. Family 1 stated the facility was called once or twice in the past to request for Resident 76 to transfer out of bed because it was a nice day and stated the family wanted to bring Resident 76 outside. During a concurrent interview and record review on 2/7/2025 at 3:52 p.m., with the Director of Nursing (DON), Resident 76's care plans were reviewed. The DON stated the facility usually got residents (in general) out of bed in the morning, at least three to four times per week. The DON stated Resident 76 laid in bed every day in accordance with Family 1's direction. The DON reviewed Resident 76's care plans and stated there was no care plan indicating Resident 76's family requested for Resident 76 to remain in bed. The DON stated (in general) nobody wanted to be in bed every day. During a review of the facility's policy and procedure (P&P) titled, Activities of Daily Living (ADLs), Supporting, revised 3/2022, the P&P indicated care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including assistance with mobility.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055 Based on observation, interview, and record review, the facility failed to obtain a podiatry (foot doctor) consult after one of three sampled resident (Resident 8) was noted with a thickened toenail of the left hallux (big toe). This deficient practice resulted in a delay of needed foot care services and had the potential to contribute to a negative physical and psychosocial wellbeing of Resident 8. Findings: During a review of Resident 8's Admission record, the admission record indicated Resident 8 was admitted on [DATE] with diagnoses including downs syndrome (a condition that can affect how he brain and body develops causing mental and physical challenges), chronic kidney disease (a long-term condition where the kidneys gradually lose their ability to filter waste products from the blood), attention to gastrostomy, (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) and reduced mobility. During a review of Resident 8's Minimum Data Set (MDS), a resident assessment tool, dated 11/29/2024, the MDS indicated, Resident 8's cognition (thinking) was severely impaired. The MDS indicated Resident 8 was totally dependent on staff with all activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 8's Order Summary Report, active orders as of 5/6/2025, the Order Summary Report indicated podiatry care every 2 months and as needed for mycotic (fungal a type of germ), hypertrophic (increase in the size) nails, corns and calluses (hardened areas of skin that occur on the toes and feet). During an observation and interview on 2/4/2024 at 10:55 a.m., in the activities room, with Restorative Nurse Assistant (RNA) 2, Resident 8's left foot was exposed and was noted to have thickened toenail in the left hallux. RNA 2 stated Resident 8's left toe needed to be looked at by a physician because the toenail looked thick and dirty. During an interview and record review on 2/7/2025 at 8 a.m., with the Infection Prevention Nurse (IPN), Resident 8's Situation, Background Assessment Request (SBAR) and Initial Change of Condition Charting and Skilled Documentation, dated 2/4/2025 at 11:59 a.m. was reviewed and the IPN confirmed Resident 8's left big toe was hardened, thickened, and had a discolored nail bed. During an interview and record review on 2/7/2025 at 8 a.m., with the Infection Prevention Nurse (IPN), Resident 8's medical records were reviewed and the IPN confirmed Resident 8's last podiatry visit was 9/2024. The IPN stated Podiatry visit should have been scheduled to address Resident 8's left hallux. During an interview on 2/7/2025, at 5 p.m., with the Director of Nursing (DON), the DON stated foot care was important, so the residents don't get fungus (germ that causes infection) on their toenails. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure titled, Foot Care, dated 10/2022, the policy indicated, Residents receive appropriate care and treatment to maintain mobility and foot health. Residents were provided with foot care and treatment in accordance with professional standards of practice.

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F 0688 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36943 49573 Based on observation, interview, and record review, the facility failed to provide services to five of 13 sampled residents (Resident 76, 48, 61, 68, and 54) with limited range of motion ([ROM] full movement potential of a joint [where two bones meet]) and mobility (ability to move) by failing to: 1.Provide Occupational Therapy ([OT] profession aimed to increase or maintain a person's capability of participating in everyday life activities [occupations]) services after identifying ROM impairments (unspecified) in both arms and indicating Resident 76 could benefit from skilled services (therapy services performed by licensed therapists and necessary to treat illness and injury) for contracture (a stiffening/shortening at any joint that reduces the joint's range of motion) prevention management during the OT Evaluation, dated 8/7/2024. 2.Provide Physical Therapy ([PT] profession aimed in the restoration, maintenance, and promotion of optimal physical function) services after identifying a ROM decline in both ankles and indicating Resident 76 could benefit from skilled services to address limitations in both ankles during the PT Evaluation, dated 8/7/2024. 3.Provide PT services after identifying further ROM decline in the right knee and both ankles and indicating Resident 76 could benefit from skilled services to address limitations in both ankles during the PT Evaluation, dated 9/9/2024. 4.Perform an accurate quarterly Joint Mobility Screen ([JMS] brief assessment of a resident's range of motion in both arms and both legs) of Resident 76's ROM in both arms and legs on 10/31/2024 and 1/27/2025. 5.Perform a quarterly JMS of Resident 48's ROM in both arms and legs between 11/21/2023 and 5/20/2024. 6.Provide an OT Evaluation after identifying a decline in both of Resident 48's elbows during the quarterly JMS, dated 5/20/2024, and prior to the application of both elbow extension (straightening) splints (material used to restrict, protect, or immobilize a part of the body to support function, assist and/or increase range of motion) for four to six hours (4-6 hours) in accordance with professional standards. 7.Provide an OT Evaluation prior to applying Resident 61's right elbow extension splint (a device that immobilizes a joint in an extended position) for 4-6 hours in accordance with professional standards on 6/20/2024. 8.Identify Resident 61's ROM decline in the left hand and left ankle since JMS on 12/23/2024. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Springs Post-Acute	10625 Leffingwell Road Norwalk, CA 90650

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F 0688 Level of Harm - Actual harm Residents Affected - Few	9.Provide PROM to Resident 68's arms and legs since admission to hospice (specialized care designed to give supportive care to people in the final phase of a terminal illness with a focus on comfort, quality of life rather than cure, and free of pain to live each day as fully as possible) on 1/9/2025. 10.Ensure Resident 54 received RNA services as ordered for the resident. Findings: a. During a review of Resident 76's General Acute Care Hospital (GACH) Documents Review Report, the GACH Documents Review Report indicted Resident 76 was admitted to the GACH on 3/27/2024 and found to have a meningioma (brain tumor). The GACH Documents Review Report indicated Resident 76 underwent surgical removal of the meningioma on 4/2/2024, partial removal of the skull on 4/3/2024, and placement of a tracheostomy tube (hole made through the front of the neck and into the windpipe [trachea] to enable the resident to breath) on 4/13/2024. During a review of Resident 76's GACH Discharge Medication Orders, dated 4/25/2024, the GACH Discharge Medication Orders indicated to discharge Resident 76 to a sub-acute (level of care that does not require hospitalization but requires more intensive skilled nursing care including medical equipment, supplies, and treatments such as ventilators [medical device to help support or replace breathing) with gastrostomy tube feeding [G-tube feeding, a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems]). The GACH Discharge Medication Orders indicated Resident 76 had a helmet and both ankle foot orthosis ([AFO] brace to position the foot and ankle) boots. During a review of Resident 76's Admission Record, the Admission Record indicated the facility admitted Resident 76 on 4/25/2024 with diagnoses including severe hypoxic ischemic encephalopathy (brain injury that occurs when the brain does not receive enough oxygen [hypoxia] and blood flow [ischemia]), cerebral infarction (brain damage due to loss of oxygen to the area) of the right posterior cerebral artery ([PCA] blood vessel that supplies blood and oxygen to a portion of the brain), cerebral edema (swelling of brain tissue due to excessive fluid), and attention to the G-tube. During a review of Resident 76's History and Physical (H&P), dated 4/26/2024, the H&P indicated Resident 76's diagnoses included a meningioma, surgical removal of the meningioma, and cerebral infarct with left sided weakness. The H&P indicated Resident 76 did not have the capacity to understand and make decisions. During a review of Resident 76's JMS, dated 4/26/2024, the JMS indicated Resident 76 had full/functional ROM in all joints of both arms and legs, including both shoulders, elbows, wrists, hands, hips, knees, and ankles. Resident 76's JMS indicated skilled rehabilitation services (therapy given to restore an individual back to their highest possible level of physical, mental, and psychosocial well-being) were not indicated (reason not indicated) and Resident 76 would benefit from the Restorative Nursing Aide ([RNA] certified nursing aide program that helps residents to maintain their function and joint mobility) program. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 76's physician orders, dated 4/26/2024, the physician orders indicated for the RNA to assist Resident 76 with passive range of motion ([PROM] movement of joint through the ROM from an external force with no effort from the person) exercises to both arms and legs, five times per week for three months or as tolerated. During a review of Resident 76's Rehab Progress Notes, dated 5/8/2024 written by the Director of Rehabilitation (DOR), the Rehab Progress Notes indicated Resident 76's family requested both AFOs for Resident 76 (date of family's request not documented). The Rehab Progress Notes indicated the DOR assessed Resident 76's ROM and muscle tone (amount of tension or resistance in muscles) to determine if Resident 76 could benefit from the AFOs. The Rehab Progress Notes indicated Resident 76 had normal tone and did not have any signs of foot drop (difficulty lifting the front part of the foot). The Rehab Progress Notes indicated the DOR did not recommend both AFOs since Resident 76's ankle ROM was within normal limits ([WNL] normal joint movement) and application of both AFOs might affect Resident 76's skin integrity. During a review of Resident 76's SBAR ([Situation, Background, Assessment, and Recommendation] communication tool used by healthcare workers when there is a change of condition among residents) and Initial COC (Change of Condition) Alert Charting and Skilled Documentation, dated 5/20/2024, the SBAR indicated Resident 76's family was at bedside with concerns of redness and discoloration above the resident's right eye. The SBAR indicated Resident 76's physician was contacted, and the physician recommended Resident 76 be transferred to the GACH for further evaluation. During a review of Resident 76's Nurses Notes, dated 5/20/2024, the Nurses Notes indicated Resident 76 was transferred to the GACH in stable condition with helmet placed. The Nurses Notes indicated Resident 76 did not have any signs or symptoms of bleeding, discomfort, or distress. During a review of Resident 76's Census (record of hospitalization s, room changes, and payor source changes), the Census indicated the facility readmitted Resident 76 on 5/25/2024. During a review of Resident 76's JMS, dated 5/29/2024, the JMS indicated Resident 76 had full/functional ROM in all joints in both arms and legs, including both shoulders, elbows, wrists, hands, hips, knees, and ankles. The JMS indicated Resident 76's skilled rehabilitation services were not indicated (reason not indicated) and would benefit from the RNA program. During a review of Resident 76's physician orders, dated 5/29/2024, the physician orders indicated for the RNA to assist Resident 76 with PROM exercises to both arms and legs, five times per week for three months or as tolerated. During a review of Resident 76's Personal Inventory Update, dated 7/10/2024, the Personal Inventory Update included three foam baseballs. During a review of Resident 76's JMS, dated 8/2/2024, the JMS indicated Resident 76 had full/functional ROM in all joints in both arms and legs, including both shoulders, elbows, wrists, hands, hips, knees, and ankles. The JMS indicated Resident 76 had an RNA ROM program. (continued on next page)

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F 0688

Level of Harm - Actual harm

Residents Affected - Few

During a review of Resident 76's OT Evaluation and Plan of Treatment, dated 8/7/2024 (five days after the JMS on 8/2/2024) written by Occupational Therapist 1 (OT 1), the OT Evaluation indicated Resident 76's prior level of function (ability prior to admission to the facility) was independent. The OT Evaluation indicated Resident 76 had impaired ROM (unspecified) in both shoulders, elbows/forearms, wrists, and hands. The OT Evaluation indicated Resident 76 had rigidity (muscle stiffness), hypertonicity (muscle with abnormally increased muscle tone, resulting in stiffness and difficulty moving), and swelling in both arms. The OT Evaluation indicated Resident 76's skin was intact without any observable issues. The OT Evaluation indicated Resident 76 could benefit from continued skilled services for neuromuscular retraining (technique used to restore movement patterns through repetitive motion to retrain the brain), cognitive (relating to the ability to think, understand, learn, and remember) and visual retraining, and contracture prevention management. The OT Evaluation indicated Resident 76 was at risk for further decline in function, immobility, and muscle atrophy (loss of muscle mass) without skilled therapy intervention.

During a review of Resident 76's PT Evaluation and Plan of Treatment, dated 8/7/2024 (five days after the JMS on 8/2/2024) written by Physical Therapist 2 (PT 2), the PT Evaluation indicated Resident 76's prior level of function was independent with all functional mobility and walked without an assistive device. The PT Evaluation indicated Resident 76 was referred to PT for assessment of mobility and function. The PT Evaluation indicated Resident 76's ROM in both hips and knees were within functional limits ([WFL] sufficient movement without significant limitation). The PT Evaluation indicated both of Resident 76's ankles had impaired ROM with the right ankle measuring negative 20 degrees (-20 degrees) of dorsiflexion (bending the ankle toward the body, normal 0 to 20 degrees) and the left ankle measuring -15 degrees of dorsiflexion. The PT Evaluation indicated Resident 76 was alert, non-verbal, had left-sided neglect (condition after a brain injury where a person is not aware of the left side), had left-sided hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), and had left leg hypertonicity. The PT Evaluation indicated Resident 76 had been bed bound since 3/2024, had limitations in both ankles into dorsiflexion, and both ankles exhibited foot drop while lying in bed. The PT Evaluation indicated Resident 76 would benefit from continued skilled PT services to address limitations in ankle dorsiflexion, improve muscle strength, and provide education on positioning and bed mobility. The PT Evaluation indicated Resident 76 was at risk for immobility, further decline in function, pressure injuries, decreased skin integrity, muscle atrophy, and increased muscle tone without skilled therapy intervention.

During a review of Resident 76's Census, the Census indicated Resident 76 moved from the facility's sub-acute area (Nursing Station 2) to Nursing Station 1 on 8/17/2024.

During a review of Resident 76's PT Evaluation and Plan of Treatment, dated 9/9/20204 written by PT 2, the PT Evaluation indicated Resident 76 was referred to PT for assessment of mobility and function. The PT Evaluation indicated Resident 76's ROM in both hips and left knee were WFL. The PT Evaluation indicated Resident 76's right knee and both ankles had impaired ROM with right knee extension measuring -30 degrees of extension (normal 0 degrees), right ankle measuring -30 degrees of dorsiflexion, and left ankle measuring -35 degrees of dorsiflexion. The PT Evaluation indicated Resident 76 had been bed bound since 3/2024, had limitations in the right knee and both ankle joints, and exhibited foot drop with right knee flexion (bent) while lying in bed. The PT Evaluation indicated Resident 76 was at risk for immobility, further decline in function, pressure injuries, decreased skin integrity, muscle atrophy, and increased muscle tone without skilled therapy intervention.

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F 0688 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 76's JMS, dated 10/31/2024 (after ROM limitations were identified on 8/7/2024 and 9/9/2024) and 1/27/2025, the JMS indicated Resident 76 had full/functional ROM in all joints in both arms and legs, including both shoulders, elbows, wrists, hands, hips, knees, and ankles. The JMS indicated Resident 76 had an RNA ROM program. During a review of Resident 76's Minimum Data Set ([MDS] a resident assessment tool), dated 1/27/2025, the MDS indicated Resident 76 did not have any speech, rarely/never expressed ideas and wants, rarely/never understood verbal content, and was severely impaired for daily decision making. The MDS indicated Resident 76 did not have any ROM limitations in both arms and legs. The MDS indicated Resident 76 was dependent (helper does all of the effort or the assistance of two or more helpers is required for the resident to complete the activity) for oral hygiene, toileting, bathing, dressing, rolling to either side in bed, and chair/bed-to-chair transfers. During an interview on 2/4/2025 at 8:53 a.m., with the DOR, the DOR stated the residents (in general) received a JMS upon admission to the facility and on a quarterly basis. The DOR stated the purpose of the JMS was to identify any changes in ROM to prevent ROM limitations and the development of contractures. The DOR described contractures as limitations in motion caused by muscle tone and/or shortening of soft tissues. The DOR stated contractures could be managed with early detection with the use of splints (material used to restrict, protect, or immobilize a part of the body to support function, assist and/or increase range of motion). The DOR stated the purpose of splints included placing the joints in the most optimal position to prevent the development of a contracture or to prevent contractures from worsening if already present. The DOR stated ROM limitations and contractures could affect a resident's skin integrity including the development of wounds, cause fractures due to increased muscle tone, and cause pain. During a concurrent observation and interview on 2/4/2025 at 4:29 p.m., with Resident 76's Family (Family1), in Resident 76's room, Resident 76 was lying in bed, without any splints on both arms and legs. Family 1 stated Resident 76's health insurance did not cover services (unspecified) Resident 76 was supposed to receive. Family 1 stated Resident 76 received ROM exercises; Family 1 stated did not know if the exercises were completed daily. Family 1 stated Resident 76 was admitted to the facility with boots on both feet and the facility staff (unidentified) informed Family 1 that Resident 76 did not need the boots since Resident 76's ankle joints were not locked up. During an observation of Resident 76's RNA session on 2/5/2025 at 8:01 a.m., in Resident 76's room, RNA 1 stood on the right side of the bed to perform ROM exercises to the right shoulder, elbow, forearm, wrist, and hand. RNA 1 performed ROM exercises to the right leg, including hip abduction (moving the leg at the hip joint away from the body), hip flexion (bending the leg at the hip joint toward the body) with the knee extended (straightened), knee flexion, ankle rotation clockwise and counterclockwise, and ankle dorsiflexion. RNA 1 was observed unable to fully bend Resident 76's right knee, which was limited to less than 90 degrees. RNA 1 was observed unable to fully bend Resident 76's right ankle into dorsiflexion and the resident's right ankle remained in plantarflexion. RNA 1 walked to the left side of Resident 76's bed to perform ROM exercises to the left shoulder, elbow, forearm, wrist, and hand. RNA 1 performed ROM exercises on the left leg, including hip abduction, hip flexion with knee flexion, ankle rotation clockwise and counterclockwise, and ankle dorsiflexion. RNA 1 was observed unable to fully bend Resident 76's left ankle into dorsiflexion and the left ankle remained in plantarflexion. RNA 1 placed small pillows underneath both of Resident 76's arms and placed a soft doll inside Resident 76's right hand. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	During an interview on 2/5/2025 at 8:27 a.m., with RNA 1, RNA 1 stated Resident 76 received PROM exercises to both arms and legs. RNA 1 stated Resident 76's right knee required gentler ROM, and the left arm and leg were tighter than the right side. RNA 1 stated Resident 76 did not wear any splints. During a concurrent interview and record review on 2/5/2025 at 3:26 p.m., with the DOR, Resident 76's JMS, dated 4/26/2024, Rehab Notes, dated 5/8/2024, Census, and OT Evaluation, dated 8/7/2024, were reviewed. The DOR stated Resident 76 was admitted to the facility on [DATE], received a JMS on 4/26/2024, and was referred to the RNA program for PROM to both arms and legs. The DOR stated Resident 76 was not a therapy candidate due to Resident 76's inability to follow directions and inability to move without assistance. The DOR reviewed Resident 76's Rehab Notes, dated 5/8/2024, and stated the DOR performed a screen of both legs after Resident 76's family requested AFOs. The DOR stated AFOs were not recommend for Resident 76 since Resident 76 did not have any signs of foot drop. The DOR reviewed Resident 76's Census and stated Resident 76 was discharged to the hospital on 5/20/2024, readmitted to the facility on [DATE], and remained at the facility since readmission. The DOR reviewed the OT Evaluation, dated 8/7/2024, which indicated Resident 76 had unspecified ROM limitations in both arms and would benefit from skilled rehabilitation services. The DOR stated the OT Evaluation was submitted to Resident 76's health insurance and Resident 76 did not receive OT treatment due to the health insurance's denial for services. The DOR stated Resident 76 continued to receive RNA services for PROM exercises. During a concurrent interview and record review on 2/5/2025 at 3:45 p.m., with the DOR, Resident 76's PT Evaluations, dated 8/7/2024 and 9/9/2024, and the JMS, dated 10/31/2024 and 1/27/2025, were reviewed. The DOR stated the PT Evaluation, dated 8/7/2024, indicated Resident 76 had ROM limitations in both ankles which were positioned in plantarflexion. The DOR stated there should have been a recommendation for ankle splints or ROM only depending on Resident 76's skin integrity. The DOR reviewed the PT Evaluation, dated 9/9/2024, and stated Resident 76 had increased tone in the right leg and was positioned in more plantarflexion at both ankles. The DOR stated the PT Evaluation indicated Resident 76 would benefit from further PT services but did not receive services since Resident 76's health insurance denied further services. The DOR stated the JMS on 10/31/2024 and 1/27/2025 (after ROM limitations were already identified) indicated Resident 76 had Full/Functional ROM in all joints of both arms and legs. During a concurrent observation and interview on 2/5/2025 at 3:59 p.m., with the DOR outside Resident 76's bedroom, Resident 76's ankles were visible from the doorway. The DOR stated Resident 76's ankles were positioned in plantarflexion. The DOR stated the facility did not provide any additional PT intervention to prevent Resident 76's plantarflexion after the family's request for AFOs on 5/8/2024 and after identifying the ROM limitation twice during the PT Evaluations, dated 8/7/2024 and 9/9/2024. The DOR stated the facility did not provide additional intervention and did not have any documentation AFO boots were trialed to determine Resident 76's wear tolerance (amount of time a person could wear a splint before experiencing discomfort or skin irritation). The DOR stated Resident 76 developed plantarflexion ROM limitations while in the facility and stated they were preventable. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	During an interview on 2/6/2025 at 8:25 a.m., with PT 2, PT 2 stated the types of splints the PTs usually recommended at the facility included hip abduction wedges (placed in-between legs to prevent legs from rubbing together), knee extension splints, AFOs for walking, and PRAFOs ([Passive Range Ankle Foot Orthoses] device worn on the calf and foot to suspend the heel and hold the ankle in a neutral [90-degree] position). PT 1 stated PRAFOs were recommended (in general) for residents who can potentially have skin integrity issues and develop contractures. PT 1 stated the professional standard to provide a splint to a resident (in general) included performing a ROM assessment, assessing skin integrity and muscle tone, and determining a resident's response to the splint, which included applying the splint initially for 30 minutes after performing skin checks and then gradually applying the splint for more time to determine the resident's splint wearing tolerance. PT 1 stated the purpose of splints included contracture prevention, especially for immobilized patients who have been bed bound and do not have the ability to reposition themselves. During a concurrent observation and interview on 2/6/2025 at 8:49 a.m., with PT 2 in Resident 76's room, PT 2 assessed Resident 76's hands and both legs. Resident 76 was observed lying in bed with both ankles positioned in plantarflexion. PT 2 stood on the right side of Resident 76's bed to move the right leg at the hip, knee, and ankle joints. PT 2 bent Resident 76's right knee and measured the knee ROM using a goniometer (device that measures joint ROM). PT 2 stated Resident 76 had 42 degrees of knee flexion (normal 135 degrees) and had increased muscle tone. PT 2 stated Resident 76 used to have more ROM in the right knee. PT 2 bent Resident 76's right ankle into dorsiflexion which measured 24 degrees of plantarflexion (or -24 degrees of dorsiflexion). PT 2 walked to the left side of Resident 76's bed to move the left leg at the hip, knee, and ankles joints. PT 2 bent Resident 76's left ankle into dorsiflexion which measured 29 degrees of plantarflexion (or -29 degrees of dorsiflexion). PT 2 described both of Resident 76's hands as closed into a fist with some swelling. PT 2 extended Resident 76's left-hand fingers and stated Resident 76's fingernails were digging into the skin of the left palm. Resident 76's left palm was observed with redness and a small scab (dry, rough protective crust that forms over a wound). PT 2 described Resident 76's left-hand scab as a previous wound that was healing. PT 2 stated Resident 76's left hand was resistive to movement as PT 2 attempted to place a rolled towel inside the left hand. PT 2 extended Resident 76's right-hand fingers and stated the middle finger was unable to completely extend at the fingertip joint. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 2/6/2025 at 9:43 a.m., with PT 2, Resident 76's PT Evaluations, dated 8/7/2024 and 9/9/2024, and JMS, dated 1/27/2025, were reviewed. PT 2 reviewed the PT Evaluation, dated 8/7/2024, and stated Resident 76 had ROM impairments in both ankles. PT 2 stated Resident 76 was receiving RNA ROM exercises to prevent worsening ROM of both ankles. PT 2 stated Resident 76 would have benefitted from PT services, including splints since the RNAs were not qualified in determining wear tolerance. PT 2 stated Resident 76 did not receive additional PT because the health insurance did not authorize therapy services. PT 2 reviewed the PT Evaluation, dated 9/9/2024, and stated Resident 76's right knee was unable to fully extend and had full flexion. PT 2 stated feeling surprised today (during the assessment) that Resident 76's right knee extended fully and had limitations in knee flexion. PT 2 stated Resident 76's PT Evaluation, dated 9/9/2024, indicated Resident 76 continued to have ROM limitations in both ankles, including the inability to bend both ankles to neutral (90-degree position) and were positioned in plantarflexion. PT 2 stated Resident 76 did not receive PT services after the PT Evaluation, dated 9/9/2024, because the health insurance did not authorize therapy services. PT 2 stated Resident 76 would have benefited from therapy services to delay further progression of the contractures after both PT Evaluations. PT 2 reviewed Resident 76's JMS, dated 1/27/2025 (10 days prior to interview), and stated Resident 76's ROM has declined. PT 2 stated Resident 76 had ROM limitations in both hands with the left hand worse than the right hand. PT 2 stated Resident 76 was developing a right knee extension contracture due to limitations into knee flexion and had plantarflexion contractures of both ankles. During a review of the Physiatrist (medical doctor who specializes in physical medicine and rehabilitation) Consultation, dated 2/6/2025 written by Medical Doctor 1 (MD 1), the Physiatrist Consultation indicated Resident 76 was at-risk for joint contractures of both hands due to positioning and recommended hand rolls (soft roll positioned in the palm of the hand and fastened with a strap) and to continue the RNA program for ROM to prevent contractures. The Physiatrist Consultation indicated Resident 76 had plantarflexion contractures in both ankles and recommended to use heel protectors to offload pressure and prevent skin breakdown (tissue damage caused by friction [surfaces rubbing against each other], shear [straight produced by pressure], moisture, or pressure) and to continue the RNA program for PROM to both legs to prevent worsening contractures. The Physiatrist Consultation indicated splinting the plantarflexion contractures would not likely provide functional progress since Resident 76 was not likely to ambulate. During an interview on 2/6/2025 at 1:54 p.m., with MD 1, MD 1 stated Resident 76 was assessed today (date of interview) due to the facility's concerns of contractures. MD 1 stated Resident 76's hands were positioned in a flexion and the fingertip joints of the left hand were bent and digging into the palm, causing redness in the palm. MD 1 stated the facility needed to monitor the resident's the hands closely, protect the left palm, and provide ROM exercises. MD 1 stated Resident 76 had plantarflexion contractures in both ankles which could have been prevented with PROM and splinting. During a concurrent interview and record review on 2/6/2025 at 2:52 p.m., with OT 1, Resident 76's OT Evaluation, dated 8/7/2024, was reviewed. OT 1 stated the OT Evaluation indicated Resident 76's ROM in both arms were impaired because of increased muscle tone and stiffness and did not have actual ROM limitations. OT 1 did not know the reason Resident 76 did not receive skilled services at the facility in accordance with OT 1's recommendations. During an interview on 2/7/2025 at 11:07 a.m., with the DOR, the DOR stated Resident 76 did not receive therapy at the facility because they did not receive authorization from Resident 76's health insurance to provide services. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on 2/7/2025 at 12:14 p.m., with Family 1, Family 1 stated Resident 76's hands have been in closed fists since admission to the facility. Family 1 stated he brought balls and dolls to the facility so the staff could place them and open both of Resident 76's hands. Family 1 stated the GACH discharged Resident 76 to the facility with splints that kept both ankles at 90-degree angles but Resident 76 did not wear them. Family 1 stated the facility found the splints but the therapist (unidentified) informed Family 1 that the splints would hinder the ankles more than help. Family 1 stated the facility did not provide therapy services due to Resident 76's health insurance. Family 1 stated feeling frustrated Resident 76 did not receive any therapy services and should have received therapy to work with the muscles early. During an interview on 2/7/2025 at 3:17 p.m., with the Director of Nursing (DON), the DON stated the purpose of therapy services (in general) was to assist residents in regaining strength, to prevent any decline in ROM to prevent contractures, prevent decline in mobility, activities of daily living ([ADLs] tasks related to personal care including bathing, dressing, hygiene, eating, and mobility), and speech. During a concurrent interview and record review on 2/7/2025 at 3:52 p.m., with the DON, Resident 76's PT and OT Evaluations, dated 8/7/2024, and the facility's policies and procedures (P&P) tilted, Rehabilitation Policy and Procedures, revised 12/30/2019, and Resident Mobility and Range of Motion, revised 7/2017, were reviewed. The DON reviewed Resident 76's PT and OT Evaluations, dated 8/7/2024, and stated the facility did not have any documentation therapy services were provided after the evaluations. The DON stated splints could prevent plantarflexion contractures in addition to ROM. The DON stated Resident 76 did not receive any therapy services to determine whether splints were appropriate. The DON reviewed the facility's P&Ps and stated the P&Ps did not indicate health insurance authorization was necessary prior to providing further intervention to prevent ROM loss. The DON stated the purpose of preventing contractures (in general) was to prevent pain, further impairment in mobility, and fractures. During a concurrent interview and record review on 2/7/2025 at 4:57 p.m. with the DON, Resident 76's JMS dated 1/27/2025 and Physiatrist Consult, dated 2/6/2025, were reviewed. The DON stated the JMS, dated 1/27/2025, indicated both of Resident 76's ankles had full/functional ROM and the Physiatrist Consult, dated 2/6/2025 (10 days after the JMS) indicated Resident 76 had plantarflexion contractures of both ankles. The DON stated Resident 76's JMS was inaccurate. The DON stated an inaccurate JMS would not identify ROM loss and would prevent treatment of ROM loss. During a review of the facility's P&P titled, Rehabilitation Policy and Procedures: Evaluation and Plan of Care, revised 12/30/2019, the P&P indicated the evaluating clinician was responsible to complete the written treatment plan. During a review of the facility's P&P titled, Resident Mobility and Range of Motion, revised 7/2017, the P&P indicated residents will not experience an avoidable reduction in ROM and residents with limited ROM will receive treatment and services to increase and/or prevent a further decrease in ROM. The P&P also indicated intervention may include therapies, the provision of necessary equipment, and/or exercises and will be based on professional standards of practice. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	b. During a review of Resident 48's Admission Record, the Admission Record indicated the facility originally admitted Resident 48 on 8/7/2020 and readmitted on [DATE]. The Admission Record indicated Resident 48's diagnoses included respiratory failure (serious condition that develops when the lungs cannot get oxygen into the blood), encephalopathy (disease that affects the brain, causing changes in its function), cerebral infarction (brain damage due to a loss of oxygen to the area), dysphagia (difficulty swallowing), attention to tracheostomy (hole made through the front of the neck an into the windpipe [trachea] to allow air into the lungs), and attention to gastrostomy ([G-tube] surgical opening fitted with a device to allow feedings to be administered directly t [TRUNCATED]

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46537 Based on observation, interview and record review, the facility failed to monitor, assess, document and discontinue a peripheral intravenous (IV) hep lock (is an intravenous catheter that is threaded into a peripheral vein, flushed with saline, and capped off for later use) site when IV therapy was completed for one of three sampled residents (Resident 42). This failure had the potential to result in Resident 42's IV hep lock site to develop an infection. Findings: During a review of Resident 42's Admission Record, the Admission Record indicated, Resident 42 was initially admitted to the facility on [DATE] and last re-admission was on 1/31/2025 with right foot open wound, sepsis (a life-threatening blood infection), and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 42's History and Physical (H&P) , dated 1/12/2025, the H&P indicated, Resident 42 had the capacity (ability) to understand and make decision. During a review of Resident 42's Minimum Data Set (MDS -a resident assessment tool), dated 1/14/2025, the MDS indicated Resident 42 required dependent assistance (Helper does all of the effort) from two or more staff for sit to lying, lying to sitting on side of bed, transfer, maximal assistance (Helper does more than half the effort) from one staff for bed mobility, and dressing. The MDS section O (Special treatments, Procedures, and Programs) indicated, Resident 42 was on IV antibiotics (medications that treat bacterial infections) and had IV access. During a review of Resident 42's Order Summary Report (OSR) , dated 2/5/2025, the OSR indicated, give Ceftriaxone Sodium one gm intravenously one time a day for sepsis for seven days was ordered 1/10/2025. During a review of Resident 42's Order Summary Report (OSR) , dated 2/5/2025, the OSR indicated, give Metronidazole intravenous solution 500 mg three times a day for Pneumonia for seven days was ordered on 1/10/2025. During a review of Resident 42's Care Plan (CP) , revised on 1/12/2025, the CP Focus indicated, Resident 42 was at high risk for infection due to immunocompromised (a weakened immune system) medical status. The CP interventions indicated, Assess all possible portals of entry for changes (IV site, GT site etc). During a concurrent observation and interview on 2/4/2025, at 11:15 a.m., with Resident 42 in Resident 42's room, there was the IV hep lock wrapped loosely with kerlix gauze (a woven gauze made in several different forms for a variety of different wound care applications) on Resident 42's right upper arm noted. Resident 42 stated, he did not know why IV hep lock was still there because he did receive IV antibiotics since last month. Resident 42 stated, it bothered him when he tried to move around his right arm. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 2/6/2025, at 3:13 p.m., with Licensed Vocational Nurse (LVN) 2, Resident 42's Medication Administration Record (MAR) , dated from 1/2025 to 2/4/2025. The MAR indicated; there was no IV solution medication was given after 1/15/2025 LVN 2 stated, IV hep lock should have discontinued when IV medications were completed to prevent possible infection. During a concurrent interview and record review on 2/6/2025, at 3:35 p.m., with Registered Nurse Supervisor (RNS) 2, Resident 42's Nurses Note (NN) , dated from 1/11/2025 to 2/4/2025 , Nurses Note indicated there was no documentation regarding IV site care and contacting physician regarding IV hep lock discontinuation. RNS 2 stated, staff should have discussed with physician regarding discontinuing IV hep lock on 1/15/2025 when IV medication was switched to oral pill. RNS 2 stated, he believed that Resident 42 had IV heplock on right hand on 1/15/2025, but he did not know what happened to that IV heplock because there was no documentation. During an interview on 2/7/2025, at 4:57 p.m. with Director of Nursing (DON), DON stated, IV hep lock should be removed as soon as IV therapy was done. DON stated, staff should have documented for IV site care, IV site assessment, and discontinuation of IV heplock, because it could be portal of entry for infection. During a review of the facility's Policy and Procedure (P&P) titled, Peripheral Catheter Needle Removal , dated 7/2023, the P&P indicated, Policy: 1. A physician's order is not required to remove a peripheral catheter/needle. 2. Peripheral catheters are discontinued every 72-96 hours and rotated to another site if therapy continues .4. Peripheral catheters/needles are removed at the completion of therapy . Documentation: Document date and time of procedure, reason for removal, length and condition of catheter, site assessment, patient response to procedure and/or medication.

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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** 44055 Based on observation, interview, and record review the facility failed to ensure one of three sampled ventilator (a medical device to help support or replace breathing) dependent resident (Resident 40)'s Heat and Moisture Exchanger (HME - way to provide humidification to adult tracheostomy [a surgical procedure that creates an opening in the trachea or windpipe to provide an airway when the natural airway is blocked or compromised]residents) portion of the ventilator circuit (tubing that connects the ventilator to the resident) was changed as scheduled. The failure had the potential to result in harboring of microorganisms (germs) in the respiratory equipment which can cause infection. Findings: During a review of Resident 40's Admission Record, the Admission Record indicated Resident 40 was readmitted to the facility on [DATE] with diagnoses including anoxic brain damage (a condition where the brain is deprived of oxygen for a prolonged period, leading to cell death and damage), dependence on ventilator, attention to tracheostomy, hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (a condition characterized by weakness or paralysis on one side of the body) following cerebrovascular accident (CVA-stroke, loss of blood flow to a part of the brain). During a review of Resident 40's Minimum Data set (MDS), A resident assessment tool, dated 1/2/2025, the MDS indicated Resident 40's cognitive skills (functions your brain uses to think, pay attention, process information, and remember things) for daily decision-making were severely impaired. The MDS indicated Resident 40 was totally dependent on staff with all Activities of Daily Living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 40's untitled care plan, initiated on 12/8/2024, the care plan focus indicated Resident 40 had a potential for infection related to break in skin at tracheostomy site. The care plan goal indicated Resident 40 will be clear of infection at stoma site (surgical opening in the trachea) daily for 3 months. One of the care plan interventions indicated to change all disposable respiratory equipment every seven days and as needed. During an observation and interview on 2/4/2025 at 10:47 a.m., in Resident 40's room, with Licensed Vocational Nurse (LVN) 1, Resident 40's respiratory equipment HME was dated 1/17/25, LVN 1 stated that equipment was dated when changed. During an interview on 2/5/2025 at 9:52 a.m., with Respiratory therapist (RT)1. RT 1 stated the HME portion of the ventilator circuit should be changed twice a day, once a shift so it's clean because it gets clogged with secretions. During an interview on 2/7/2025 at 5 p.m., with the Director of Nursing (DON), the DON stated disposable respiratory equipment should be changed as scheduled. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Changing Disposable Equipment, undated, the P&P indicated to minimize infections disposable respiratory equipment will be changed regularly as scheduled and labeled with a date. HMEs are changed daily.

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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. 45777 Based on observation, interview, and record review, the facility failed to ensure food containers that are opened were labeled with an open date and use by date. This deficient practice had the potential to result in pathogen (germ) exposure to residents and placed residents at risk for developing foodborne illness (food poisoning) with symptoms including upset stomach, stomach cramps, nausea, vomiting, diarrhea and fever and can lead to other serious medical complications and hospitalization . Findings: During an observation on initial tour of the kitchen on 2/4/2025 at 08:18 a.m., with the Dietary Aide 1 (DA 1), there were several items in refrigerator that had no preparation dates or use by date. Those items found in the refrigerator were 8 wrapped turkey sandwiches, 1 large jar of pickle relish, 2 prepared fruit cups and 2 prepared salads. During a concurrent interview and observation on 2/4/2024 at 12:47 p.m. with Dietary Aide 1 (DA 1), DA 1 observed the sandwiches, fruit cup jar of pickles and salad had no prepared dates on them . DA1 stated staff are responsible for dating the foods that are prepared with a use by date . DA 1 stated if we are not dating the prepared foods you will never know when to throw it out or if a resident get the undated food they can get sick . During an interview on 2/6/2025 at 08:30 a.m., with [NAME] 1, [NAME] 1 stated when preparing food like sandwiches a plastic wrap is place around the sandwich date and put a used by date on the item. [NAME] 1stated we can only use the food up until the third day and you must throw it out the resident can get sick with bacteria if used after 3 days. During an interview on 2/6/2025 at 09:01 a.m. with the Dietary Supervisor (DS), the DS stated when preparing food for the residents there must be a date when the food is prepared to make sure we do not serve bad food to the residents. During a review of the facility's undated policy titled Labeling and Dating of Foods, indicates all prepared foods to be need covered labeled and dated. Items can be dated individually or in bulk stored on a tray with masking tape if going to be used for meal service (i.e salads, drinks and other miscellaneous items for tray line.)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident.

36943

Based on observation, interview, and record review, the facility failed to provide Speech Therapy (SLP, profession aimed in the prevention, assessment, and treatment of speech, language, communicative, and swallowing disorders) services to one of 13 sampled residents (Resident 76) with limited range of motion ([ROM] full movement potential of a joint [where two bones meet]) and mobility (ability to move) by failing to:

1. Provide SLP services to Resident 76 in accordance with the SLP Evaluation recommendations, dated 8/6/2024.

2. Provide a SLP Evaluation in accordance with Resident 76's physician orders, dated 1/23/2025.

These failures had the potential to prevent Resident 76 from improving speech, cognition, and the ability to eat by mouth.

Findings:

During a review of Resident 76's General Acute Care Hospital (GACH) Documents Review Report, the GACH Documents Review Report indicted Resident 76 was admitted to the GACH on 3/27/2024 and found to have a meningioma (brain tumor). The GACH Documents Review Report indicated Resident 76 underwent surgical removal of the meningioma on 4/2/2024, partial removal of the skull on 4/3/2024, and placement of a tracheostomy tube (hole made through the front of the neck and into the windpipe [trachea]) on 4/13/2024.

During a review of Resident 76's General Acute Care Hospital (GACH) Discharge Medication Orders, dated 4/25/2024, the GACH Discharge Orders included to discharge Resident 76 to a sub-acute (level of care that does not require hospitalization but requires more intensive skilled nursing care including medical equipment, supplies, and treatments such as ventilators [medical device to help support or replace breathing) with gastrostomy tube feeding [G-tube feeding, a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems]). The GACH Discharge Medication Orders indicated Resident 76 had a helmet.

During a review of Resident 76's Admission Record, the Admission Record indicated the facility admitted Resident 76 on 4/25/2024 with diagnoses including severe hypoxic ischemic encephalopathy (brain injury that occurs when the brain does not receive enough oxygen [hypoxia] and blood flow [ischemia]), cerebral infarction (brain damage due to loss of oxygen to the area) of the right posterior cerebral artery ([PCA] blood vessel that supplies blood and oxygen to a portion of the brain), cerebral edema (swelling of brain tissue due to excessive fluid), and attention to the G-tube.

During a review of Resident 76's Rehab Progress Notes, dated 5/7/2024, 5/27/2024, 7/9/2024, and 8/2/2024, the Rehab Progress Notes indicated SLP screened Resident 76 and indicated for Resident 76 to have nothing by mouth [NPO].

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 76's SLP Evaluation and Plan of Treatment, dated 8/6/2024, the SLP Evaluation indicated Resident 76 had little to no attempts to participate. The SLP Evaluation indicated Resident 76 would benefit from intensive acute rehabilitation (free standing hospital or rehabilitation unit within a hospital that provides intensive rehabilitation in which patient must tolerate three hours of therapy services per day) to stimulate pharyngeal (throat muscle in the middle of the neck) abilities and assess for the safest level of oral intake to enhance Resident 76's quality of life. The SLP Evaluation indicated recommendations for Resident 76 to be NPO. During a review of Resident 76's Rehab Progress Notes, dated 8/30/2024, the Rehab Progress Notes indicated Resident 76 continued to demonstrated poor potential for intake by mouth. During a review of Resident 76's Minimum Data Set ([MDS] a resident assessment tool), dated 1/27/2025, the MDS indicated Resident 76 did not have any speech, rarely/never expressed ideas and wants, rarely/never understood verbal content, and was severely impaired for daily decision making. The MDS indicated Resident 76 did not have any ROM limitations in both arms and legs. The MDS indicated Resident 76 was dependent (helper does all of the effort or the assistance of two or more helpers is required for the resident to complete the activity) for oral hygiene, toileting, bathing, dressing, rolling to either side in bed, and chair/bed-to-chair transfers. During a review of Resident 76's physician orders, dated 1/23/2025, the physician orders indicated for Speech Therapy evaluation and treatment as indicated for possible oral intake. During an interview on 2/4/2025 at 8:53 a.m. with the Director of Rehabilitation (DOR), the DOR stated the SLP's purpose included to provide intervention for the muscles of the throat involved in swallowing and speaking. During an observation on 2/5/2025 at 8:01 a.m. in Resident 76's room, Resident 76 was lying in bed with the head-of-bed elevated while the G-tube feeding was running at 55 milliliters (unit of measurement) per hour. Resident 76 was awake, non-verbal, and blinked to answer yes and no questions. During a concurrent interview and record review with the DOR on 2/5/2025 at 3:52 p.m., Resident 76's SLP Evaluation, dated 8/6/2024, was reviewed. The DOR stated the SLP Evaluation indicated Resident 76 to continue to be NPO. During a concurrent interview and record review on 2/7/2025 at 11:07 a.m., with the DOR, Resident 76's SLP Evaluation, dated 8/6/2024, SLP Rehab Progress Notes, and physician orders for SLP Evaluation, dated 1/23/2025, were reviewed. The DOR stated Resident 76 was not provided with further therapy services in accordance with the SLP Evaluation recommendations, dated 8/6/2024, because Resident 76's insurance authorization did not approve therapy services. The DOR stated the SLP was supposed to complete the SLP Evaluation within three days of the physician's order, dated 1/23/2025. The DOR reviewed the Resident 76's Rehab Progress Notes and stated the SLP did not complete the documentation in response to the physician's order, dated 1/23/2025. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 2/7/2025 at 3:52 p.m. with the Director of Nursing (DON), Resident 76's SLP Evaluation, dated 8/6/2024, and the facility policy and procedure (P&P) titled, Rehabilitation Policy and Procedures, revised 12/30/2019, were reviewed. The DON stated the facility did not have any documentation therapy services were provided to Resident 76 after the SLP Evaluation. The DON reviewed the facility's Rehabilitation Policy and Procedures and stated the P&P did not indicate health insurance authorization was necessary prior to providing further intervention. During a review of the facility's P&P titled, Rehabilitation Policy and Procedures: Evaluation & Plan of Care, revised 12/30/2019, the P&P indicated the evaluation process should be initiated within 72 hours of the date of the physician's order.

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F 0826 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide specialized rehabilitative services by qualified personnel, when ordered for a resident by a doctor. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36943 Based on observation, interview, and record review, the facility failed to ensure one of two Physical Therapists (PT 1) had a current and active license to provide Physical Therapy ([PT] profession aimed in the restoration, maintenance, and promotion of optimal physical function) treatment at the facility. This deficient practice resulted in PT 1 providing intervention to Resident 90 and had the potential for PT 1 to provide intervention to other residents requiring PT treatment with an invalid PT license. Findings: During a review of Resident 90's Admission Record, the Admission Record indicated the facility admitted Resident 90 on [DATE] with diagnoses including displaced fracture (break in bone) of the medial condyle (middle upper bone bump) of the left tibia (larger of the two bones located in the leg between the knee and ankle), right foot drop (a condition that makes it difficult to lift the front of the right foot), difficulty in walking, and muscle weakness. During a review of Resident 90's Minimum Data Set ([MDS] a resident assessment tool), dated [DATE], the MDS indicated Resident 90 had clear speech, had the ability to express ideas and wants, had the ability to understand verbal content, and had moderately impaired cognition (ability to think, understand, learn, and remember). The MDS also indicated Resident 90 had range of motion ([ROM] full movement potential of a joint [where two bones meet]) impairments in both legs and was dependent (helper does all of the effort or the assistance of two or more helpers is required for the resident to complete the activity) for rolling to either side in bed, moving from lying in bed to sitting on the side of the bed, transferring from sitting to standing, and transferring to and from the bed to a wheelchair. The MDS indicated Resident 90 began receiving PT services on [DATE]. During a review of PT 2's Daily Activity Schedule, dated [DATE], the Daily Activity Schedule indicated eight residents, including Resident 90, would receive treatment from PT 2. During an observation on [DATE] at 8:53 a.m., in the rehabilitation room, PT 2 was observed providing therapy to Resident 90, who was seated in a wheelchair while Resident 90's right leg slid forward and backward on a slanted board. During a review of PT 2's Physical Therapy Board of California (PTBC) licensing details provided by the Director of Rehabilitation (DOR), dated [DATE] timed at 9:50 a.m., PT 2's PTBC license status was current and inactive. PT 2's PTBC license's expiration date was on [DATE]. During a review of PT 2's PTBC licensing details, dated [DATE] timed at 11:09 a.m., PT 2's inactive license status indicated no practice was permitted. (continued on next page)

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F 0826 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on [DATE] at 1:57 p.m., with the PTBC, the PTBC stated PT 2's license was current and had an inactive status. The PTBC reviewed PT 2's renewal application (date unspecified) and stated PT 2 clicked the option to change PT 2's license to inactive. The PTBC stated PT 2 could have selected this option in error but should not be practicing since PT 2's license was inactive. During a concurrent interview and record review on [DATE] at 2:12 p.m., with the DOR, PT 2's PTBC license was reviewed. The DOR stated a therapists' license (in general) was renewed every two years and expired at the end of the therapist's birthday month. The DOR stated therapists (in general) needed a license to ensure the therapist maintained the standards of practice and completed continuing education to stay updated to provide care. The DOR reviewed PT 2's PTBC license, which indicated the license was inactive. The DOR stated not knowing PT 2's PTBC license was inactive. The DOR stated it was the DOR and the therapist's responsibility to ensure the therapist had an active license. During an interview on [DATE] at 2:20 p.m. with PT 2, PT 2 did not know there was an option to place PT 2's PTBC license in an inactive status and did not know PT 2's PTBC's license was inactive.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46537 Based on interview and record review, the facility failed to identify unresolved quality deficiencies, some of which had been cited on previous surveys, and ensure actions were developed and implemented to attempt to correct the deficiencies through the quality assessment and assurance (QAA) process as evidenced by the severity and number of deficiencies cited involving assessment, monitoring, and documentation of physical restraints(any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body), and accurate resident assessment with documentation. This failure had potential to result in the residents residing in the facility not receiving services and care they need. Findings: During a review of Resident 86's Admission Record, the Admission Record indicated, Resident 86 was admitted to the facility on [DATE] with traumatic subarachnoid hemorrhage (bleeding in the space below one of the thin layers that cover and protect your brain), hemiplegia of right side (total paralysis of the arm, leg, and trunk on the same side of the body), and generalized muscle weakness. During a review of Resident 86'sHistory and Physical (H&P), dated 1/3/2025, the H&P indicated, Resident 86 had no capacity (ability) to understand and make decision. During a review of Resident 86's Minimum Data Set (MDS - a resident assessment tool), dated 11/20/2025, the MDS indicated Resident 86 required dependent assistance (helper does all of the effort) from two or more staff for dressing, hygiene, bed mobility, and transfer. The MDS indicated, Resident 86 had impairment (A loss of part or all of a physical or mental ability) on both upper extremity (shoulder, elbow, wrist, hand) and lower extremity (hip, knee, ankle, foot) for one side. During a concurrent interview and record review on 2/6/2025, at 3:02 p.m., with Licensed Vocational Nurse (LVN) 3, Resident 86's Medication Administration Records (MAR), dated from 10/1/2024 to 2/4/2025. The MAR indicated, there was no documentation regarding the left hand-mitten physical restraints assessment and monitoring. LVN 3 stated, she could not find the documentation regarding the left-hand mitten monitoring and assessment. LVN 3 stated, staff did not transcribe the physician order to MAR, and no one followed up. LVN 3 stated, the restraints should be removed for 15 minutes every two hours, assess skin integrity, and document on MAR. LVN 3 stated, it was important to assess and monitor restraints every two hour to prevent injury. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 2/7/2025, at 9:40 a.m., with Minimum Data Set Coordinator (MDSC), the facility's Resident Matrix (a system that is used to identify pertinent care categories), revised 2/7/2025. The Matrix indicated, there was no resident with physical restraints on 2/4/2025, and it was revised by MDSC on 2/7/2025. The Resident Matrix indicated, there are six residents with restraints on. MDSC stated, the facility was the restraint free facility per Director of Nursing (DON), and she did not realize the hand mittens (type of physical restraint used to prevent patients from removing tubes and lines that are used for treatment) was considered as physical restraints. MDSC stated, that was why she did not code the hand mittens as physical restraints in MDS and revised the resident matrix. During a concurrent interview and record review on 2/7/2025, with Administrator (ADM), the facility's and Quality Assurance Performance Improvement ([QAPI] takes a systemic, interdisciplinary, comprehensive, and data driven approach to maintaining and improving safety and quality in nursing homes while involving residents and families, and all nursing home caregivers in practical and creative problem solving) binder for 2024 and 1/2025. The QAPI binder indicated, there was no documentation regarding physical restraints and accurate resident assessment with documentation. ADM stated, he realized those issues were identified in previous survey and QAPI committee meeting did not implement effective plan to resolve them. ADM stated, these were more like clinical issues, and he believed they were discussed in different meeting, but he did not have documentations to prove. During an interview on 2/7/2025, at 4:57 p.m., with DON, DON stated, restraints should be monitored as frequent as ordered and documented to prevent injury. DON stated, all orders should be transcribed to the MAR and carried out, assessment and monitoring order for the mitten was not carried out correctly and there was no place to document. DON stated, inaccurate assessment could prevent resident from getting proper care. DON stated, these issues were identified during last survey, but it has not been corrected through QAA/QAPI committee meeting. During a review of the facility's Policy and Procedure (P&P), titled, Quality Assurance and Performance Improvement (QAPI) Program, revised 2/2020, the P&P indicated, establish systems through which to monitor and evaluate corrective actions . The QAPI plan describes the process for identifying and correcting quality deficiencies. Key components of this process include a. tracking and measuring performance; b. establishing goals and thresholds for performance measurement; c. identifying and prioritizing quality deficiencies, systematically analyzing underlying causes of systemic quality deficiencies; e. developing and implementing corrective action or performance improvement activities; and monitoring or evaluating the effectiveness of corrective action/ performance improvement activities and revising as needed .Disclosure of Information 2. The QAPI plan is presented to the state survey agency annually during tJ1e recertification survey, and as requested during any other survey or by CMS.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49573 Based on, interview, and record review, the facility failed to ensure one of five sampled residents (Resident 29) was offered the pneumococcal vaccine (a vaccination that protects against pneumococcal bacteria, which can cause serious infections such as pneumonia, meningitis, and sepsis) upon admission to the facility. This deficient practice had the potential to increase the risk of Resident 29 acquiring, transmitting, or experiencing complications from the pneumococcal disease. Findings: During a review of Resident 29's Admission Record, the Admission Record indicated Resident 54 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including chronic respiratory failure with hypoxia (a condition in which the lungs are unable to adequately exchange oxygen and carbon dioxide over a prolonged period), , traumatic brain injury (TBI-a disruption in the normal function of the brain that can be caused by a bump, blow, or jolt to the head), and seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness) During a review of Resident 29's history and physical (H/P) dated 1/14/25, the H/P indicated Resident 29 did not have the capacity to understand and make decisions. During a review of Resident 29's Minimum Data Set ([MDS], a resident assessment tool) dated 1/20/25, the MDS indicated Resident 29 was rarely/never understood and was dependent (helper does all of the effort, resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity) with self-care abilities such as oral hygiene, toileting hygiene, shower/bathe, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene. During an interview and record review on 2/6/25 at 3:35 p.m. with Infection Prevention Nurse (IPN)of the pneumococcal consent form. IPN stated the pneumococcal vaccine was not offered to the Resident 29 and/or their responsible party when Resident 29 was first admitted to the facility and when readmitted back to the facility. IPN stated the importance of Resident 29 being offered the pneumococcal vaccine was for the prevention of the resident catching the pneumococcal disease especially since Resident 29 had a tracheostomy and receiving oxygen through the tracheostomy. During an interview on 2/7/25 at 4:40 p.m. with Director of Nursing (DON), DON stated the facility offers vaccines to the residents such as the influenza ([flu], a common, sometimes deadly viral infection of the nose, throat and lungs), respiratory syncytial virus ([RSV], a common respiratory virus that primarily infects the lungs and airways), pneumococcal, and covid-19 (an infectious disease caused by the SARS-CoV-2 virus causing mild to moderate respiratory illness). DON stated the vaccines are offered on the day of admission or the following day. DON stated the importance of residents being offered the pneumococcal vaccine was to prevent residents from getting the pneumococcal disease, especially the elderly and vulnerable residents such as Resident 29 who had a tracheostomy and receiving oxygen through the tracheostomy. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P/P) titled, pneumococcal vaccine, revised March 2022, indicated, prior to or upon admission, residents are assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, are offered the vaccine series within thirty (30) days of admission to the facility unless medically contraindicated or the resident has already been vaccinated . assessments of pneumococcal vaccination status are conducted within five (5) working days of the resident's admission if not conducted prior to admission .administration of the pneumococcal vaccines are made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 44055 Based on interview and record review, the facility failed to provide documented evidence of all employees screening, education, offering, and current Corona virus disease, COVID-19 (contagious infectious disease), vaccination (medications used to prevent diseases usually given by injection or by mouth) status. This failure had the potential to place staff and residents at risk for serious outcomes such as being hospitalized due to COVID-19. Findings: During an interview and record review on 2/6/2025 at 11:15 a.m., with the Infection Prevention Nurse (IPN), the facility's employee records of COVID-19 status 2024 to 2025 and the physicians, and consultants COVID-19 immunization status were unknown. The IPN stated she did not know she had to get the physicians and consultants Covid-19 immunization status. During an interview on 2/7/2025 at 5 p.m. with the Director of Nursing (DON), the DON stated all staff include board members, licensed practitioners, lab, and hospice (a type of care that focuses on improving the quality of life for people who are terminally ill and nearing the end of their life) personnel. During a review of the facility's policy and procedure (P&P) titled, Coronavirus disease. (COVID -19) -Vaccination of staff, revised 10/20/2022, the P&P indicated all staff will be vaccinated against COVID-19. Staff means individual who provide any care, treatment, or other services for the facility and or its residents, regardless of clinical responsibility or residence contact, including facility employees, Licensed practitioners, students, trainees and volunteers and individuals under contract or other arrangement, for example, hospice, therapy personnel, mental health professionals and social workers, and portable X-ray suppliers.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49573 Based on observation, interview, and record review: a) The facility failed to ensure one of one resident (Resident 80) had a call light the resident could use. b) The facility failed to ensure one of three sampled residents (Resident 30) had a working call light. This deficient practice resulted in a delay of care and services. Findings: a) During a review of Resident 80's Admission Record, the Admission Record indicated Resident 80 was originally admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (brain problem), seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), and Resident 80 had a gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems)tube. During a review of Resident 80's Minimum data Set (MDS- a resident assessment tool), dated 11/20/2024, the MDS indicated Resident 80 had severe cognitive impairment and was dependent (helper does all the effort) with all activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 80's Order Summary report active orders as of 2/7/2025, the report indicated may apply hand mitten (accessory used to restrain the persons grip) to the right hand. During a review of Resident 80's care plan (untitled), initiated on 11/25/2024, the care plan indicated Resident 80 has Self-care deficit with ADLs. The care plan intervention indicated the call light will be within reach. During a concurrent observation and interview on 2/4/2025 at 8:59 a.m., with the Infection prevention nurse (IPN) at Resident 80's room, Resident 80 was observed with a push button call light on the resident's chest just below the right shoulder. Resident 80 had a mitten on the right hand and was unable to move the left hand. The IPN stated Resident 80 had a call light but was unable to use it because the resident had a mitten and could not move the left hand. The IPN stated Resident 80 would benefit with an adaptive call light (a device that allows physically challenged and special needs to call for assistance). (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b) During a review of Resident 30's Admission Record, the Admission Record indicated Resident 30 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including chronic obstructive pulmonary disease ([COPD]-a chronic lung disease causing difficulty in breathing), chronic respiratory failure with hypoxia (a condition in which the lungs are unable to adequately exchange oxygen and carbon dioxide over a prolonged period), tracheostomy (a surgical procedure that creates an opening in the trachea (windpipe) to provide an airway when the natural airway is blocked or compromised), and diabetes mellitus ([DM]-a disorder characterized by difficulty in blood sugar control and poor wound healing) During a review of Resident 30's history and physical (H/P) dated 2/3/25, the H/P indicated Resident 30 had the capacity to understand and make decisions. During a review of Resident 30's MDS dated [DATE], the MDS indicated Resident 30 had intact cognitive (thinking process) skills and required setup or clean assistance (helper sets up or cleans up, resident completes activity but helper assist only prior to or following the activity) with self-care abilities such as eating, and oral hygiene, and required moderate assistance (helper does less than half the effort, helper lifts, holds or supports trunk or limbs but provides less than half the effort) for toileting hygiene, shower/bathe, upper body dressing, and was dependent (helper does all the effort, resident does none of the effort to complete the activity) on lower body dressing, putting on/taking off footwear, and personal hygiene. The MDS also indicated Resident 30 required moderate assistance with mobility abilities such as rolling left and right, required maximal assistance (helper does more than half the effort) with sit to lying position, and lying to sitting position, chair/bed to chair transfers, toilet transfers, tub/shower transfers and dependent for sit to stand position. During a review of Resident 30's comprehensive care plan, initiated on 2/20/2024, the care plan indicated Resident 30 was at risk for injury or accident due to preferences of lying towards the edge of the bed secondary to resident's preference to lie towards the edge of bed. The care plan intervention indicated to keep the call light in reach at all times. During a concurrent observation and interview on 2/4/25 at 11:16 a.m. with Resident 30 in his room, Resident 30 was sitting in his bed watching TV. Resident 30 signaled for help and when he pushed the call light, the call light did not turn on nor did the light in the room or outside the door light up. Resident 30 had a tracheostomy and was not able to vocalize what he wanted but can move his lips to mouth his words. Resident 30 mouthed that he was pushing the call light for almost an hour, and no one came to see him. During an interview on 2/7/25 at 9:19 a.m. with Registered Nurse Supervisor (RNS) 1, RNS 1 stated residents like Resident 30 cannot verbalize their wants and needs so the residents would need a working call light to be able get help. RNS 1 stated if the call lights are not working, the residents would be waiting for a while before any staff can come check on them and it might be a medical emergency if staff does not come right away to assess residents. During an interview on 2/7/25 at 11:37 a.m. with Maintenance Supervisor (MS), MS stated the call light for Resident 30 was not working and he had to replace the call light. MS stated the importance of having a working call light in the room for residents was so the residents can communicate and get assistance when needed and if the call light was not working, staff won't know if the residents need help. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/7/2025 at 5 p.m., with the Director of Nursing (DON), the DON stated all residents must have a working call light to be able to verbalize the residents' needs. DON stated if there was an emergency, residents needed a working call light to be able to ask for help. During a review of the facility's policy and procedure (P&P) titled, Assistive Devices and Equipment, revised 1/2020, the P&P indicated certain devices and equipment that assist resident safety and independence are provided. During a review of the facility's P/P titled, Answering the Call Light, revised 9/2022, the P&P indicated call lights will be answered in a timely manner. The P&P indicated the resident call system will be answered immediately. During a review of the facility's (P&P) titled, Call system, Resident, 9/2022, the P&P indicated residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized workstation. The call system remains functional at all times. If the resident has a disability preventing him/her from using the call system, an alternative means of communication that is usable for the resident shall be provided and documented in the care plan.