STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055344	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Claremont Heights Post Acute	590 S. Indian Hill Blvd. Claremont, CA 91711

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49252 Based on observation, interview, and record review, the facility failed to ensure staff promoted dignity while assisting three of three sampled residents (Residents 55, 19 and 52) during meals when the facility fed Residents 55, 19 and 52 and did not maintain eye level with the residents. This deficient practice had the potential to affect Resident 55's, 19's and 52's self-worth and dignity. Findings: a. During a review of Resident 55's Admission Record (AR), the AR indicated Resident 55 was admitted to the facility on [DATE] with diagnoses that included polyneuropathy (peripheral [relating to the edge of the body] nerve damage that causes problems with sensation, coordination, or other body functions), dementia (a progressive state of decline in mental abilities), chronic obstructive pulmonary disease (COPD-a long standing lung disease causing difficulty in breathing), and dysphagia (difficulty swallowing). During a review of Resident 55's History and Physical (H&P), dated 4/5/2024, the H&P indicated Resident 55 had dementia, was only alert to herself, and did not have the capacity to understand and make decisions. During a review of Resident 55's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 12/13/2024, the MDS indicated Resident 55 had severely impaired cognition (ability to think and make decisions) and needed partial/moderate assistance (helper does less than half the effort. Helper lifts holds, or supports the trunk or limbs, but provides less than half the effort) for eating. During a review of Resident 55's Order Summary Report, dated 1/10/2025, the report indicated Resident 55 had a diet order started on 11/19/2024 for a fortified diet with pureed texture, regular/thin consistency and was to receive a standard portion. During a review of Resident 55's Dietary Profile, dated 12/3/2024, the Dietary Profile indicated Resident 55 required total assistance while eating. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 1/6/2025 at 12:45 PM in the dining room, Licensed Vocational Nurse 1 (LVN 1), was seated on a chair, LVN 1's face was about one foot higher than Resident 55's face. LVN 1 bent over to provide feeding assistance to Resident 55 during lunch time. During an interview on 1/6/2025 at 12:56 PM with LVN 1, LVN 1 stated she fed Resident 55 lunch. LVN 1 further stated, residents (in general) should be fed at eye-level to observe how the resident tolerated the feeding. During an interview on 1/10/2025 at 12:55 PM with Registered Nurse 1 (RN 1), RN 1 stated when feeding residents, nursing staff should sit at eye-level, facing them (the residents) to make eye contact and give proper cues. RN 1 stated standing or being above a resident during feeding assistance was a dignity issue. During a review of the facility's policy and procedure (P&P) titled, Resident Rights - Accommodation of Needs, last revised 1/1/2012, the P&P indicated, the facility's environment is designed to assist the resident in achieving independent functioning maintaining the resident's dignity and well-being with facility staff assisting residents in achieving these goals. The P&P indicated, facility staff interacted with residents in a way that accommodated the physical or sensory limitations of the residents, promoted communication, and maintained each resident's dignity. 38108 b. During a review of Resident 19's AR, the AR indicated Resident 19 was admitted to the facility on [DATE] with diagnosis that included contracture (deformity and rigidity of the muscle), dementia (a decline in mental ability severe enough to interfere with daily life), and dysphagia (difficulty swallowing). During a review of Resident 19's MDS, dated [DATE], the MDS indicated Resident 19 had unclear speech (slurred or mumbled words) and had the ability to sometimes understand others (responds to simple commands) and sometimes be understood. The MDS indicated Resident 19 needed maximal assistance (helper does more than half the work) with eating (ability to use utensils to bring food/liquids to mouth and swallow food), showering/bathing, and upper body dressing. During a review of Resident 19's Care Plan (CP) for decreased ability to perform self care related to impaired activity tolerance revised on 1/7/2025, the CP's goal indicated Resident 19 would have improved ability to self-feed by the next review. The CP's interventions indicated Resident 19 to demonstrate varying participation in self-feeding due to fluctuating cognitive (ability to understand and process information) impairment. During a dining observation and a concurrent interview with LVN 1, on 1/6/25 at 12:57 pm, in the facility's main dining room, Resident 19 was observed sitting on a wheelchair being feed by LVN 1. LVN 1 was observed sitting on an elevated chair looking down on Resident 52, above eye level. LVN 1 stated staff should be at eye level while feeding a resident. LVN 1 stated I am not really at eye level with Resident 19 to respect the resident's dignity. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. During a review of Resident 52's AR, the AR indicated Resident 52 was admitted to the facility on [DATE] with diagnosis that included Parkinson's disease (uncontrolled movement of the muscles), dementia (a decline in mental ability severe enough to interfere with daily life), and dysphagia (difficulty swallowing). During a review of Resident 52's H&P, dated 4/26/2026, the H&P indicated Resident 52 could make needs known but could not make medical decisions. During a review of Resident 52's MDS, dated [DATE], the MDS indicated Resident 52 had clear speech and had the ability to sometimes understand others (responds to simple commands) and sometimes be understood. The MDS indicated Resident 52's cognition was severely impaired, and the resident needed maximal assistance with eating, dressing, and rolling from left to right. During a dining observation and a concurrent interview with CNA 1, on 1/6/25 at 12:55 pm, in the facility's main dining room, Resident 52 was sitting on a wheelchair being feed by CNA 1. CNA 1 was sitting on an elevated counter [NAME] stool and sat next to Resident 52. CNA 1 stated while feeding residents, staff was supposed to remain at eye level with the residents. CNA 1 stated I am a little higher than eye level. CNA 1 stated it was important to sit at resident eye level so CNA 1 could see (Resident 52) chew. A review of the facility ' s P&P, titled Resident Rights - Accommodation of Needs, revised on 1/1/2012, the P&P indicated to ensure the facility provides an environment and services that meets resident's individual needs. The facility's environment is designed to assist the resident in achieving independent functioning and maintaining the resident's dignity ad well-being. The facility staff will assist residents in achieving these goals. In order to accommodate resident's individual needs and preferences, facility staff attitude and behavior are directed towards assisting the resident's in maintaining independence, dignity and well-being to the extent possible according to resident wishes. During a review of the facility's P&P titled, Resident Rights - Quality of Life, revised on 3/2017, the P&P indicated demeaning practices and standards of care that compromise dignity is prohibited. The P&P indicated facility staff promotes dignity and assist residents as needed .

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38108 Based on interview and record review, the facility failed to ensure one of two sampled discharged residents (Resident 83's), physician was informed of Resident 83 leaving the facility Against Medical Advice (AMA, when a resident chooses to leave the hospital before their doctor recommends discharge) as indicated by the facilits's policy and procedure (P&P) titled, Discharge Against Medical Advice. This deficient practice had the potential for Resident 83 not to be adequately prepared for a smooth transition back home. Findings: During a review of Resident 83's Admission record (AR), the AR indicated Resident 83 was admitted to the facility on [DATE] with diagnosis that included hypertension (elevated blood pressure), difficulty walking, and lack of coordination. During a review of Resident 83's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 10/26/2024, indicated the resident was cognitive intact and needed supervision (helper provides cueing minimal assistance) for oral hygiene, upper body dressing and from st to laying position. During a review of Resident 83's physician ' s order, dated 10/19/2024, the order indicated Resident 83 was to be admitted to the facility. During an interview and concurrent record review of Resident 83's paper and electronic medical record, with Registered Nurse 1 (RN 1), on 1/10/2025 at 9:28 AM, RN 1 stated Resident 83 left the faciity on [DATE] AMA. RN 1 stated there were no orders indicating discharge for Resident 83 from the facility. RN 1 stated Resident 83's physician should have been informed of Resident 83 leaving the facility AMA to ensure any recommendations, post care, or medication adjustments Resident 83 may have needed after leaving the facility were done. During a review of the facility's P&P titled, Discharge Against Medical Advice dated 12/1/2014, indicated to respect the right of a resident/responsible party to make informed decision that are against medical advice and to inform them of the potential risk and consequences of their actions. A Licensed Nurse will notify the attending physician, on call physician, or medical director of the resident/responsible party's desire to leave the facility AMA. The Licensed Nurse will document in the progress notes all pertinent information concerning the resident's actions, including the resident/responsible party's stated reasons for his/her desire to leave the facility.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50016 Based on observation, interview, and record review, the facility failed to ensure one of two sampled residents (Resident 67) was provided with a comfortable and homelike environment during lunch in the dining room area, when, On 1/6/2025, Resident 72, repeatedly, regurgitated and spit into a trashcan located inside the dining room area without staff intervention. Due to this action, Resident 67, who witnessed the incident, felt uncomfortable, nauseated, and lost her appetite. This deficient practice had the potential to result in a decline in Resident 67's physical and psychosocial well-being and the potential for no communal dining participation by Resident 67. Findings: During a review of Resident 67's Admission Record (AR), the AR indicated the facility admitted Resident 67 on 3/7/2023, with diagnosis including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), hemiparesis (weakness on one side of your body), and anxiety disorder. During a review of Resident 67's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 12/20/2024, the MDS indicated Resident 67's cognition (the ability to think and process information) was severely impaired. The MDS indicated Resident 67 required substantial/maximal assistance (helper does more than half the effort) with activities of daily living (ADL, term used in healthcare that refers to self-care activities) and required partial/moderate assistance (helper does less than half the effort) with mobility. During a review of Resident 72's AR, the AR indicated the facility admitted Resident 72 on 3/7/2024, and readmitted the resident on 9/13/2024, with diagnosis including syncope (fainting) and collapse, esophageal obstruction (esophagus, when the tube that carries food from your throat to your stomach, is blocked, preventing food from passing through normally), and gastro-esophageal reflux disease (GERD- a digestive condition that occurs when stomach acid leaks into the esophagus). During a review of Resident 72's MDS, dated [DATE], the MDS indicated Resident 72's cognition was severely impaired. The MDS indicated Resident 67 required partial/moderate assistance (helper does less than half the effort) with ADL's and required partial/moderate assistance with mobility. During an observation on 1/6/2025 at 12:37 PM, Resident 72 was observed regurgitating and spitting into a trash can located inside the dining room. Certified Nursing Assistant (CNA) 1 asked Resident 72 are you okay and Resident 72 nodded his head and walked back to his table and continued eating. During an observation on 1/6/2025 at 12:45 PM and at 12:54 PM, Resident 72 was observed regurgitating and spitting into the trash can located inside the dining room area. Dining room staff did not approach Resident 72. Resident 72 walked back to his table and continued eating. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/6/2025 at 12:59 PM, Resident 72 stated that his acid reflux flared up when Resident 72 ate too fast. Resident 72 stated that he was okay and felt fine. During an interview on 1/6/2024 at 1:15 PM, Resident 67 stated that she felt uncomfortable witnessing the Resident 72 spitting his food into the trash can. Resident 67 stated she felt uncomfortable, [this action] made Resident 67 gag, queasy, and nauseated to the point Resident 67 lost her appetite. Resident 67 stated this wasn't the first time Resident 72 regurgitated and spit into the dining room trash can. During an interview on 1/10/2024 at 8:45 AM, with Certified Nursing Assistant (CNA) 1, CNA 1 stated when CNA 1 observed Resident 72 spitting in the trashcan located in the dining area during lunch, it could have affected the other residents in a negative way. CNA 1 stated [Resident 72's action] could have made the other residents feel uncomfortable and made them feel sick. CNA 1 stated that it could have led to residents losing their appetite or become reluctant to continue participating in communal meals. CNA 1 stated communal meals in the dining area should reflect a homelike experience for the residents, meant to feel welcoming and pleasant. CNA 1 stated CNA 1 asked Resident 72 if Resident 72 was okay and the resident nodded his head to indicate yes. CNA 1 stated Resident 72 should have been provided immediate assistance to maintain his privacy. During an interview on 1/10/2024 at 9:01 AM, with Registered Nurse (RN) 1, RN 1 stated RN 1 has observed Resident 72 spitting and hurling Resident 72 ' s food and liquid contents during mealtimes in the dining area. RN 1 stated witnessing or being near someone in that condition, especially in the dining area could cause discomfort, anxiety, or distress to other residents. RN 1 stated such occurrences might discourage other residents from gathering in the dining room for meals, isolating them, and impacting their quality of life. RN 1 stated dining spaces were often designed to promote a sense of normalcy, comfort, and social interaction, and such incidents could disrupt that homelike environment. RN 1 stated respect and compassion were key to handling such situations, prioritizing both the resident's dignity and the comfort of others in the facility. During a review of the facility's P&P titled, Resident Rooms and Environment, date revised 1/1/2012, the P&P indicated that the facility provides residents with a safe, clean, comfortable, and homelike environment. Facility staff will provide residents with a pleasant environment and person-centered care that emphasizes the resident ' comfort, independence, and personal needs and preferences. To this end, the facility encourages residents to use their personal belongings to the extent possible.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42307 Based on observation, interview and record review, the facility failed to ensure one of two sampled residents (Resident 185) had a baseline care plan (CP, provides direction on the type of nursing care an individual needs that include goals of treatment, specific nursing interventions [actions, treatments, procedures, or activities designed to meet an objective] and an evaluation plan]) as indicated in the facility's policy and procedure (P&P) titled, Comprehensive Person-Centered Care Planning. This failure resulted in Resident 185, who was readmitted with a gastrostomy tube (GT, a tube inserted through the belly to bring nutrition and/or medications directly to the stomach) and on oxygen (02, a colorless, odorless, tasteless gas essential for living) did not have a baseline CP, and had the potential for Resident 185 to not receive the right level of care due to the lack of communication among staff on how to manage Resident 185's care for GT and O2 administration which could compromise Resident 185's health and safety. Findings: During a review of Resident 185's Admission Record (AR), the AR indicated, Resident 185 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including chronic respiratory failure (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide [C02, a colorless, odorless gas that is a waste product made by the body) with hypoxia (low levels of 02 in the body), encounter for attention to gastrostomy and dependence for supplemental oxygen. During a review of Resident 185's Minimum Data Set (MDS, a resident assessment tool), dated 11/22/24, the MDS indicated, Resident 185's cognitive skills (ability to think and process information) for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated, Resident 185 did not have a feeding tube and not on 02 therapy. During a review of Resident 185's History and Physical (H&P), dated 1/2/25, the H&P indicated, Resident 185 did not have the capacity to understand and make decisions. During a review of Resident 185's Order Summary Report (OSR), active orders as of 1/6/25, the OSR indicated, Enteral Feed (nutrition taken through the mouth or through a tube that goes directly to the stomach or small intestine) Order every shift Elevate HOB 30-45 degrees during feedings and oxygen at 2-4 L/min (liters per minute) via NC (nasal cannula, a small flexible tube that delivers extra 02 into your nose) to keep 02 sat (oxygen saturation [Sp02], a measurement of how much oxygen your blood is carrying) at/above 92% Hypoxia, ordered on 12/31/24. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an concurrent interview and record review on 1/10/25 at 8:08 a.m. with the Registered Nurse Supervisor (RN), Resident 185's care plans were reviewed. The RN stated, Resident 185 was readmitted on [DATE] with a GT and on 02, that's new. The RN stated, there was no specific care plan to address Resident 185's GT and O2. The RN stated, nursing created the care plan upon admission and a care plan should have been created to address Resident 185's GT and O2 upon admission so there was a plan specific for Resident 185 and the goals and interventions of the care plan so Resident 185 would be free from complications. During a review of the facility's P&P titled, Comprehensive Person-Centered Care Planning, revised November 2018, the P&P indicated, the baseline care plan would be developed and implemented, using the necessary combination of problem specific care plans, within 48 hours of the resident's admission.

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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** 49252 Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan (a form where licensed nurses can summarize a person's health conditions, specific care needs, and current treatments), for one of one sampled resident (Resident 43), that addressed Resident 43's impaired vision. This deficient practice had the potential to result in unmet individualized needs for Resident 43 and the potential to affect the resident ' s physical and psychosocial well-being. Findings: During a review of Resident 43's Admission Record, the Admission Record indicated Resident 43 was admitted to the facility on [DATE] with diagnoses that included amputation (body part surgically removed due to disease or injury), End Stage Renal Disease (ESRD -irreversible kidney failure) and Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) with diabetic neuropathy (nerve damage caused by diabetes). During a review of Resident 43's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 12/4/2024, the MDS indicated Resident 43 had intact cognition (ability to think and make decisions) and normally used a wheelchair. During a review of Resident 43's History & Physical (H&P), dated 12/16/2024, the H&P indicated the resident had nystagmus (a vision condition in which the eyes make repetitive, uncontrolled movements), wore eyeglasses, and had the capacity to understand and make decisions. During a review of Resident 43's Order Summary Report, dated 1/10/2025, the Order Summary Report indicated Resident 43 had orders for an eye health and vision consult, with follow-up treatment as indicated, ordered on 12/16/2024 and a re-scheduled eye appointment on 1/23/2025 at 1:30 pm, ordered on 1/6/2025. During a concurrent observation and interview on 1/6/2025 at 10:53 AM with Resident 43 in the resident's room, Resident 43 was observed wearing eyeglasses. Resident 43 stated, he had blurred vision in his right eye and had last received an eye injection treatment in December 2024. During a review of Resident 43's Eye Consultation Record, dated 10/3/2024, the consult indicated Resident 43 had: worsening eye health, a family history of glaucoma (a group of eye conditions that can cause blindness or vision loss), diabetic retinopathy (when diabetes damages the blood vessels and nerve tissue in the eye causing vision problems including blindness), cataracts (clouding of the eye's lens that can cause blurry or distorted vision) in the left eye, was legally blind, and had a recent injection on the right eye. The consult indicated Resident 43 may require surgery for the right eye. During a review of Resident 43's Care Plans, there was no documented evidence that indicated Resident 43's visual impairment was care planned. (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 1/10/2025 at 11:06 AM with Licensed Vocational Nurse 2 (LVN 2), Resident 43's current Care Plans were reviewed, the Care Plans indicated there were no care plan in place that addressed Resident 43's impaired vision. LVN 2 stated, Resident 43 received injections on the right eye every six months and Resident 43 recently had an eye consultation rescheduled. LVN 2 stated, care plans provided interventions that helped the residents and allowed for updates to the plan of care. LVN 2 further stated Resident 43 needed a care plan for impaired vision, to allow them (nursing staff) to monitor Resident 43's care and any changes in the resident's condition. During an interview on 1/10/2025 at 12:46 pm with Registered Nurse 1 (RN 1), RN 1 stated a care plan should have been implemented for Resident 43's impaired vision. Care planning would allow them to create goals and interventions to maintain the function of his vision, improve his vision and activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). RN 1 further stated, without a care plan Resident 43's vision and ADLs could decline because no plan and interventions were in place. During a review of the facility's policy and procedure (P&P) titled, Comprehensive Person-Centered Care Planning, last revised 11/2018, the P&P indicated, it was the policy of the facility to provide person-centered, comprehensive and interdisciplinary care that reflects best practice standards for meeting health, safety, psychosocial, behavioral, and environmental needs of residents in order to obtain or maintain the highest physical, mental, and psychosocial well-being. The P&P indicated, additional changes or updates to the resident's comprehensive care plan will be made based on the assessed needs of the resident and it will be reviewed and revied during the onset of new problems, change of condition, and other times as appropriate or necessary.

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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. 50016 Based on observation, interview, and record review, the facility failed to ensure one of two sampled residents (Resident 285) was provided care and services to maintain good grooming and personal hygiene. This deficient practice resulted in no fingernail care to Resident 285 and had the potential to negatively impact Resident 285. Findings: During a review of Resident 285's Admission Record (AR), the AR indicated the facility admitted Resident 285 on 8/21/2024, and readmitted the resident on 1/2/2025 with diagnosis including, rhabdomyolysis (the breakdown of muscle tissue that leads to the release of muscle fiber contents into the blood), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) with foot ulcer (an open sore on your foot that won't heal properly), and pneumonia (an infection/inflammation in the lungs). During a review of Resident 285's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 8/28/2024, the MDS indicated Resident 285 was dependent (helper does all the effort) with activities of daily living (ADL, term used in healthcare that refers to self-care activities) and was dependent with mobility. During a review of Resident 285's History and Physical (H&P), dated 1/2/2025, the H&P indicated Resident 285 did not have the capacity to understand and make decisions. During an observation on 1/6/2025 at 10:16 AM, Resident 285 had black residue on the undersides and distal edge (the free end of the nail) of her fingernails on both hands. During an interview on 1/6/2025 at 3:10 PM, with the Infection Preventionist Nurse (IPN), at Resident 285's bedside, the IPN stated Resident 285 had soiled fingernails and Resident 285 should have been kept well-groomed. The IPN stated maintaining proper nail hygiene was a fundamental part of personal care and infection control. The IPN stated dirty nails could harbor bacteria (small single celled living microscopic living organism), fungi (microorganism such as yeast, molds, and mushrooms), and other pathogens (organisms that cause disease), increasing the risk of infection. During an interview and concurrent record review on 1/10/2025 at 2:58 PM, Resident 285's Order Summary Report, dated 1/7/2024 was reviewed, Registered Nurse (RN) 1 stated Resident 285 had orders for podiatry services and the referral should have been made as the orders indicated. RN 1 stated dirty nails could harbor bacteria, viruses, and fungi that can lead to infections. RN 1 stated Resident 285 had diabetes and the disease could impair the body's ability to fight infections. RN 1 stated if an infection occurred, it could have led to a slower healing process increasing the risk for the infection to spread. RN 1 stated dirty nails could create an entry point for infections. RN 1 stated staff should immediately refer a diabetic patient with dirty or unkempt nails to a podiatrist to void complications. (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 the facility's P&P titled, Grooming Care of the Fingernails and Toenails, dated 10/21/2021, the P&P indicated: -Nail care is given to clean the nail bed and keep the nails trimmed. -Fingernails are trimmed by Certified Nursing Assistants (CNAs), except for Residents with diabetes or circulatory impairments, this includes all toenails except for high-risk Residents. Note: A licensed nurse will trim those Residents' nails. -High risk Residents and Residents with hypertonic, myotic and keratotic toenails are referred to a podiatrist.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49252 Based on observation, interview and record review, the facility failed to ensure the low air loss mattress (LAL, a mattress designed to distribute body weight and prevent and treat pressure wounds) was set correctly for one of three sampled residents (Resident 76) who was at risk for developing pressure ulcer/injury (PI - localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence). This failure had the potential to result in the development of a PI to Resident 76. Findings: During a review of Resident 76's Admission Record (AR), the AR indicated Resident 76 was readmitted on [DATE] with diagnoses that included dysphagia (difficulty swallowing), muscle weakness, and quadriplegia (paralysis from the neck down, including legs and arms, usually due to a spinal cord injury). During a review of Resident 76's Minimum Data Set (MDS - a federally mandated resident assessment tool) assessment, dated 12/5/2024, the MDS indicated Resident 76's ability to make decisions regarding tasks of daily life were severely impaired (never/rarely made decisions). The MDS indicated Resident 76 needed substantial/maximal assistance (helper does more than half the effort and lifts or holds the resident's trunk or limbs) to roll left and right and move from a sitting to a lying position in bed or vice versa. The MDS further indicated, Resident 76 was at risk for developing pressure ulcers/injuries and needed a pressure reducing device for Resident 76's bed as a skin and ulcer/injury treatment. During a review of Resident 76's Order Summary Report (OSR), dated 1/10/2025, the OSR indicated Resident 76 had an order placed for a LAL mattress for wound management on 8/24/2024. During a review of Resident 76's Care Plan (CP), initiated 9/17/2024, the CP indicated Resident 76 had the potential for pressure ulcer development related to being diabetic, receiving a diuretic and tube feedings, being incontinent, and having impaired mobility and cognition. The CP's interventions indicated a LAL mattress for wound management and to follow facility policies/protocols for the prevention/treatment of skin breakdown. During a review of Resident 76's Weights and Vitals Summary, the summary indicated Resident 76 last weighed 137 pounds on 1/5/2025. During a concurrent observation and interview on 1/6/2025 at 9:48 AM with the Director of Staff Development (DSD) in Resident 76's room, Resident 76 was laying on the LAL mattress. The LAL mattress' static/alternating control (button that sets the air mattress either in static mode or alternating mode) showed static lit up and the pressure-adjust knob (soft/firm knob that uses weight to set a pressure level) was set at 350 pounds (lbs., unit of weight). The DSD confirmed these were Resident 76 ' s LAL mattress settings. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 1/6/2025 at 9:51 AM with Treatment Nurse 1 (TN 1) in Resident 76's room, TN 1 verified Resident 76's mattress settings and stated, treatment nurses were responsible for LAL settings. TN 1 stated, Resident 76's LAL mattress' static control should not have been on because the bed remained still, and the mattress' air cells failed to alternate. TN 1 further stated, 350 lbs. was too firm for Resident 76 and TN 1 adjusted the pressure-adjust knob to 100 lbs. TN 1 stated, Resident 76 needed the LAL mattress [for wound management] because Resident 76 had a pressure injury history, and those settings prevented [PIs]. During an interview on 1/10/2025 at 12:57 PM with Registered Nurse 1 (RN 1), RN 1 stated Resident 76 had a history of a cerebrovascular accident (CVA-stroke, loss of blood flow to a part of the brain) and was unable to reposition herself. RN 1 stated, Resident 76's LAL mattress was important to prevent a PI and when settings were incorrect and the mattress was too firm, it could cause Resident 76 to develop a PI rather than prevent it. During a review of the facility's LAL mattress manual Drive: Med-Aire 8 Alternating Pressure Mattress Replacement System with Low Air Loss, copy righted 2012, the manual indicated the mattress was a support surface suitable for medium and high-risk pressure ulcer treatment which was specifically designed for prevention of PI and offered 24-hour pressure area care. The manual indicated, in static mode the mattress provided a firm surface and the pressure level could be adjusted to the desired firmness according to the patient's weight and comfort. During a review of the facility's policy and procedure (P&P) titled, Pressure Injury Prevention, revised 6/27/2024, the P&P indicated CP interventions should be implemented such as pressure redistributing devices for the bed and chair. During a review of the facility's P&P, titled, Mattresses revised 1/1/2012, the P&P indicated the facility provided mattresses capable of meeting resident needs by providing pressure reduction and stimulation to residents at risk for skin breakdown, relieving areas of pressure by distributing body weight, promoting comfort to the bedridden resident, helping prevent pressure injuries and other complications of immobility, and reducing pressure and evenly distributing body weight over a larger area of body surface. The P&P indicated, alternating air mattresses were routinely checked to ensure it was properly working and were used to relieve pressure as indicated by the resident's physical condition.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42307 Based on observation, interview and record review, the facility failed to ensure one of four sampled residents (Resident 185) who was receiving enteral feeding (nutrition taken through the mouth or through a tube that goes directly to the stomach or small intestine) through a gastrostomy tube (GT, a tube inserted through the belly to bring nutrition and/or medications directly to the stomach) received appropriate care and services as indicated in the physician order. This failure had the potential to result in Resident 185 to aspirate (when something like a fluid or solid enters your airway or lungs by accident) that could lead to serious health problems and complications such as pneumonia (infection in the lungs). Findings: During a review of Resident 185's Admission Record (AR), the AR indicated, Resident 185 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including chronic respiratory failure (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide [C02, a colorless, odorless gas that is a waste product made by the body) with hypoxia (low levels of 02 in the body), encounter for attention to gastrostomy and pneumonitis (swelling, irritation and inflammation of your lung tissues) due to inhalation of food and vomit. During a review of Resident 185's Minimum Data Set (MDS, a resident assessment tool), dated 11/22/24, the MDS indicated, Resident 185's cognitive skills (ability to think and process information) for daily decision making was severely impaired (never/rarely made decisions). During a review of Resident 185's History and Physical (H&P), dated 1/2/25, the H&P indicated, Resident 185 did not have the capacity to understand and make decisions. During a review of Resident 185's Order Summary Report (OSR), active orders as of 1/6/25, the OSR indicated, Enteral Feed Order every shift Elevate HOB (head of bed) 30-45 degrees during feedings, ordered on 12/31/24. During a concurrent observation and interview on 1/6/25 at 9:50 a.m. with Licensed Vocational Nurse (LVN) 4, Resident 185 was positioned almost flat in bed while Resident 185's tube feeding was infusing. LVN 4 stated, Resident 185's HOB should be higher at least 30 degrees to prevent aspiration. During an interview on 1/10/25 at 8:08 a.m. with the Registered Nurse Supervisor (RN), the RN stated, one of the interventions for residents on tube feeding was to elevate the HOB for aspiration precautions.

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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** 42307 Based on observation, interview and record review, the facility failed to ensure one of three sampled residents (Resident 185) received proper respiratory (relating to breathing) care such as oxygen (02, a colorless, odorless, tasteless gas essential for living) therapy to meet Resident 185's needs consistent with professional standard of practice and in accordance with the physician's order. This failure had the potential to cause Resident 185's respiratory status (the movement of air in and out of the lungs and exchange of carbon dioxide [a colorless, odorless gas] and 02 at the alveolar level [alveoli, the functional units of the lung with the overall task to warrant gas exchange, i.e., 02 supply and carbon dioxide removal from the body]) to be compromised that could potentially lead to hypoxia (a medical condition that occurs when there is a lack of oxygen in the body's tissues). Findings: During a review of Resident 185's Admission Record (AR), the AR indicated, Resident 185 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including chronic respiratory failure (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide [C02, a colorless, odorless gas that is a waste product made by the body) with hypoxia (low levels of 02 in the body), encounter for attention to gastrostomy (GT, a tube inserted through the belly to bring nutrition and/or medications directly to the stomach) and dependence for supplemental oxygen. During a review of Resident 185's Minimum Data Set (MDS, a resident assessment tool), dated 11/22/24, the MDS indicated, Resident 185's cognitive skills (ability to think and process information) for daily decision making was severely impaired (never/rarely made decisions). During a review of Resident 185's History and Physical (H&P), dated 1/2/25, the H&P indicated, Resident 185 did not have the capacity to understand and make decisions. During a review of Resident 185's Order Summary Report (OSR), active orders as of 1/6/25, the OSR indicated, to administer oxygen at 2-4 L/min (liters per minute) via NC (nasal cannula, a small flexible tube that delivers extra 02 into your nose) to keep 02 sat (oxygen saturation [Sp02], a measurement of how much oxygen your blood is carrying) at/above 92% Hypoxia ((low levels of 02 in the body), ordered on 12/31/24. During a concurrent observation and interview on 1/6/25 at 9:50 a.m. with Licensed Vocational Nurse (LVN) 4, Resident 185 was positioned almost flat in bed with Resident 185's NC on the left side of Resident 185's head. The NC tubing was hooked up to the 02 tank (02 reservoir) set at 2L/min. LVN 4 stated, Resident 185 was on 2L/min 02, and the NC should be on Resident 185 (nostrils) to keep 02 sat above 94% and to prevent Resident 185 from getting short of breath and hypoxia. LVN 4 stated, we don't want that. During a review of the facility's policy and procedure (P&P) titled, Oxygen Therapy, date revised on November 2017, the P&P indicated for staff to administer oxygen per physician orders. (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 Lesson Plan (LP), titled, Oxygen, dated 11/27/24, the LP indicated, oxygen therapy equipment should be administered properly; nasal cannula should be placed correctly in residents' nostrils. Licensed nurses should monitor the tubing and 02 therapy frequently.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38108 Based on interview and record review, the facility failed to communicate the pharmacy recommendations for one of five sampled residents (Resident 68). When, for Resident 68, the facility did not follow pharmacy recommendations to obtain laboratory test (labs) for Complete Metabolic Panel (CMP, a blood test that measures the levels of various substances in blood), Complete Blood Count (CBC, a blood test that measures the number and types of cells in your blood), Lipid Panel (a blood test that measures the amount of lipids, or fats, in your blood), A1C (a blood test that measures the average level of blood sugar in your body over the past three months) and Thyroid-stimulating hormone (TSH, indicate whether your thyroid is producing the right amount of thyroid hormones) for Resident 68. This deficient practice had the potential to result in unnecessary medication administration due to inconsistent lab values and result in a physical decline to Resident 68. Findings: During a review of Resident 68's Admission Record (AR), the AR indicated Resident 68 was admitted to the facility on [DATE] with diagnoses that included depression (feelings of sadness and/or a loss of interest in activities once enjoyed), atrial fibrillation (fast irregular heartbeats), and diabetes (elevated blood sugar). During a review of Resident 68's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 9/27/2024, the MDS indicated Resident 68 ' s cognition (ability to understand and process information) was moderately impaired, and Resident 68 needed maximal assistance (helper does more than half the effort) with toilet hygiene, shower/bath and lower body dressing. During a review of the facility's Consultant Pharmacist's Medication Regimen Review, created between 12/1/2024 and 12/23/2024, the review indicated a blood draw (LABS, procedure in which a needle is used to take blood from a vein, usually for laboratory testing) order request, recommended by the facility's pharmacist, dated on 12/21/2024 to obtain labs for CMP, CBC, LIPID panel, A1c, and TSH levels for Resident 68. During an interview and concurrent record review of Resident 68's paper and electronic chart, with Registered Nurse 1 (RN 1), on 1/10/2025 at 2:48 PM. RN 1 stated Resident 68 did not have physician orders for labs recommended by the pharmacist. RN 1 stated pharmacist recommendations should be followed to prevent medication interactions, provide correct monitoring, and ensure the resident's medication was effective and safe. (continued on next page)

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F 0756 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, Consultant Pharmacist Reports; Medication Regimen Review, dated 5/2022, the P&P indicated the consultant pharmacist performs a comprehensive review of each resident' medication regimen and clinical record at least monthly. The Medication Regimen Review (MRR) includes evaluating the resident's response to medication therapy to determine the resident maintains the highest practicable level of functioning and preventing or minimizing adverse consequences related to medication therapy. The MRR also involves a thorough review of the resident records and may include collaboration with other members of the interdisciplinary team, collaboration with the resident's family members or representatives. The MRR also involves reporting of findings with recommendations for improvement. All findings and recommendation are reported to the director of nursing and the attending physician, the medical director, and the administrator. Recommendations are acted upon and documented by the facility staff and/of the prescriber.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50016 Based on observation, interview, and record review, the facility failed to ensure, two of five sampled residents (Resident 54 and 286) were free of unnecessary drugs by failing to: 1A, 1B. Indicate specific targeted behaviors for the administration of antipsychotic medications (main class of drugs used to treat people that have mental disorders like schizophrenia [mental disorder characterized by loss of contact with the environment]) for Resident 54 and 286. 2. Ensure Resident 54's physician order for Lorazepam (medication used to treat anxiety disorders) indicated the duration for the use of the medication. This deficient practice had the potential to result in overuse of antipsychotic medications, without monitoring for effectiveness and/or ineffectiveness of the medications and could have led to adverse drug events (injuries resulting from medication use including physical and mental harm, or loss of function) for Residents 54 and 286. Findings: 1A. During a review of Resident 54's Admission Record (AR), the AR indicated the facility admitted Resident 54 on 10/2/2024, with diagnoses including metabolic encephalopathy (a change in how the brain works due to an underlying condition), adult failure to thrive, cognitive (the ability to think and process information) communication deficit. During a review of Resident 54's History and Physical (H&P), dated 10/2/2024, indicated Resident 54 did not have the capacity to understand and make decisions. During a review of Resident 54's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 11/20/2024, the MDS indicated Resident 54 was dependent (helper does all the effort) with activities of daily living (ADL, term used in healthcare that refers to self-care activities) and required partial/moderate assistance (helper does less than half the effort) with mobility. During a review of Resident 54 ' s Order Summary Report (OSR), active orders as of 1/7/2025, the OSR indicated Resident 54 had an active order of Lorazepam oral tablet 0.5 milligrams (mg-metric unit of measurement) give 1 tablet sublingually (under the tongue) every 6 hours as needed for anxiety/agitation with a start date of 11/13/2024. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and a concurrent record review on 1/7/2025 at 1:51 PM, Resident 54's OSR, dated 1/7/2025 was reviewed with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 54's Lorazepam order did not include a target behavior or indicated a manifestation behavior to justify the administration of the medication. LVN 1 stated antipsychotic medication orders should have a manifestation of a behavior or a target behavior to ensure the medication was used appropriately, safely, and in compliance with best practices. LVN 1 stated staff should always clarify a psychotropic medication order with the physician when the manifestation of a behavior was not indicated in the physician order. LVN 1 stated a manifestation with a specific behavior ensured the medication was tailored to the resident ' s needs and targeted an appropriate behavior or symptom. LVN 1 stated without the physician ' s clarification, staff may administer the medication inappropriately, risking harm or unnecessary sedation. LVN 1 stated an example of a target behavior for anxiety could be pacing and a target behavior for agitation could be yelling. During an interview on 1/10/2025 at 2:31 PM, with Registered Nurse (RN) 1, RN 1 stated psychotropic medication orders were incomplete without a target behavior. RN 1 stated lorazepam is a benzodiazepine (category of medication, slow down activity in the brain and nervous system) commonly prescribed for anxiety, agitation, or as a sedative, and its use should be targeted and symptom-driven to ensure both effectiveness and safety. RN 1 stated without further clarification from the physician, it may not adequately justify the use of the antipsychotic medication. RN 1 stated orders for antipsychotic medications must be clarified and modified to a include specific behaviors to indicate what agitation looked like, such as: yelling or screaming. 1B. During a review of Resident 286's AR, the AR indicated the facility admitted Resident 286 on 12/23/2024, with diagnoses including traumatic hemorrhage (bleeding) of cerebrum (largest part of brain), chronic kidney disease (a long-term condition where the kidneys do not work as well as they should), and dementia (a progressive state of decline in mental abilities) with agitation. During a review of Resident 286's H&P, dated 12/24/2024, indicated Resident 286 did not have the capacity to understand and make decisions. During a review of Resident 286's MDS, dated [DATE], the MDS indicated Resident 285 was dependent (helper does all the effort) with activities of daily living (ADL, term used in healthcare that refers to self-care activities) and was dependent (helper does all the effort) with mobility. During a review of Resident 286's OSR, order date range: 12/23/2024 to 1/9/2025, the OSR indicated Resident 286 had an active order for Ziprasidone (used to treat symptoms of psychotic [a state of losing touch with reality] mental disorders, such as schizophrenia, mania [mental state of an extreme highs or depressive lows], or bipolar disorder [sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs]) hydrochloride (HCL- a strong, corrosive acid commonly found in stomach acid that helps digest food, unit of measurement) oral capsule 20mg, give 1 capsule by mouth in the morning for dementia with behavioral disturbance manifested by agitation with a start date of 12/31/2024. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/7/2025 at 1:51 PM, with LVN 1, LVN 1 stated antipsychotic medication orders required a manifestation with a specific behavior or symptom to ensure the medication was used appropriately, safely, and in compliance with regulations and best practices. LVN 1 a specific targeted behavior ensured the medication was tailored to the resident ' s needs and targeted an appropriate behavior or symptom. LVN 1 stated without clarification, staff may administer the medication inappropriately, risking harm or unnecessary sedation. During an interview and a concurrent record review on 1/10/2025 at 2:31 PM, Resident 285's OSR, order date range: 12/23/2024 to 1/9/2025, was reviewed with RN 1, RN 1 stated Resident 285 ' s Ziprasidone order was incomplete because using agitation as a manifestation behavior for antipsychotic use was broad and could mean or describe a wide range of behaviors that may stem from multiple underlying causes. RN 1 stated without further clarification from the physician, it may not adequately justify the use of the antipsychotic medication. RN 1 stated broad terms like agitation can lead to overuse or inappropriate use of antipsychotics and the orders must be clarified and modified to include specific behaviors to indicate what agitation looked like, such as: yelling or screaming. 2. During an interview and a concurrent record review on 1/7/2025 at 1:51 PM, Resident 54's OSR, dated 1/7/2025 was reviewed with LVN 1, LVN 1 stated Resident 54's lorazepam order did not indicate the extent of how long the medication would be used for. LVN 1 stated there should be an indication of a 14-day limit on PRN (PRN-as needed) psychoactive medication orders which was designed for resident safety and to promote responsible medication use. LVN 1 stated the 14-day limit ensured residents received the right medication for the right reasons and their care was regularly reassessed. LVN 1 stated after 14 days the physician must reassess the resident's condition to determine whether it was necessary to continue the administration of the medication. LVN 1 stated if the physician determined continued use was appropriate, the order would be renewed with documentation justifying its ongoing use. LVN 1 stated each lorazepam order should indicate a 14-day window use or must have an end date after the 14 days. During an interview on 1/10/2025 at 2:31 PM, with RN 1, RN 1 stated psychotropic medications could carry significant risks, including dependency, tolerance, and withdrawal symptoms when used. RN 1stated a 14-day window allowed healthcare providers to closely monitor the patient's use patterns and prevented potential misuse or overuse of the medication. RN 1 stated psychotropic medication PRN orders should not exceed 14-days without a physician assessment to determine its continued use. RN 1 stated the order should indicate the PRN order was not to exceed the 14-day window. During a review of the facility's P&P titled, P-NP106 Behavior/Psychoactive Medication Management, revision dated 1/25/2024, the P&P indicated: Any order for Psychoactive Medications must include a specific behavior manifestation. Any Psychoactive Medication ordered on a prn basis, must be ordered not to exceed 14 days. If the physician feels the mediation needs to be continued, he/she must document the reason(s) for the continued usage and write the order for the medication; not to exceed a 90-day time frame.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42307 Based on observation, interview and record review, the facility failed to ensure one of four sampled residents (Resident 10) observed during medication pass (term used to describe the process through which medication is administered [given] to patients) was free of significant medication errors by failing to ensure Resident 10's eye drop medication, TobraDex (a medication used for eye infections caused by certain bacteria, and to help relieve eye inflammation and swelling from the infection) was administered properly in accordance with professional standard of practice and the facility's policy and procedure (P&P). This failure resulted in Resident 10's physician ordered an extra dose of TobraDex for Resident 10 and had the potential for ineffective medication (a medication that does not work as intended to treat a condition) and/or enhance systemic side effects that could potentially cause harm to Resident 10's eyes. Findings: During a review of Resident 10's Admission Record (AR), the AR indicated, Resident 10 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including encounter for attention to gastrostomy (GT, a tube inserted through the belly to bring nutrition and/or medications directly to the stomach), unspecified age-related cataract (clouding of the normally clear lens of the eye) and legal blindness, as defined in USA. During a review of Resident 10's Care Plan (CP), titled, The resident has impaired visual function ., date initiated 3/3/23, the CP indicated one of the interventions was to administer eyedrop and eye ointment medications as ordered. During a review of Resident 10's History and Physical (H&P), dated 7/21/24, the H&P indicated, Resident 10 did not have the capacity to understand and make decisions. During a review of Resident 10's Minimum Data Set (MDS, a resident assessment tool), dated 11/22/24, the MDS indicated, Resident 10's cognitive skills (ability to think and process information) for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated, Resident 10 was dependent (helper does all of the effort) with activities of daily living. During a review of Resident 10's Order Summary Report (OSR), active orders as of 1/8/25, the OSR indicated, TobraDex ophthalmic suspension 0.3-0.1%, instill 1 drop in both eyes one time a day for blepharoconjunctivitis (irritation and inflammation of your inner eyelid, the surface of your eye, and the area around the base of your eyelids) for 7 days, ordered on 1/6/25. During an observation on 1/8/25 at 9:05 a.m. during the medication pass, Licensed Vocational Nurse (LVN) 6 instilled 1 drop of TobraDex into Resident 10's inner corner of the left eye then applied a tissue over the eye for about 3 seconds and repeated the same steps for the right eye. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 10's Phone Order (PO), dated 1/8/25, timed at 10:39 a.m., the PO indicated, TobraDex ophthalmic suspension 0.3-0.1%, instill 1 drop in both eyes one time only for blepharoconjunctivitis x 1 only until 1/8/25. During a review of Resident 10's Medication Administration Record (MAR), dated for the month of January 2025, the MAR indicated, TobraDex was administered on 1/8/25 at 9:00 a.m. one time at 1:33 p.m. During a concurrent interview and record review on 1/8/25 at 10:45 a.m. with the Director of Staff Development (DSD), the facility's P&P titled, Specific Medication Administration Procedures - Eye Drop Administration, update date June 2021, was reviewed. The P&P indicated, while the eye is closed, use one finger to compress the tear duct in the inner corner of the eye for 1-2 minutes. The DSD stated, LVN 6 should have pressed the inner corner of the eye for 1-2 minutes. The DSD stated, LVN 6 notified Resident 10's physician and the physician ordered to give the eyedrop again for one time only today. During an interview on 1/8/25 at 1:35 p.m. with LVN 4, LVN 4 stated, after applying the eye drop into the inner cannula, she needed to press the inner corner of the eye firmly for about at least a minute, then repeat process with the other eye. LVN 4 stated, it was important to press the inner corner of the eye for at least 1 minute to ensure the eye drop medication did not leak out so the resident got the full dose (of the TobraDex) and the medication was absorbed. During an interview on 1/10/25 at 8:08 a.m. with the Registered Nurse Supervisor (RN), the RN stated, to press the eye for about a minute after instilling the eye drop to ensure the medication spread across and dissolved into the eye area and absorbs the medication fully. During a review of the facility's policy and procedure (P&P) titled, Medication - Administration, date revised 1/1/12, the P&P indicated, to ensure the accurate administration of medications for residents in the facility.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50016 Based on observation, interview, and record review, the facility failed to follow proper sanitation and food handling practices by failing to ensure one of one kitchen staff (Cook [CK] 1) was wearing a beard net during the preparation of food. This deficient practice had the potential to result in foodborne illnesses (also called food poisoning caused by eating contaminated food with infectious organisms) for the residents in the facility who were able to consume the food. Findings: During an observation on 1/6/2025 at 8:30 AM, CK 1 was observed in the kitchen prepping lunch rolls and placing the rolls on a baking tray. CK 1 had a beard and CK 1 was not wearing a beard net. CK 1 was wearing a surgical mask that did not fully cover the sides of the face and exposed CK 1's beard. During an interview on 1/6/2025 at 8:35 AM, with CK 1, CK 1 stated that CK 1 should have worn a beard net while prepping food and should have placed the beard net underneath the surgical mask. CK 1 stated the purpose of the beard net was for contamination control which protected against foodborne illnesses. During an interview on 1/6/2025 at 8:40 AM, with the Dietary Supervisor (DS), the DS stated cooks that had facial hair should wear a beard net when preparing food. The DS stated this practice ensured compliance with hygiene and food safety standards, especially in environments serving vulnerable populations. The DS stated beard nets prevented loose facial hair from falling into the resident's food, minimizing the risk of contamination. The DS stated by combining a beard net with a surgical mask, food preparers maintained a higher standard of hygiene, ensuring safe and high-quality meal preparation for residents. During a review of the facility's P&P titled, Dietary Department-Infection Control for Dietary Employees, revision dated 11/9/2016, the P&P that all dietary employees will follow infection control policies as established and approved by the facility's infection control committee. -Personal cleanliness is required in sanitary food preparation. -Clean hair - covered with an effective hair restraint while in the kitchen and food storage areas. (And beard/mustache covering when applicable). During a review of the facility's P&P titled, Dietary Department-General, revision dated 6/1/2014, the P&P indicated: -The primary objectives of the dietary department include: -Maintenance of standards for sanitation and safety. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The Dietary Manager is responsible for the day-to-day education of dietary staff with regard to topics such as sanitation, food preparation, etc.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50016 Based on observation, interview and record review, the facility failed to ensure accuracy of medical records for one of one sampled resident (Resident 54) by failing to ensure there was a physician's order for the use of a LAL (LAL, a mattress designed to distribute body weight and prevent and treat pressure wounds) mattress in Resident 54's medical record. This deficient practice had the potential to result in inconsistent or inaccurate treatments provided to Resident 54. Findings: During a review of Resident 54's AR, the AR indicated the facility admitted Resident 54 on 10/2/2024, with diagnoses including metabolic encephalopathy (a change in how the brain works due to an underlying condition), adult failure to thrive, cognitive (the ability to think and process information) communication deficit. During a review of Resident 54's History and Physical (H&P), dated 10/2/2024, the H&P indicated Resident 54 did not have the capacity to understand and make decisions. During a review of Resident 54's MDS, dated [DATE], the MDS indicated Resident 54 was dependent (helper does all the effort) with activities of daily living (ADL, term used in healthcare that refers to self-care activities) and required partial/moderate assistance (helper does less than half the effort) with mobility. During an observation on 1/6/2025 at 9:30 AM, Resident 54 was observed with a LAL mattress connected to her bed with settings on alternating pressure and a weight set at 100lbs (lbs.-unit of weight). During an interview and concurrent record review on 1/6/2025 at 1:45 PM, Resident 54's Order Summary Report was reviewed with Treatment Nurse (TN) 1, TN 1 stated Resident 54's medical record did not have a physician ' s order for use of the LAL mattress. TN 1 stated Resident 54 had the LAL mattress for skin breakdown preventative measures. TN 1 stated a LAL mattress was a specialized medical device that required a physician's order, since it was used to prevent or treat PIs and managed patients with impaired mobility, such as Resident 54. TN 1 stated the need for a LAL mattress was required when a patient was at high risk for [developing] PIs, and a physician assessed the patient's condition to determine the most appropriate intervention. During a review of the facility's Policy and Procedure (P&P) titled, Mattresses, revision dated 1/1/2012, the P&P indicated: -An air mattress is used under the direction of the Attending Physician's order or when the resident's clinical condition warrants pressure reducing devices. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Completion & Correction-Medical Records Manual-General, dated 1/1/2012, the P&P's purpose indicated to ensure medical records were complete and accurate. The P&P indicated the facility would work to complete and correct medical records in a standardized manner to provide the highest quality and accuracy in documentation. The P&P indicated information concerning pertinent observation, psychosocial and physical manifestations, incidents .will be documented as soon as possible. The P&P indicated, documentation will reflect medically relevant information concerning ther resident and will be documented in a professional manner.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38108 Based on interview and record review, the facility failed to ensure one of five sampled residents (Resident 24) had coordinated care between the facility and the hospice (provides medical services, emotional support, and spiritual resources for people who are in the last stages of a terminal illness) agency, by ensuring Resident 24 had calendars to notify staff when the hospice staff visited and/or have sign in/flow sheets indicating the type of care that was provided while the hospice staff was at the facility. This deficient practice had the potential for Resident 24 not receive the appropriate and coordinated care and/or services from the facility and the hospice agency needed by Resident 24. Findings: During a review of Resident 24's Admission Record (AR), the AR indicated Resident 24 was admitted to the facility on [DATE] with diagnoses that included encephalopathy (brain disease that alters brain function or structure), and palliative care (specialized care that focuses on providing patients relief from pain and other symptoms of a serious illness, no matter the diagnosis or stage of disease). During a review of Resident 24's History and Physical (H&P), dated 3/7/2024, the H&P indicated Resident 24 did not have the capacity understand and make decisions. During a review of Resident 24's Order Summary Report (OSR), the OSR indicated hospice services were ordered for Resident 24 on 7/31/2024. During a review of Resident 24's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 11/7/2024, the MDS indicated the Resident 24 required total dependence (full staff performance every time) from staff for dressing, toileting, and bathing. During a review of Resident 24 Care Plan (CP) for, Admit to Hospice Service provided by VNA Care, dated 8/16/2024, the CP indicated to work cooperatively with the hospice team to ensure the resident's spiritual, emotional, intellectual, physical, and social needs were meet. The CP indicated to work with nursing staff to provide maximum comfort to the resident. During an interview and concurrent record review of Resident 24's medical record (chart) and hospice binder on 1/10/2025 at 10:22 am, with Registered Nurse 1 (RN 1), RN 1 stated Resident 24 was under hospice care. RN 1 stated Resident 24's hospice calendar for November 2024, located inside Resident 24 ' s hospice binder, was incomplete. RN 1 stated Resident 24 ' s hospice calendar for December 2024 was not filled out and left [blank, empty] and the January 2024 calendar was missing. RN 1 stated hospice staff communicated with the facility staff via the hospice calendar. RN 1 stated Resident 24 ' s hospice calendar was an important communication tool between hospice staff and the facility staff to indicated hospice resources wee seeing and treating Resident 24 and to ensure the overall health, including any changes of condition, was being addressed. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Hospice Care of Residents dated 1/1/2012, the P&P indicated the facility and hospice staff will collaborate on a regular basis concerning the resident's care. The P&P indicated all documentation concerning hospice services would be maintained in the resident's medical record.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50016 Based on observation, interview, and record review, the facility failed to ensure infection control practices were followed for four of fourteen sampled residents (Resident 72, 4, and 58) by failing to: A. Ensure Resident 7 's restroom's toilet was kept and maintained under sanitary conditions. B1 and B2. Ensure unlabeled personal toiletry was not stored inside the shared restroom of Resident 4 and 58. These deficient practices resulted in contamination of the resident's environment and had the potential to result in cross contamination (the process by which bacteria or other microorganisms are unintentionally transferred from one substance or object to another, with a harmful effect) between the residents residing at the facility. Findings: A. During a review of Resident 72's Admission Record (AR), the AR indicated the facility admitted Resident 72 on 3/7/2024, and readmitted the resident on 9/13/2024, with diagnosis including syncope (fainting) and collapse, esophageal obstruction (esophagus, when the tube that carries food from your throat to your stomach, is blocked, preventing food from passing through normally), and gastro-esophageal reflux disease (GERD- a digestive condition that occurs when stomach acid leaks into the esophagus). During a review of Resident 72's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 12/19/2024, the MDS indicated Resident 72's cognition (the ability to think and process information) was severely impaired. The MDS indicated Resident 67 required partial/moderate assistance (helper does less than half the effort) with activities of daily living (ADL, term used in healthcare that refers to self-care activities) and required partial/moderate assistance (helper does less than half the effort) with mobility. During an observation on 1/6/2025 at 9:59 AM, Resident 72's bathroom was screened. The toilet bowl in Resident 72's bathroom toilet had fecal-like matter around the toilet rim and inside the toilet bowl. The toilet seat was soiled with dark brown residue and had a pungent [strong] smell. During an interview on 1/6/2025 at 10:01 AM, Resident 72 stated his toilet had been soiled since last night. Resident 72 stated Resident 72 mentioned it to the night-shift staff, but no one cleaned it. Resident 72 stated he had been using the toilet in that condition and stated it made him feel uncomfortable, embarrassed, and frustrated. Resident 72 stated he just wanted staff to do their job. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/6/2025 at 11:25 AM, with the Infection Preventionist Nurse (IPN), the IPN stated visibly soiled toilets required immediate attention, thorough cleaning, and disinfection to restore sanitary conditions. The IPN stated if housekeeping staff were not available during afterhours, other direct care staff should assist with the cleaning, as long as the staff followed infection control protocols to minimize the risk of spreading infections. The IPN stated if cleaning was necessary due to an immediate sanitary issue staff should address the problem promptly to maintain the resident's comfort, dignity, and well-being. The IPN stated the restroom in that condition did not conduce a sanitary environment. During an interview on 1/6/2024 at 11:30 AM, with Housekeeper (HK) 1, HK 1 stated no one had notified her about Resident 72's toilet being soiled. HK 1 stated housekeeping was typically in the facility from 4 AM to 2 PM every day. HK 1 stated housekeeping staff was not on-site after 2 PM. HK 1 stated any direct care staff should assist with cleaning toilets if housekeeping staff were unavailable, particularly in situations where immediate action was needed to maintain sanitary conditions. HK 1 stated she was currently making her rounds and cleaning resident's rooms and had she known or been notified Resident 72's toilet needed cleaning HK 1 would have addressed the situation. During a review of the facility's P&P titled, Infection Control - Policies & Procedures, revision dated 1/1/2012, the P&P indicated: -The facility's infection control policies and procedures are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections. -Objective: Maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public. During a review of the facility's P&P titled, Resident Rights - Accommodation of Needs, revision dated 1/1/2012, the P&P indicated the facility ' s environment is designed to assist the resident in achieving independent functioning and maintaining the resident's dignity and well-being. Facility staff will assist residents in achieving these goals. During a review of the facility's P&P titled, Resident Rooms and Environment, revision dated 1/1/2012, the P&P indicated the provides residents with a safe, clean, comfortable, and homelike environment and person-centered care that emphasizes the residents' comfort, independence, and personal needs and preferences. To this end, the Facility encourages residents to use their personal belongings to the extent possible. 42307 B1. During a review of Resident 4's Admission Record (AR), the AR indicated, Resident 4 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing), heart failure, unspecified, and dementia (a progressive state of decline in mental abilities) in other diseases classified elsewhere, unspecified severity, without behavioral disturbance, psychotic (a mental disorder characterized by a disconnection from reality) disturbance, mood disturbance, and anxiety (intense, excessive, and persistent worry and fear about everyday situations). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 4's History and Physical (H&P), dated 1/3/24, the H&P indicated, Resident 4 did not have the capacity to understand and make decisions. During a review of Resident 4's Minimum Data Set (MDS, a resident assessment tool), dated 11/21/24, the MDS indicated, Resident 4's BIMS Summary Score (Brief Interview for Mental Status, an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) was moderately impaired. The MDS indicated, Resident 4 required partial/moderate assistance (helper does less than half the effort) with toileting hygiene and required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with personal hygiene. B2. During a review of Resident 58's AR, the AR indicated, Resident 58 was admitted to the facility on [DATE] with multiple diagnoses including type 2 diabetes mellitus (adult-onset high blood sugar) without complications, COPD, and immunodeficiency (the decreased ability of the body to fight infections and other diseases) due to conditions classified elsewhere. During a review of Resident 58's MDS, dated [DATE], the MDS indicated, Resident 58's BIMS Summary Score was intact. The MDS indicated, Resident 58 required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene and required supervision or touching assistance with personal hygiene. During a review of Resident 58's H&P, dated 10/11/24, the H&P indicated, Resident 58 was a poor historian, awake and oriented x 2-3 (a person is alert and oriented to person, place, and time but not what is happening to them.) During a concurrent observation and interview on 1/6/25 at 10:53 a.m. with Certified Nursing Assistant (CNA) 2, inside the shared restroom of Resident 4 and Resident 58, an opened and unlabeled 7.5 Fl oz (fluid ounce, a unit to measure liquid volume) Clean & Free Full Body Wash & Peri Cleanser was stored on top of the toilet paper holder box. CNA 2 stated, the peri cleanser was used to clean the private parts (the genital organs on the outside part of the body) and should be labeled with the resident (in general) name and date and should be kept at the resident's bedside so staff would know who the peri cleanser belonged to and when the peri cleanser was opened for infection control. During an interview on 1/8/25 at 4:11 p.m. with the Infection Preventionist (IP), the IP stated, the peri cleanser was used to clean the resident's private. The IP stated, the peri cleanser was supposed to be labeled with resident's name, room number and should be kept at resident's nightstand. The IP stated, You don't want different resident using it, it's cross contamination for infection control. During a review of the facility's policy and procedure (P&P) titled, Infection Control - Policies & Procedures, date revised 1/1/12, the P&P indicated, the facility's infection control P&P were intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections. (continued on next page)

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	055344	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Claremont Heights Post Acute	590 S. Indian Hill Blvd. Claremont, CA 91711

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Prevention of Cross-Contamination: Resident care items, revision date of 4/27/23, the P&P indicated, resident care items would be clearly labeled with the resident's name and/or room number upon placing them into services for that resident. The P&P indicated, the purpose was to prevent cross-contamination from use of another resident's/unidentified personal care items/belongings and to prevent healthcare associated infections.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 40913 Based on interview and record review, the facility failed to follow the facility's Policy and Procedure for Antibiotic Stewardship Program (ASP, a set of actions that work to improve how antibiotics are used in healthcare settings. ASPs aim to ensure that antibiotics are prescribed and used appropriately, which can lead to better patient outcomes and reduced antibiotic resistance.) for one of three sampled residents (Resident 40). This deficient practice had the potential to increase Resident 40's antibiotic resistance (occurs when bacteria no longer respond to the antibiotics, the antibiotics become ineffective and infections become difficult or impossible to treat increasing the risk of disease spread, severe illness, disability, and death). FINDINGS: During a review of Resident 40's Admission Record (AR), the AR indicated the facility admitted Resident 40 on 7/5/24, with diagnoses that included Alzheimer's disease (irreversible, progressive brain disorder that slowly destroys memory and thinking skills, and eventually the ability to carry out the simplest tasks), and dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning). During a review of Resident 40's Minimum Data Set (MDS - a resident assessment tool) dated 10/11/24, the MDS indicated Resident 40 sometimes understands verbal content and sometimes able to express ideas and wants. During a review of Resident 40's Order Summary Report (OSR), dated 12/3/24, the OSR indicated an active order for Trimethoprim (antibiotic used mainly in the treatment of bladder infections) oral tablet 100 milligrams (mg), give one tablet by mouth one time a day for urinary tract infection (UTI) prophylaxis (a preventive treatment against disease). During a review of Resident 40's urine culture result, dated 12/5/24, the urine culture result indicated the urine was positive for bacteria and Resident 40 had a resistance to Trimethoprim/Sulfamethoxazole. The IPN stated the facility continued to give Trimethoprim which could increase Resident 40 to develop resistance to more antibiotics. During a record review of Resident 40's Antibiotic Stewardship/Surveillance Data Collection Form and a concurrent interview on 1/10/24 at 10:08 am, The Infection Prevention Nurse (IPN) stated there was no Surveillance Data Collection Form (SDCF) filled up for Resident 40. The IPN stated the process for the facility's Antibiotic Stewardship would start when a physician ordered antibiotics, there would be a communication to the facility's computer system that a new antibiotic was ordered and the IPN would follow up that the SDCF was started by the licensed nurse who received the order, this form would guide the licensed nurses on what steps to follow. A reviewed of a blank Antibiotic Stewardship/Surveillance Data Collection Form (SDCF) for UTI without an Indwelling Catheter. The SDCF indicated 2 criteria needed to be met for Antibiotic Stewardship Program. Criteria 1 was a sign and symptom of the sub-criteria and Criteria 2 was a positive urine culture result. (continued on next page)

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F 0881 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, Antibiotic Stewardship, the P&P indicated the IP is responsible for tracking the following antibiotic stewardship processes, that included whether or not the Resident's condition met MCGeers criteria (a set of signs and symptoms used to identify infections in long-term care facilities.) when the antibiotic was ordered, if cultures were ordered. The P&P indicated the facility will provide education on antibiotic stewardship to prescribing medical providers, nursing staff, other staff (as appropriate), residents and families.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40913 Based on interview and record review, the facility failed to provide and/or document the provision of vaccination (a simple, safe and effective way of protecting you against harmful diseases, before you come into contact with them) to three of three sampled residents (Residents 22, 23 and 32) during the flu season (per CDC, in the United States, flu viruses typically circulate during the fall and winter between December and February). This deficient practice had the potential to put Residents 22, 23 and 32 at risk for influenza infection during the flu season. Findings: a. During a review of Resident 22's Admission Record (AR), the AR indicated the facility admitted the resident on 11/22/21, with diagnoses that included hemiplegia and hemiparesis (weakness and paralysis to one side of the body), and malignant neoplasm of the colon (colon cancer). During a review of Resident 22's Minimum Data Set (MDS- a resident assessment tool) dated 12/11/24, the MDS indicated Resident 22 had intact cognition and required supervision/touching assistance (helper sets up or cleans up; resident completes activity) with oral hygiene and bed mobility. b. During a review of Resident 23's AR, the AR indicated the facility admitted the resident on 12/21/21, with diagnoses that included heart failure (condition when the heart is unable to pump sufficiently to maintain blood flow to meet the body's needs), and diabetes mellitus type 2 (a disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in elevated levels of glucose/sugar in the blood and urine). c. During a review of Resident 32's AR, the AR indicated the facility admitted the resident on 8/1/24, with diagnoses that included diabetes mellitus type 2, and chronic kidney disease, stage 4 (condition characterized by a gradual loss of kidney function over time). During a review of Resident 32's MDS dated [DATE], the MDS indicated Resident 32 had intact cognition and dependent with toileting hygiene. During a record review of the Influenza Vaccine Informed Consent and Immunization Reports and a concurrent interview with the Infection Prevention Nurse (IPN) on 1/10/24 at 11:01 am, the Resident Influenza Vaccine Informed Consent for the for Residents 22, 23 and 32 indicated the following: Resident 22's Representative (RP) signed the consent for influenza vaccine via phone on 9/27/24. Resident 23's RP signed the consent for influenza vaccine via phone on 9/27/24. Resident 32's signed an undated consent for influenza vaccine, there was a check mark for Influenza for 2024/2025. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the same record review and interview on 1/10/24 at 11:01 am, the Immunization Reports for Residents 22, 23 and 32 indicated the following: Resident 22's Immunization Report indicated Influenza vaccine was refused, the date was missing. Resident 23's Immunization Report indicated Influenza vaccine was pending consent. Resident 32's Immunization Report indicated Resident 32 was not eligible, the date was missing. The IPN stated he was planning to contact the local health department to set up a vaccination clinic. The IPN did not provide proof of such communication or contact. During a review of the facility's Policy and Procedure (P&P) titled, Influenza Prevention and Control, dated 10/10/20, the P&P indicated the purpose of the P&P would be to prevent and control the spread of influenza in the facility. The P&P indicated residents are offered an influenza immunization every year during flu season, unless the immunization is medically contraindicated, of the resident has already been immunized during the current flu season. The P&P indicated the resident of representative must give consent prior to receiving the vaccine. They can refuse the immunization- with such refusal being noted in the resident's medical record.

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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. 40913 Based on interview and record review, the facility failed to provide and/or document the provision of pertinent information regarding the immunizations (a process by which a person becomes protected against a disease [a disorder of structure or function in a human, animal, or plant]) through vaccination (a simple, safe and effective way of protecting you against harmful diseases, before you come into contact with them) for 9 of 21 residents upon admissions (Residents 43, 185, 186, 286, 335, 337, 338, 339, 340) regarding the benefits and potential side effects of the COVID-19 (a mild to severe respiratory illness that spread from person to person). These deficient practices resulted in Residents 43, 185, 186, 286, 335, 337, 338, 339 and Resident 340 were not provided the education regarding COVID-19 vaccination an the opportunity to decline or agree to be immunized and be at lower risk for acquiring, transmitting, or experiencing complications from the COVID-19 disease. Findings: During a review of Resident 43's Admission Record, the AR indicated the facility admitted Resident 43 on 8/27/24, with diagnoses that included end stage renal disease (ESRD- is a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis [procedure to remove metabolic waste products or toxic substances from the bloodstream] or a kidney transplant to maintain life). During a review of Resident 185's AR, the AR indicated the facility admitted Resident 185 on 11/15/24, with diagnoses that included chronic respiratory failure with hypoxia (when the body is not getting the oxygen it needs). During a review of Resident 186's AR, the AR indicated the facility admitted Resident 186 on 12/19/24, with diagnoses that included Human Immunodeficiency Virus Disease (HIV, a virus that attacks cells that help the body fight infection, making a person more vulnerable to other infections and diseases). During a review of Resident 286's AR, the AR indicated the facility admitted Resident 286 on 12/23/24, with diagnoses that included acute pulmonary edema (a condition caused by too much fluid in the lungs). During a review of Resident 335's AR, the AR indicated the facility admitted Resident 335 on 12/27/24, with diagnoses that included type 2 diabetes mellitus (a disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in elevated levels of glucose/sugar in the blood and urine). During a review of Resident 337's AR, the AR indicated the facility admitted Resident 337 on 1/4/25. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 338's AR, the AR indicated the facility admitted Resident 338 on 12/21/24, with diagnoses that included chronic pulmonary edema. During a review of Resident 339's AR, the AR indicated the facility admitted Resident 339 on 1/3/25. During a review of Resident 340's AR, the AR indicated the facility admitted Resident 340 on 12/31/24, with diagnoses that included chronic respiratory failure with hypoxia. During a record review of Residents 43, 185, 186, 286, 335, 337, 338, 339, 340's Immunization Report on 1/10/24, from 11:01 am to 3:51 pm, and a concurrent interview, the Infection Prevention Nurse (IPN) stated there was no record of immunization history for the following residents because the IPN did not have access to California Immunization Registry, the IPN stated the IPN applied for access. The IPN stated the IPN was responsible for collecting the immunization data for COVID-19 and to provide education to the residents and representative regarding COVID-19 vaccine. During the same record review and interview, the IPN stated there was no log for COVID-19 vaccinations for both staff and residents. The IPN provided a print-out of the Resident's Immunization Report for 69 residents. The facility's census was 94 as of 1/6/24. During a review of the facility's Policy and Procedure (P&P) titled, COVID-19 Vaccination Program, dated 3/15/22, the P&P indicated the facility will offer SARS-CoV-2 (the virus that causes COVID-19) vaccinations (including additional and booster doses) to all residents. They will be encouraged but are not required to be vaccinated or boosted. The P&P indicated the facility will register with the California Immunization Registry (CAIR) for vaccine reporting. The P&P indicated separate logs will be maintained to track the vaccination status of residents and staff.