STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055350	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Culver West Health Center	4035 Grandview Blvd. Los Angeles, CA 90066

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48903 Based on observation, interview, and record review, the facility failed to provide adequate storage and conduct inventory for personal belongings for homelike environment for one of six sampled residents (Resident 38). This deficient practice resulted in Resident 38 storing personal belongings in several boxes on the floor and the resident complaining of having lost some personal belongings. Cross Reference F584 Findings: A review of Resident 38's Admission Record indicated Resident 38 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes (a disease in which your body does not produce enough insulin needed to control sugar levels in the blood) and morbid obesity (when a person's weight is more than 80 to 100 pounds above their ideal body weight). A review of Resident 38's History and Physical Examination dated 11/9/23 indicated, Resident 38 had the capacity to understand and make decisions. A review of Resident 38's Minimum Data Set (MDS - a standardized assessment and care screening tool) dated 3/1/24, indicated the resident had intact cognition (capable of remembering, learning new things, concentrating, or making decisions that affect everyday life) and required assistance from staff for hygiene (oral and physical), dressing and toileting. A review of Resident 38's Care Plan dated 6/12/23 indicated, Resident 38 had self-care deficit related to musculoskeletal impairment, limited mobility, and activity intolerance. During a concurrent observation and interview on 4/16/24 at 12:49 PM with Resident 38 in his room, several boxes were on the floor next to Resident 38's bed. Resident 38 stated, I have no pants, my belonging are boxed, and staff doesn't want to get it. Staff packed up all my clothes and lost my pants. I'm missing my sweatpants. I have boxes at bedside, but staff doesn't want to help go through the boxes to find my belongings. (continued on next page)

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

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/16/24 at 9:39 AM, Certified Nurse Assistant 1 (CNA 1) stated, he [Resident 38] has told me he can't find his clothes, I tried to get things organized from his boxes. His clothes are in the box because there is not enough space in the closet. It is not a homelike environment to have all things in a box. CNA 1 stated, When a resident is admitted the CNA does the inventory. The supervisor gives CNA the inventory form, CNA inventories the belongings and fills it out, it's three papers, you write down all the clothes, anything he has, all his belongings. CNA 1 further stated, If a resident reports something is lost, the CNA reports it to the Charge Nurse and supervisor. During a concurrent interview and record review on 4/18/24 at 9:45 AM with Licensed Vocational Nurse 1 (LVN 1), Resident 38's medical chart was reviewed. LVN 1 stated, there is no admission inventory found in the chart. During an interview on 4/18/24 at 10:14 AM, Social Worker (SW), stated When residents are readmitted there should be an inventory list of belongings. Missing property is reported to SW, SW does investigation, looks at inventory list, searches rooms. If missing item is not found, it's reported to the Administrator (ADM), then the ADM decides to reimburse or replace. They [residents] can be affected psychosocially and feel less of a homelike environment if their property is lost. During an interview on 4/18/24 at 10:56 AM, Registered Nurse 1 (RN 1), stated, When residents get admitted they need to have resident's clothing and possessions form filled out. The CNA fills out the form upon admission. RN 1 confirmed and stated, the form is not filled out for [Resident 38] upon admission. RN 1 further stated, Resident 38's, belongings can be misplaced and not be able to be located if form is not filled. This could cause the resident to feel sad if their possessions get lost. During an interview on 4/18/24 at 3:09 PM, Director of Nursing (DON), stated, we have to do inventory of residents' belongings. We have a form that the CNA fills out to document all their belongings, the resident gets a copy, and another copy goes in the chart. DON further stated, The resident might say something is missing and we can't find it without this form. We wouldn't know how to track the belongings. The resident might get upset that their things are missing. A review of the facility's policy and procedures (P&P) titled, Personal Property dated 9/12, indicated, The resident's personal belongings and clothing shall be inventoried and documented upon admission and as such items are replenished. The facility will promptly investigate any complaints of misappropriation or mistreatment of resident property.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48903 Based on observation, interview, and record review, the facility failed to: 1. Provide appropriate bed to accommodate one of six sampled residents (Resident 38). 2. Ensure call light was within reach for one of 28 sampled Residents (Resident 29). These deficient practices had the potential to result in Resident 38 developing new pressure injuries (Injury to skin and underlying tissue resulting from prolonged pressure on the skin), and for staff not to meet Resident 29's needs, which could place the resident at risk for incidents. Findings: a. A review of Resident 38's Admission Record indicated Resident 38 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes (a disease in which your body does not produce enough insulin needed to control sugar levels in the blood) and morbid obesity (when a person's weight is more than 80 to 100 pounds above their ideal body weight). A review of Resident 38's History and Physical Examination dated 11/9/23 indicated, Resident 38 had the capacity to understand and make decisions. A review of Resident 38's Minimum Data Set (MDS - a standardized assessment and care screening tool) dated 3/1/24, indicated the resident had intact cognition (capable of remembering, learning new things, concentrating, or making decisions that affect everyday life) and required assistance from staff for hygiene (oral and physical), dressing and toileting. A review of Resident 38's Care Plan dated 6/12/23 indicated, Resident 38 had self-care deficit related to musculoskeletal impairment, limited mobility, and activity intolerance. During an observation on 4/16/24 at 9:16 AM, Resident 38 was in bed. Resident 38's feet were pressing against the foot board of the resident's bed. Resident 38's head was at the highest part of the bed. During an interview on 4/18/24 at 9:01 AM, Resident 38 stated, this bed is too short for me, my feet are pressing on the leg board, The bottom of my feet are in constant pressure on the leg board. I fear that I will develop pressure ulcers on my feet. Resident 38 further stated, I have told the Social Worker (SW) about this bed. I first told someone about this bed the moment I came back to this facility on 4/3/24. During an interview on 4/18/24 at 9:23 AM with Maintenance Supervisor (MS), MS stated, nobody has informed me that resident [Resident 38] needs a longer bed. During an interview on 4/18/24 at 9:28 AM with Maintenance Assistant (MA), MA measured Resident 38's bed and stated, 'it (Resident 38's bed) is 6 feet long, 3 feet wide. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/18/24 at 9:52 AM with SW, SW stated, Resident 38 told me just this morning that his bed is too short for him. His feet can develop a pressure ulcer and he can be uncomfortable from having a short bed. During a concurrent observation, interview, and record review on 4/18/24 at 12:36 PM with Licensed Vocational Nurse 1 (LVN 1), Resident 38's electronic medical record (eMAR) was reviewed. Resident 38 was observed on his bed. LVN 1 stated, he is too tall for this bed and his feet are under pressure on the foot board. The consequences of having his feet apply constant pressure to the foot board are that he can develop pressure ulcers. His documented height is 73 inches. That is over 6 feet tall. During an interview on 4/18/24 at 3:14 PM, Director of Nursing (DON) stated, whoever admits a resident should know what the resident needs, they should know when they accept the resident. If a resident needs a special bed it [bed] should be addressed before the resident is admitted or as soon as possible. The resident will be uncomfortable if the bed is small for the resident. DON further stated, there could be pressure related injuries if he [Resident 38] is too tall and his feet are pressing against the footboard. A review of the facility's policy and procedures (P&P) titled, Pressure Ulcer and Wound Management, dated 1/1/15, indicated, It is the policy of this facility to ensure that resident's skin status is assessed, and appropriate interventions are developed and implemented to maintain skin integrity and or prevent avoidable skin breakdown, in order to attain or maintain the highest practicable physical, mental, and psychosocial wellbeing. 45455 b. A review of Admission Record indicated Resident 29 was initially admitted to the facility on [DATE], and was readmitted on [DATE], with diagnoses that included epilepsy (a disorder of the brain characterized by repeated seizures), asthma (a chronic disease in which the bronchial airways in the lungs become narrowed and swollen, making it difficult to breathe.) schizophrenia(a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions) and hemiplegia and hemiparesis (loss of strength in the arm, leg, and sometimes face on one side of the body) affecting the left non-dominant side. A review of Resident 29's MDS dated [DATE], indicated Resident 29's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was moderately impaired. The MDS indicated Resident 29 required substantial to maximum assistance with rolling from left to right, was totally dependent on staff for sit to lying position. Resident 29 was unable to move from a lying to sitting on the side of the bed or move from a sit to standing or transfer from chair to bed/chair. During a concurrent observation and interview with Resident 29 in Resident 29's room on 4/16/2024, at 9:15 AM, Resident 29 was lying in bed awake. Resident 29's call light was observed to be hanging against the wall and not within the resident's reach. Resident 29 stated she is an asthmatic and is unable to reach her call light. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Certified Nurse Assistant 2 (CNA 2) on 4/16/2024 at 9:18 AM, CNA 2 stated, we [staff] are supposed to be checking on residents frequently. CNA 2 stated Resident 29, is supposed to have her call light within reach on her right side. CNA 2 further stated staff would not know if the resident needed help immediately if the call light was not within reach for resident to call, CNA 2 stated not having a call light within reach could cause a delay in care, resulting in poor outcomes and/or unnecessary hospitalization and even death. During an interview with Director of Nursing (DON) and Quality Assurance (QA), on 4/19/2024 at 11:45 AM, DON stated call light is a communication tool between staff and residents. DON stated staff must ensure call lights are reachable and available to all residents before exiting the residents' rooms, DON further stated If a call light was not within reach and the resident was in acute distress, there could be a delay in care because of the resident not being able to call for help, which might worsen the resident's medical condition. DON also stated a resident could end up in the hospital due to a change in condition caused by delay in care, resulting in unnecessary hospitalization and death if treatment and care were not provided timely. A review of facility policy and procedures titled Answering the call light, revised October 2020, indicated the purpose of the procedure is to respond to the resident's request and needs, the policy further stated When the resident is in bed ., be sure the call light is within easy reach of the resident.

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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** 48903 Based on observation, interview, and record review, the facility failed to provide a homelike environment for one of six sampled residents (Resident 38). This deficient practice resulted in Resident 38 storing personal belongings in boxes on the floor. Cross Reference F557 Findings: A review of Resident 38's Admission Record indicated Resident 38 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes (a disease in which your body does not produce enough insulin needed to control sugar levels in the blood) and morbid obesity (when a person's weight is more than 80 to 100 pounds above their ideal body weight). A review of Resident 38's History and Physical Examination dated 11/9/23 indicated, Resident 38 had the capacity to understand and make decisions. A review of Resident 38's Minimum Data Set (MDS - a standardized assessment and care screening tool) dated 3/1/24, indicated the resident had intact cognition (capable of remembering, learning new things, concentrating, or making decisions that affect everyday life) and required assistance from staff for hygiene (oral and physical), dressing and toileting. A review of Resident 38's Care Plan dated 6/12/23 indicated, Resident 38 had self-care deficit related to musculoskeletal impairment, limited mobility, and activity intolerance. During a concurrent observation and interview on 4/16/24 at 12:49 PM with Resident 38 in his room, several boxes were on the floor next to Resident 38's bed. Resident 38 stated, I have no pants, my belonging are boxed, and staff doesn't want to get it. Staff packed up all my clothes and lost my pants. I'm missing my sweatpants. I have boxes at bedside, but staff doesn't want to help go through the boxes to find my belongings. During an interview on 4/16/24 at 9:39 AM, Certified Nurse Assistant 1 (CNA 1) stated, he [Resident 38] has told me he can't find his clothes, I tried to get things organized from his boxes. His clothes are in the box because there is not enough space in the closet. It is not a homelike environment to have all things in a box. CNA 1 stated, When a resident is admitted the CNA does the inventory. The supervisor gives CNA the inventory form, CNA inventories the belongings and fills it out, it's three papers, you write down all the clothes, anything he has, all his belongings. CNA 1 further stated, If a resident reports something is lost, the CNA reports it to the Charge Nurse and supervisor. During a concurrent interview and record review on 4/18/24 at 9:45 AM with Licensed Vocational Nurse 1 (LVN 1), Resident 38's medical chart was reviewed. LVN 1 stated, there is no admission inventory found in the chart. (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 4/18/24 at 10:14 AM, Social Worker (SW), stated When residents are readmitted there should be an inventory list of belongings. Missing property is reported to SW, SW does investigation, looks at inventory list, searches rooms. If missing item is not found, it's reported to the Administrator (ADM), then the ADM decides to reimburse or replace. They [residents] can be affected psychosocially and feel less of a homelike environment if their property is lost. During an interview on 4/18/24 at 10:56 AM, Registered Nurse 1 (RN 1), stated, When residents get admitted they need to have resident's clothing and possessions form filled out. The CNA fills out the form upon admission. RN 1 confirmed and stated, the form is not filled out for [Resident 38] upon admission. RN 1 further stated, Resident 38's, belongings can be misplaced and not be able to be located if form is not filled. This could cause the resident to feel sad if their possessions get lost. During an interview on 4/18/24 at 3:09 PM, Director of Nursing (DON), stated, we have to do inventory of residents' belongings. We have a form that the CNA fills out to document all their belongings, the resident gets a copy, and another copy goes in the chart. DON further stated, The resident might say something is missing and we can't find it without this form. We wouldn't know how to track the belongings. The resident might get upset that their things are missing. A review of the facility's policy and procedures (P&P) titled, Personal Property dated 9/12, indicated, The resident's personal belongings and clothing shall be inventoried and documented upon admission and as such items are replenished. The facility will promptly investigate any complaints of misappropriation or mistreatment of resident property.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45455 Based on observation, interview, and record review, the facility failed to assess and identify environmental hazards and risk factors for accidents for one of twenty-eight sampled Residents (Resident 35). This deficient practice had the potential to result in, harm through ingestion of hazardous liquid leading to poisoning and/or allergic reactions (A condition in which the immune system reacts abnormally to a foreign substance), unnecessary hospitalization s, and even death. Findings: A review of Resident 35's admission record indicated Resident 35 was initially admitted to the facility on [DATE], with diagnoses that included diabetes mellitus (high sugar in the blood), chronic obstruction pulmonary disease (COPD- is a common lung disease causing restricted airflow and breathing problems), pneumonia (an infection that inflames the air sacs in one or both lungs) and congestive heart failure (CHF- a condition that develops when your heart doesn't pump enough blood for your body's needs.) A review of Resident 35's Minimum Data Set (MDS - a standardized assessment and care screening tool) dated 3/27/24, indicated Resident 35's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was moderately impaired. The same MDS indicated Resident 35 required setup or cleanup assistance with eating and partial/moderate assistance with oral hygiene. During an observation and a concurrent interview with Resident 35, on 4/16/24, at 10:12 AM, Resident 35 was observed awake lying in bed. An open one-gallon sized bottle with strawberry pink colored liquid was observed on top of Resident 35's bed side drawer. Resident 35 stated the bottle was not hers and she did not know what liquid was in the bottle. During an interview with Licensed Vocational Nurse 4 (LVN 4) on 4/16/24 at 10:20 AM, LVN 4 stated the liquid inside the one-gallon container was shampoo and body wash used by facility to bath and/or shower residents. LVN 4 stated the bottle needed to be tightly capped and should not be left at bedside, LVN 4 further stated, a confused and/or wandering resident could confuse the liquid as ingestible and drink it which could lead to allergic reaction from poisoning, resulting in unnecessary hospitalization , and even death. During an interview with Director of Nursing (DON), on 4/19/24, at 11:55 AM, DON stated, staff are required to observe and assess environment for safety when entering and exiting resident's rooms. DON stated an uncapped bottle with unsafe liquids shouldn't be left at the bedside because a confused and/or wandering resident may consume it which could lead to poisoning, illness, unnecessary hospitalization and even death. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedures (P &P) tilted Safety and Supervision of Resident, dated, revised 2024, indicated . Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. The same P & P further stated the facility-oriented and resident oriented approaches to safety are used together to implement a system . which considers the hazards identified in the environment and individual resident risk factors .

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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** 45528 Based on observation, interview, and record review, the facility failed to ensure one of four sampled residents (Resident 65) received continuous feeding of isosource 1.5 (Nutritional formula) as per physician's order, This deficient practice had the potential to cause inadequate nutrition for Resident 65. Findings: A review of Resident 65's Admission Record indicated Resident 65 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including moderate protein-calorie malnutrition (poor nutrition), dysphagia (swallowing difficulties), and gastro-esophageal reflux disease (a common condition in which the stomach content move up into the esophagus). A review of Resident 65's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 3/1/24, indicated Resident 65's cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision-making were impaired. The MDS indicated Resident65 was dependent to substantial/maximal on assistance from staff with activities of daily living (ADL-dressing, toilet use, showering and personal hygiene). A review of Resident 65's Physician Orders indicated continuous feeding of isosource 1.5 via gastrostomy (g-tube -a tube inserted through the belly that brings nutrition directly to the stomach) using enteral pump to run at 65 cubic centimeters (cc -unit of measurement) per hour. During an observation on 4/16/24, at 9:54 AM, in Resident 65's room, tube feeding connected to a pump, was running at 65cc/hr. However, the tube feeding was not connected to Resident 65. The tube feeding was looped on the side rail and was hanging/dangling in midair under Resident 65's bed and feeding formula was spilling on the floor. During a concurrent observation and interview on 4/16/24, at 9:56 AM, with Licensed Vocational Nurse 2 (LVN 2), in Resident 65's room, LVN 2 stated, feeding pump was running, however, tube feeding is not connected to the patient's g-tube. It needs to be connected to make sure [Resident 65] gets adequate nutrition and calories. If [Resident 65] is not connected to the tube feeding as ordered the resident may not get the correct nutrition ordered which may lead to weight loss and dehydration. During an interview on 4/19/24, at 1:13 PM, Quality Assurance (QA) and the Director of Nursing (DON), stated tube feeding needs to be connected to the resident g-tube so that resident can get adequate nutrition and calories. DON stated potential adverse (negative) outcome of not having feeding appropriately connected to resident is that it may lead to weight loss and dehydration. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedures (P &P) titled Gastrostomy Feeding, with effective date of 1/1//2015, indicated, The purpose of the gastrostomy tube is to provide a direct route to the stomach through a surgical abdominal incision to the stomach. The same P & P indicated, The tube is sutured into place and liquid feedings are performed through this tube .Connect the feeding formula filled tubing to the tube.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45528 Based on interview, and record review, the facility failed to ensure that pain was managed in a timely manner for one of four sampled residents (Resident 33). This deficient practice resulted in Resident 33 experiencing unnecessary pain. Findings: A review of Resident 33's Admission Record indicated the resident was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including atherosclerotic heart disease (hardening of the arteries [blood vessels that distribute oxygen -rich blood to the entire body] cause by buildup of plaque [small, abnormal patch of tissue on a body part or an organ] in the inner lining of an artery of native coronary [relating to heart] artery with unspecified angina), autonomic neuropathy (damage to the nerves that control automatic body function), and heart failure (when heart muscle does not pump blood as well as it should). A review of Resident 33's History and Physical (H&P - physicians' examination of patient), dated 7/26/23, indicated Resident 33 had the capacity to understand and make decisions. A review of Resident 33's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 2/1/24, indicated Resident 33's cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision-making were intact. MDS indicated Resident 33 required substantial/maximal to partial/moderate assistance from staff with activities of daily living (ADL-dressing, toilet use, showering and personal hygiene). A review of Resident 33's Physician Orders indicated an active order for pain: Oxycodone HCL (drug used to treat moderate to severe pain) 10 milligrams (mg -unit of measure) one tablet by mouth every 6 hours as needed for pain management. A review of Resident 33's Medication Administration Record (MAR) for 4/24 indicated Oxycodone HCL oral tablet 10 mg 1 tablet by mouth every 6 hours as needed for pain. The same MAR did not indicate any pain medication was given during the 11 PM to 7 AM shift on 4/16/24. A review of Resident 33's Individual Resident's Controlled Drug Record indicated there were no medication sign out for Oxycodone HCL oral tablet 10 mg during the 11 PM to 7 AM shift on 4/16/24. During an interview with Resident 33 on 4/16/24 at 8:55 P.M., Resident 33 stated, I have a history of chest pain, I am on oxycodone every 6 hours. I asked for it at 3AM in the morning today and I did not get it. (continued on next page)

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	055350	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Culver West Health Center	4035 Grandview Blvd. Los Angeles, CA 90066

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Licensed Vocational Nurse 3 (LVN 3) on 4/19/24 at 11:04 AM, LVN 3 stated pain medication for Resident 33 was ordered as needed, but with Resident 33, pain medication is an everyday thing, and the resident would ask for it every 6 hours. LVN 3 also stated I did not give her pain medication that night, I should have. LVN 3 further stated pain medication needs to be given when requested (and) as ordered to get the patient comfortable and take care of the pain. During an interview with Quality Assurance (QA) and Director of Nursing (DON) on 4/19/24, at 1:17 PM, DON stated pain management is for resident comfort, quality of life and to promote resident functionality of day-to-day life. Pain medication needs to be given as ordered, if not given it (pain medication) may potentially affect their (residents) comfort and they (residents) may not be able to function due to discomfort which would affect their quality of life. A review of facility's policy and procedures titled Pain -Clinical Protocol with revised date of 6/2013, indicated, The physician and staff will identify individuals who have pain or who are at risk for having pain . Staff will assess pain using a consistent approach and a standardized pain assessment instrument appropriate to the residents cognitive level.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45528 Based on observation, interview and record review, the facility failed to prepare and store food in safe and sanitary condition and/or manner to prevent growth of microorganisms when: 1. Hairnets were not worn in the kitchen according to the facility's policy and procedures. 2. Hand hygiene and apron change were not performed during dishwashing when transition from dirty dishes to clean dishes. 3. Drinks and other food items were left at bedside for Resident 33 without proper storage and/or refrigeration for over 14 hours. Those deficient practices had the potential to cause foodborne illness (infections or irritations of the gastrointestinal tract caused by food or beverages that contain harmful bacteria, parasites, viruses, or chemicals) among 75 of 85 residents, who received the food from kitchen. Findings: a. A review of the Facility Resident Census and Minimum Data Set (MDS - a standardized assessment and care screening tool and matrix (is used to identify pertinent care categories), indicated there were nine of 85 residents were receiving tube feedings, and 75 of 85 residents were receiving diets from the facility's kitchen. During an initial kitchen tour on 4/16/24, at 7:39 AM, a staff was assisting with the breakfast tray line while hair net was partially on the staff's head leaving hair ponytail fully exposed. During an interview with Dishwasher (DW) on 4/16/24, at 7:40 AM, DW stated the hair net needs to cover all my hair, my ponytail is not covered. DW further stated potential adverse outcome of not wearing a hair net that does not cover the hair is that hair can get in the resident's food and cause an infection. During an observation in the kitchen on 4/17/24, at 9:52 AM, a staff loaded the dishwasher with dirty dishes and then transitioned to offload clean dishes from the dishwasher without performing hand hygiene or changing the apron. During an interview with Dietary Aid 1(DA 1) on 4/16/24, at 9:53 AM, DA 1 stated hand hygiene and apron change is supposed to be done when moving from dirty dishes to clean dishes to prevent infection that may make the residents sick. During a concurrent observation and interview with Dietary Aid 2 (DA 2) in the Kitchen, on 4/18/24 at 12:33 PM, DA 2 was in the Kitchen without a hairnet on. DA 2 stated, I need to put on a hairnet at the door before I come into the Kitchen to prevent infection which can make the residents sick. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview with Dietary Supervisor (DS) on 4/18/24, at 12:35 PM, DS stated hairnet needs to completely cover the hair; if hair is not completely covered, it (hair) may get in the food which could lead to infection that may cause diarrhea to the residents. DS further stated, during dishwashing, when moving from dirty dishes to clean dishes, hand hygiene and a change of apron needs to be done to prevent cross contamination which may lead to sicknesses such as vomiting and diarrhea. A review of the facility's Policy and Procedures (P&P) titled Preventing Foodborne Illness - Employee Hygiene and Sanitary Practices, dated 10/2023, indicated Food Services employees shall follow appropriate hygiene and sanitary procedures to prevent the spread of foodborne illnesses . Employees must wash their hands: .After handling soiled equipment's or utensils .to prevent cross contamination when changing tasks; and/or after engaging in other activities that contaminate the hands (ex. Dishwashing, food preparation . Hair nets or caps and/or beard restraints must be worn to keep hair from contacting, exposed food, clean equipment, utensils and linens. 45455 b. A review of Admission Record indicated Resident 31 was initially admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses that included osteoporosis (medical condition in which the bones become brittle and fragile from loss of tissue), atrial fibrillation (afib - an irregular and often very rapid heart rhythm), weakness and difficulty walking. A review of Resident 31's MDS dated [DATE], indicated Resident 31's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was intact. The MDS indicated Resident 31 was independent with eating but required setup or clean-up assistance with oral hygiene. During a concurrent observation and interview in Resident 31's room on 4/16/24, at 10:45 AM, Resident 31 was lying in bed awake. There were Five 8oz (Ounces) milk cartons and partially consumed food and drinks on Resident 31's bedside table. Resident 31 stated the five milk cartons had been on her bedside table for past 24 hours. Resident 31 stated the half drunken juice, the teacups with half consumed tea with tea bags had been on her bedside table since the previous night. Resident 31 further stated the covered container had a piece of cake that was given to her as dessert with the previous evening dinner. During an interview with Infection Prevention Nurse (IPN) on 4/16/24 at 10:55 AM, IPN stated, milk, juice, cake and tea from the previous evening and night were not supposed to be at bedside due to lack of proper storage and/or refrigeration. IPN stated consuming food that was not properly stored and/or refrigerated could lead pathogen (germ) exposure resulting in unnecessary hospitalization and/or poor health outcomes. During an interview with Director of Nursing (DON) and Quality Assurance nurse (QA) on 4/19/24, at 12 PM, DON stated food should not be left at bedside once a resident was done eating because the food can get spoilt with disease causing microorganisms. DON stated the consumption of spoilt food could lead to food borne illness, causing unnecessary hospitalization , poor outcomes and even death. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of facility policy and procedures (P&P) titled Food Stored in Residents Rooms, revised 7/14/2024, indicated, snacks stored in room must be kept to a minimum to prevent clutter. Food stored for later consumptions must be able to fit in bedside storage only and must be properly sealed/contained. Policy further states, food/drinks that are meant to be stored in the refrigerator may not be stored in resident's room, unless being consume at that time.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45455 Based on observation, interview and record review, the facility failed to provide at least 80 square feet (sq. ft. -unit of measure) per resident in multiple resident bedrooms for 38 out of the 38 resident rooms. 30 rooms consist of 2 beds each and 8 rooms consist of 3 beds in each room. This deficient practice had the potential to result in inadequate useable living space for the residents' safety and freedom and working space for the staff to provide resident care. Findings: A review of the Request for Room Size Waiver letter, dated 4/18/24, submitted by the Administrator (ADM), indicated there are 36 rooms not meeting the requirement of 80 square feet per resident according to federal regulation. The letter indicated that the room sizes would not interfere with the daily nursing care or safety of the residents. The letter also indicated there would be enough space to provide for each resident's care, dignity and privacy in those rooms which are in accordance with the special needs of the residents. The letter indicated the spaces would not have an adverse effect on the residents' health and safety or impede the ability of any resident in the rooms to attain his or her highest practicable well-being. A review of the undated Client Accommodations Analysis submitted by the facility indicated the following rooms with their corresponding measurements: Rooms # total Sq. Ft/Resident # Beds Floor Area Sq. Ft/Resident. room [ROOM NUMBER] is 154 square feet with 2 beds (77 square feet per resident) room [ROOM NUMBER] is 154 square feet with 2 beds (77 square feet per resident) room [ROOM NUMBER] is 154 square feet with 2 beds (77 square feet per resident) room [ROOM NUMBER] is 154 square feet with 2 beds (77 square feet per resident) room [ROOM NUMBER] is 154 square feet with 2 beds (77 square feet per resident) room [ROOM NUMBER] is 154 square feet with 2 beds (77 square feet per resident) room [ROOM NUMBER] is 154 square feet with 2 beds (77 square feet per resident) room [ROOM NUMBER] is 154 square feet with 2 beds (77 square feet per resident) room [ROOM NUMBER] is 154 square feet with 2 beds (77 square feet per resident) room [ROOM NUMBER] is 154 square feet with 2 beds (77 square feet per resident) (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	room [ROOM NUMBER] is 154 square feet with 2 beds (77 square feet per resident) room [ROOM NUMBER] is 154 square feet with 2 beds (77 square feet per resident) room [ROOM NUMBER] is 154 square feet with 2 beds (77 square feet per resident) room [ROOM NUMBER] is 154 square feet with 2 beds (77 square feet per resident) room [ROOM NUMBER] is 154 square feet with 2 beds (77 square feet per resident) room [ROOM NUMBER] is 154 square feet with 2 beds (77 square feet per resident) room [ROOM NUMBER] is 154 square feet with 2 beds (77 square feet per resident) room [ROOM NUMBER] is 154 square feet with 2 beds (77 square feet per resident) room [ROOM NUMBER] is 154 square feet with 2 beds (77 square feet per resident) room [ROOM NUMBER] is 154 square feet with 2 beds (77 square feet per resident) room [ROOM NUMBER] is 154 square feet with 2 beds (77 square feet per resident) room [ROOM NUMBER] is 154 square feet with 2 beds (77 square feet per resident) room [ROOM NUMBER] is 154 square feet with 2 beds (77 square feet per resident) room [ROOM NUMBER] is 154 square feet with 2 beds (77 square feet per resident) room [ROOM NUMBER] is 154 square feet with 2 beds (77 square feet per resident) room [ROOM NUMBER] is 154 square feet with 2 beds (77 square feet per resident) room [ROOM NUMBER] is 154 square feet with 2 beds (77 square feet per resident) room [ROOM NUMBER] is 154 square feet with 2 beds (77 square feet per resident) room [ROOM NUMBER] is 154 square feet with 2 beds (77 square feet per resident) room [ROOM NUMBER] is 154 square feet with 2 beds (77 square feet per resident) room [ROOM NUMBER]is 220 square feet with 3 beds (73 square feet per resident) room [ROOM NUMBER] is 220 square feet with 3 beds (73 square feet per resident) room [ROOM NUMBER]is 220 square feet with 3 beds (73 square feet per resident) room [ROOM NUMBER]is 220 square feet with 3 beds (73 square feet per resident) (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	room [ROOM NUMBER] is 220 square feet with 3 beds (73 square feet per resident) room [ROOM NUMBER] is 220 square feet with 3 beds (73 square feet per resident) room [ROOM NUMBER] is 220 square feet with 3 beds (73 square feet per resident) room [ROOM NUMBER] is 220 square feet with 3 beds (73 square feet per resident) The minimum square footage for a 2-bed room shall be 160 sq. ft. per federal regulation. During multiple observations of the residents' rooms from 4/17/24 to 4/18/24, the residents had ample space to move freely inside the rooms. There were sufficient spaces to provide freedom of movement for the residents and for nursing staff to provide care to the residents. There was also sufficient space for beds, side tables and resident care equipment. However, during an interview with Certified Nurse Assistant 3 (CNA 3) on 4/19/24 at 7:49 AM, CNA 3 stated the limited space in rooms made it difficulty when using a Hoyer lift (type of patient lifts used by caregivers to safely transfer patients from one place to another) for residents whose beds are close to the window.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48903 Based on observation, interviews, and record review, the facility failed to: 1. Provide functioning call light to one of six sampled residents (Resident 37). 2. Ensure call light was within reach for one of 28 sampled Residents (Resident 29). This deficient practice had the potential for staff not to the needs for Residents 37 and 29, which could result in physical and emotional harm to the residents. Findings: a. A review of Resident 37's Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included Type 2 Diabetes (a disease that results in blood sugar being too high), lung transplant, heart failure and major depressive disorder (decreased interest in pleasurable activities, feelings of guilt or worthlessness, lack of energy, poor concentration, appetite changes, psychomotor retardation or agitation, sleep disturbances, or suicidal thoughts). A review of Resident 38's History and Physical Examination dated 4/3/24 indicated, Resident 37 had the capacity to understand and make decisions. A review of Resident 37's Minimum Data Set (MDS- a standardized assessment and care screening tool) dated 3/15/24, indicated the resident had moderately intact cognition (capable of remembering, learning new things, concentrating, or making decisions that affect everyday life). MDS also indicated Resident 37 required substantial assistance from staff for hygiene (physical), dressing and toileting. A review of Resident 37's Care Plan, dated 3/11/24, indicated Resident 37 was at risk for fall and injury due to balance problem when standing/ambulating, due to impaired cognition/ poor safety awareness, and due to use of medication that could affect balance. During an interview with Resident 37 on 4/16/24 at 9:10 AM, Resident 37 stated he had a broken call light for days and was given a bell, but staff would not be able to hear the bell. During an interview with Maintenance Supervisor (MS) on 4/18/24 at 9:25 AM, MS stated, we have a maintenance log. Certified Nursing Assistants (CNA)s are trained to report malfunctioning equipment. We have a work order binder at the nurses' station. We check it every day. It's a very old call light system .We are trying to fix them. We have received a lot of reports that they are broken. If we don't have the parts needed to fix the call lights it will take a few days to receive them (the parts). We then provide them (residents) with call bells. During an interview with CNA 1 on 4/18/24 at 9:30 AM, CNA 1 stated, if a resident complains of a broken call light, we tell Charge Nurse, we tell maintenance person, about broken call light. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Social Worker (SW) on 4/18/24 at 9:54 AM, SW stated, residents will not be able to alert staff of needs if their call lights are not working, this delays care, they (residents) can have trouble breathing and not be able to receive help. A review of the facility's Maintenance Log dated for the month of 4/24, indicated Resident 37 reported that the call light for Resident 37, was broken and the resident was given a bell on 4/14/24. During an interview with Resident 37 on 4/18/24 at 12:56 PM, Resident 37 stated, my call light was not working for 5 days, and I got a bell. When I used the bell they did not come in a timely manner because it's hard for them to hear it. It made me feel frustrated and angry that nobody would come. I told the CNA and RN (Registered Nurse) and they said they would tell maintenance, but they (maintenance) never came. During an interview with Director of Nursing (DON) on 4/18/24 at 3:17 PM, DON stated, Malfunctioning Call lights are reported to the maintenance supervisor; we fill out the log to (request for a) repair. If there is no call light supplies available to fix it, a bell is provided to resident. I don't know how long it would take to obtain those supplies. DON stated the resident will not be able to ask for assistance if the call light is not working. DON further stated If a resident was having trouble breathing, there would be health consequences if the resident did not have a call light to call for help. A review of the facility's policy and procedures (P&P) titled, Building Systems Nurse's Call System, dated 1/1/15, indicated, It is the policy of this facility to maintain building systems in good working order, inspecting them at intervals which comply with state and federal standards to repair as necessary. Replace immediately defective light bulbs or buzzers and cords. Maintain a parts supply consisting of spare call cords, buttons, replacement lamps and fuses. 45455 b. A review of Admission Record indicated Resident 29 was initially admitted to the facility on [DATE], and was readmitted on [DATE], with diagnoses that included epilepsy (a disorder of the brain characterized by repeated seizures), asthma (a chronic disease in which the bronchial airways in the lungs become narrowed and swollen, making it difficult to breathe.) schizophrenia(a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions) and hemiplegia and hemiparesis (loss of strength in the arm, leg, and sometimes face on one side of the body) affecting the left non-dominant side. A review of Resident 29's MDS dated [DATE], indicated Resident 29's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was moderately impaired. The MDS indicated Resident 29 required substantial to maximum assistance with rolling from left to right, was totally dependent on staff for sit to lying position. Resident 29 was unable to move from a lying to sitting on the side of the bed or move from a sit to standing or transfer from chair to bed/chair. During a concurrent observation and interview with Resident 29 in Resident 29's room on 4/16/24, at 9:15 AM, Resident 29 was lying in bed awake. Resident 29's call light was observed to be hanging against the wall and not within the resident's reach. Resident 29 stated she is an asthmatic and is unable to reach her call light. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Certified Nurse Assistant 2 (CNA 2) on 4/16/24 at 9:18 AM, CNA 2 stated, we [staff] are supposed to be checking on residents frequently. CNA 2 stated Resident 29, is supposed to have her call light within reach on her right side. CNA 2 further stated staff would not know if the resident needed help immediately if the call light was not within reach for resident to call, CNA 2 stated not having a call light within reach could cause a delay in care, resulting in poor outcomes and/or unnecessary hospitalization and even death. During an interview with Director of Nursing (DON) and Quality Assurance (QA), on 4/19/24 at 11:45 AM, DON stated call light is a communication tool between staff and residents. DON stated staff must ensure call lights are reachable and available to all residents before exiting the residents' rooms, DON further stated If a call light was not within reach and the resident was in acute distress, there could be a delay in care because of the resident not being able to call for help, which might worsen the resident's medical condition. DON also stated a resident could end up in the hospital due to a change in condition caused by delay in care, resulting in unnecessary hospitalization and death if treatment and care were not provided timely. A review of facility policy and procedures titled Answering the call light, revised 10/2020, indicated the purpose of the procedure is to respond to the resident's request and needs, the policy further stated When the resident is in bed ., be sure the call light is within easy reach of the resident.