STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055353	A. Building B. Wing	04/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shoreline Healthcare Center	4029 East Anaheim Street Long Beach, CA 90804

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 44958 45537 Based on observation, interview and record review, the facility failed to ensure a comprehensive care plan was: 1. implemented for 1 of 3 sampled residents (Resident 114) when nursing staff assist Resident 114 with fracture of the fourth thoracic vertebrae (upper back) during her turning and repositioning in bed), 2. revised for 1 of 3 sampled residents (Resident 115) to include a dialysis emergency kit (E-Kit- supplies including gauze, tape and clamp used to stop bleeding) in Resident 115's interventions to address possible bleeding emergencies. 3. formulated for 1 of 3 sampled residents (Resident 53) who was prescribed and taking a medication Plavix (a medication used to prevent clots forming in the blood vessels to prevent a stroke, heart attack or death, with prolonged and excessive bleeding as an adverse or side effect). These failures had caused Resident 114 to be uncomfortable when assisted by the nursing staff during turning and repositioning and had the potential for delay of care and services to Resident 115 and Resident 53. Findings: A. During a review of Resident 114's Admission Record, the admission record indicated Resident 114 was admitted to the facility on [DATE] with diagnoses including fracture of the fourth thoracic vertebrae (upper back), fracture of one rib on left side and atrial fibrillation (irregular and fast heartbeat). During a review of Resident 114's history and physical (H/P), dated 4/12/2024, the H/P indicated Resident 114 can understand and be understood by others. During an interview on 4/13/2024, at 7:30 a.m., Resident 114 stated, I have a rib fracture on my left side, but it hurts when the staff moves me in bed. I do not think they know it is broken. I wish they would be gentler when they move me around the bed (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 4/14/2024, at 8:20 a.m., with Resident 114 in her room, Resident 114 was observed to be in her hospital gown sitting straight up in bed. Resident 114 stated it hurts to be sitting up in this position because I have broken ribs. I don't think the certified nurse assistants (CNAs) and nurses know my ribs are broken unless I tell them. During an interview on 4/14/2024, at 8:47 a.m., CNA 1 stated she is assigned to take care of Resident 114CNA 1 stated she was not informed of any fractures for Resident 114 . CNA 1 stated if she had been informed by the off going nurse she would be able to take special care of Resident 114 to avoid causing her additional pain when she positioned her in bed. During a review of Resident 114's, care plan dated 4/13/2024, the care plan indicated Resident 114 had an alteration in musculoskeletal (related to muscles, bones, tendons, ligaments) status related to nondisplaced (break in bone but no change in bone's alignment) left fourth rib fracture. The care plan indicated the following goals, Resident 114 will remain free from pain or at a level of discomfort acceptable to the resident through the review dated on 7/11/2024, the resident will remain free of injuries or complications through review date on 7/11/2024. The care plan indicated the following interventions, anticipate, and meet needs, be sure call light is within reach and respond promptly, educate resident/family/caregivers on joint conservation techniques, follow MD orders for weight bearing status, give analgesia (pain medications as ordered by the physician). Monitor and document for side effectives and effectiveness, monitor for side effects to NSAIDS (pain medications) such as gastrointestinal (includes mouth, throat, stomach, intestines, rectum) bleeding or renal(kidney-body part that filters out toxins out of blood) impairment, monitor for fatigue, plan activities during optimal times when pain and stiffness is abated, monitor risk for falls, educate resident, family and caregivers on safety measures that need to be taken in order to reduce risk of falls. During an interview on 4/14/2024, at 5 p.m., the Director of Nursing (DON) stated, Resident 114's care plans should be reviewed with the CNA's that provide the care. The DON stated all nursing staff that care for Resident 114 should be aware of Resident 114's rib fractures to ensure they are not causing discomfort or pain to Resident 114. The DON stated care plans are used for nursing staff to plan residents' care and for consistency in care to ensure residents receive necessary care and services. B. During a review of Resident 115's Admission Record, the admission record indicated Resident 115 was admitted to the facility on [DATE] with diagnoses including end stage renal disease (Kidneys [part of body that filters out toxins in blood] stop working), muscle weakness and atrial fibrillation. During a review of Resident 115's H/P dated 4/3/2024, the H/P indicated Resident 115 had the capacity to understand and make decisions. During an interview on 4/13/2024, at 7:30 a.m., Resident 115 stated, I go to dialysis (treatment that filters toxins out of blood, when kidneys stop working) on Tuesdays, Thursdays, and Saturdays. During a review of Resident 115's , care plan dated 4/13/2024, the care plan indicated Resident 115 had renal insufficiency (kidney do not work as well as they should) related to End Stage Renal Disease (ESRD-when kidney [part of the body that filters blood and toxins] no longer work), the care plan indicated the following goals, Resident 115 will have no signs and symptoms (s/s) of complications related fluid deficit through review date of 7/2/2024,. CP did not indicate that Resident 115 needs dialysis E-kit at the bedside. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/14/2024, at 1 p.m., Registered Nurse (RN) 1 stated, Resident 115 is a dialysis resident and must have an emergency kit (E-kit includes a tape, gauze, tourniquet and tongue depressor and clamp) available at bedside in case Resident 115 has a bleeding emergency. RN 1 stated Resident 115 should have a care plan reflecting the interventions nursing staff must implement in case of a bleeding emergency and the E-Kit is one of those interventions. During an interview on 4/14/2024, at 5 p.m., the Director of Nursing (DON) stated, Resident 115's care plans did not include an emergency kit (E-Kit) to be at bedside in case of emergency. The DON stated the E-Kit holds supplies nurses will use if Resident 115's dialysis access site starts bleeding. The DON stated the nursing staff must use, review, and revise resident care plans to reflect their resident specific needs. The DON stated failing to revise Resident 115's care plan to include the E-kit places Resident 115 at risk for a delay of care and services. C. During a review of Resident 53's Admission Record (face sheet), the face sheet indicated Resident 53 was admitted to the facility on [DATE] with diagnoses including cerebral infarction (also known as stroke- a medical condition that happens when there is a loss of blood flow to the part of the brain). During a review of Resident 53's Order Summary Report dated 4/2024, the Order Summary Report indicated Resident 53 was prescribed by her physician and has been taking a medication Plavix 75 (seventy-five) mg (a unit of measurement used to determine the amount or dosage of a medication or substance) by mouth daily since 2/27/2024. During a review of Resident 53's comprehensive care plan, the care plan did not indicate a specific plan of care aimed to identify the risks, side effects/ adverse effects and interventions for Resident 53 while taking the medication Plavix. During a review of Resident 53's Minimum Data Set ([MDS] a standardized assessment and care screening tool), dated 3/4/2024, the MDS indicated the MDS indicated Resident 53 was able to make independent decisions that were reasonable and consistent. During an observation and interview on 4/13/2024 at 7:50 a.m., Resident 53 stated she had a stroke, and she is taking a blood thinner medication, but she does not know the side effects of the medication. During an interview and concurrent record review on 4/14/2024 at 2:24 p.m., Licensed Vocational Nurse 1 (LVN 1) stated Resident 53 has no plan of care while prescribed and/ or taking Plavix. LVN1 stated a care plan that specify and/ or help identify the overt (can be seen) and covert (hidden) side effects and /or adverse effects of the medication Plavix is necessary so the licensed staff can escalate (rapid and accelerate) Resident 53's care as needed. LVN1 stated formulating a care plan should also involve education of the resident and their family. During an interview on 4/1/4/20204 at 2:46 p.m., Registered Nurse 1 (RNS 1) stated a change of condition can be missed if the resident has no plan of care and there is a possibility of delay of care and services. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/14/2024 at 5:27 p.m., the Director of Nursing (DON) stated the resident care plan is a tool to administer, monitor and evaluate the effectivity of the residents' interventions and to identify any, if not, all side effects and/ or adverse reactions on all medication prescribed to the residents. The DON stated the residents' plan of care must ensure provision of timely care and services. During a review of the facility's policy and procedure, (P/P) titled, Comprehensive Resident Centered Care Plan revised January 2021, the P/P indicated it was the policy of the facility that the interdisciplinary team (IDT- team of medical professionals and the Resident and or Resident's representative) shall develop and implement a comprehensive person-centered care plan for each resident.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44958 Based on observation, interview, and record review, the facility failed to ensure two of three sampled residents (Resident 27 and Resident 116) received care consistent with standards of practice by failing to: A. monitor Residents 116's left upper extremity for skin breakdown per care plan and physician orders. B. monitor Resident 27 for the side effects of Aspirin (medication to thin blood) consistent with the facility policy. These deficient practices: A. resulted in a delay in care and services for Resident 116, whose wound on the left upper extremity was not assessed and not treated for approximately six hours leading to discomfort and risk or skin infections. B. resulted in a lack of assessment for Resident 27 and the potential to cause a delay in needed services. Findings: A. During a review of Resident 116's Admission Record (Face Sheet), the Face Sheet indicated Resident 116 was admitted to the facility on [DATE] with diagnoses including Parkinson's Disease (brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination)unsteadiness on feed and type two diabetes mellitus (disease when body cannot control the amount of blood sugar in the body). During a review of Resident 116's History and Physical (H/P), dated 4/10/2024, the H/P indicated Resident 116 could understand and be understood by others and can make his needs known. During a concurrent observation and interview on 4/14/2024 at 8:24 a.m. with Resident 116, in Resident 116's room, Resident 116 was observed to be sitting on the edge of his bed. Resident 116 was observed to have areas of reddened discoloration on the left upper extremities and an area of reddened open skin near his left elbow. Resident 116 said I think I hit my arm this morning and tore my skin and told the nurses this morning, but no one has done anything, Resident 116 added wish they would do something about it, it is uncomfortable. Resident 116 stated Licensed Vocational Nurse (LVN) 2 gave him his scheduled morning medications but did not assess his skin or treat his wound. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of Resident 116's care plan dated 4/10/2024, the care plan indicated Resident 116 had actual impairment related to skin injury related to skin discoloration related to left upper extremity, the care plan indicated the following goals, Resident 116 will have no complications related to skin injury through the review date on 7/9/2024, the care plan indicated the following interventions, encourage good nutrition and hydration in order to promote healthier skin, identify and document potential causative factors and eliminate/resolve where possible, keep skin clean and dry , use lotion on dry skin, provide treatment as ordered. During a review of Resident 116's physician orders dated 4/9/2024 through 4/15/2024, the orders indicated to start on 4/10/2024, left upper extremity multiple discoloration, monitor for changes such as hematoma (bruise), skin breakdown and notify MD if any for seven days. During an interview on 4/14/2024, at 2:27 p.m., LVN 2, stated she is Resident 116's assigned nurse for today's shift 7pm through 3pm. LVN 2 stated she administered medication to Resident 116 at approximately 10 am and 1pm, LVN 2 stated she did not assess Resident 116's skin during her shift because she was not informed by Resident 116's CNA of any changes in Resident 116's skin. LVN 2 stated, I will assess a resident's skin if a CNA alerts me to a change. I was not aware of any new skin changes in Resident 116, but I knew Treatment nurse (TN) 1 would be coming to check Resident 116 later that day. During an interview on 4/14/2024, at 3:40 p.m., TN 1 stated during today's shift at approximately 2pm, she observed on Resident 116's, a new skin abrasion near the left elbow. The TN 1 stated Resident 116 has a physician's order and a care plan addressing the need to monitor Resident 116's for skin changes. The TN 1 stated, I did not see Resident 116 until around 2pm. The TN 1 stated, Resident 116's assigned CNA and LVN should have observed the skin change while providing Resident 116 care throughout the morning (7am -3pm) shift. The TN 1 stated Resident 116 received a delay in care and services for wound treatment. During an interview on 4/14/2024, at 5 p.m., the DON stated Resident 116 has a physician order and care plan indicating the need to monitor and document any changes to Resident 116's skin. The DON stated the assigned CNA should have completed a C.N.A skin observation (indicates if a resident has any bruising, skin tears, red areas, open areas and rashes) document during the start of the shift for Resident 116. The DON stated, during LVN 2's morning and or afternoon medication pass, Resident 116 should have been assessed for skin changes. The DON stated all licensed nurses can initiate a change of condition; the nursing staff does not have to wait for a treatment nurse to complete her rounds The DON stated Resident 116 had a delay in care and services of approximately five hours. The DON stated failing to properly to assess Resident 116 's skin resulted in Resident 116's discomfort and put it him at risk for infection. During a review of the facility's policy and procedure, (P/P) titled, Comprehensive Resident Centered Care Plan revised January 2021, the P/P indicated it was the policy of the facility that the interdisciplinary team (IDT- team of medical professionals and the Resident and or Resident's representative) shall develop and implement a comprehensive person-centered care plan for each resident , consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing and mental and psychosocial needs that are identified in the comprehensive assessment. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. During a review of Resident 27's Admission Record, the Admission Record indicated Resident 27 was admitted to the facility on [DATE]. Resident 27's diagnosis included cerebral infarction (stroke- lack of blood flow to brain), diabetes mellitus type 2 (condition when sugar in the blood too high), myocardial infarction (heart attack-lack of blood flow to heart). During a review of Resident 27's H/P dated 4/2/2024, the H/P indicated Resident 27 had the capacity to understand and make decisions. During a review of Resident 27's Minimum Data Set (MDS- comprehensive assessment and screening tool) dated 4/2/2024, the H/P indicated Resident 27 had the capacity to understand and make decisions. During a review of Resident 27's Physician's orders dated 4/1/2024 through 4/30/2024, the Physician orders indicated Aspirin 81 milligrams (mg- unit of measurement), give 1 tablet by orally (by mouth) one time a day for blood thinner (prevents blood clots). During a review of Resident 27's Medication Administration Record (MAR) dated 4/1/2024 through 4/30/2024, the MAR indicated Resident 27 was receiving one tablet of Aspirin 81 mgs by mouth one time a day. During an interview on 4/14/2024, at 2:27 p.m., LVN 2, stated she is Resident 27's assigned nurse for today's shift 7pm through 3pm. LVN 2 stated she administered Aspirin to Resident 27 at approximately 9 am, LVN 2 stated she did not assess Resident 27's skin during her shift because she was not informed by Resident 27's CNA of any changes in Resident 116's skin. LVN 2 stated, I will assess a resident's skin if a CNA alerts me to a change. I was not aware of any new skin changes in Resident 27. LVN 2 stated Resident 27 is at risk for increased bleeding, and she should have checked Resident 27's skin for new skin changes such as bruising, cuts or bruising. During a concurrent interview and record review, on 4/14/2024, at 5:30 p.m., with the Director of Nursing (DON), Resident 27's physician orders, care plans, C.N.A skin observation document and nurse's notes were reviewed. The DON stated based on the review of Resident 27's records, Resident 27 has not been monitored for the side effects of Aspirin. The DON stated there is no physician order to monitor for Aspirin and there is no care plan addressing Resident 27's prescribed Aspirin. The DON stated the nursing staff must monitor Resident 27 for signs of bleeding such as bruising, blood in stool, cuts, and abrasions on the skin. The DON stated failure to monitor Resident 27 for the side of effects of Aspirin resulted in the lack of assessments which can lead to a delay of treatment and services. During a review of the facility's policy and procedure, (P/P) titled, Administration Procedures for all medications revised October 2019, the P/P indicated monitor resident for side effects or adverse drug reactions immediately after administration and throughout the shift. During a review of the facility's policy and procedure, (P/P) titled, Quality of Care revised June 2023, the P/P indicated it is the policy of the facility that residents are given treatments and services to maintain or improve their abilities.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44958 Based on interview and record review, the facility failed to follow the physician order for Restorative Nursing Assistant (RNA- nursing aide program that helps residents maintain their function and joint mobility) program for one of three sampled residents (Resident 10) when RNA was provided four times a week instead of five times a week as per the physician order. This deficient practice had a potential to place Resident 10 at risk for a decline in range of motion (ROM). Findings: During a review of Resident 10's Admission Record, the record indicated Resident 10 was admitted on [DATE] with the diagnoses including a history of falling and difficulty in walking. During a review of Resident 10's Minimum Data Set ([MDS]-a standardized assessment and care screening tool) dated 3/12/2024 indicated Resident 10's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was moderately impaired and Resident 10 was dependent on facility staff for activities of daily living (ADLs- eating, dressing, walking, and toileting). During a review of Resident 10's physician order dated 6/23/2023, the order indicated Resident 10 was to receive RNA daily 5 times a week for active assisted range of motion (AAROM) to bilateral lower extremities as tolerated. During a review of Resident 10's Restorative nursing flowsheet for the 4/2024, the flowsheet indicated Resident 10 received RNA on the following dates: 4/1/2024, 4/2/2024, 4/3/2024, 4/4/2024, 4/8/2024, 4/9/2024, 4/10/2024, and 4/12/2024. During an interview on 4/14/2024 at 9:00am with Restorative Nursing Assistant 1 (RNA 1), RNA 1 stated sometimes Resident 10 will refuse RNA but the RNA's should document their initials in the box. RNA 1 stated there was no documentation of Resident 10 refusing RNA. RNA 1 stated if Resident 10 refuses, the RNA's will try to see Resident 10 on another day. RNA 1 could not provide the risk of Resident 10 not being provided the ordered frequency of RNA per the physician order. During an interview on 4/14/2024 at 5:22 p.m. with the Director of Nursing (DON), the DON stated the purpose of the RNA program is to maintain the resident's functional mobility, without the RNA program, the resident could suffer a decline in ROM if not being performed. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/14/2024 at 5:43 p.m. with the Director of Staff Development (DSD), the DSD stated blank squares on the Restorative Nursing Flowsheet indicated RNA was not provided on those days. The DSD stated if the resident is refusing RNA, there should be documentation of the refusal and how the RNA's should offer to residents at least 3 times and the interventions that were provided. The DSD stated if a resident does not receive RNA, the resident could develop blood clots and they can become stiff. The DSD stated participating in the RNA program can also help with the resident's mental health. During a review of the facility's policy titled ROM and Contracture Prevention dated 5/2019, the policy indicated it is the policy of the facility to ensure the residents receive services, care, and equipment to assure that every resident maintains, and/or improves to his/her highest level of range of motion and mobility.

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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** 45425 Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 47) medication regimen review (MRR-) thorough evaluation of the medication regimen of a resident) order clarification for Ibuprofen (medication is used to treat pain) to be given with food was acted upon. This deficient practice had the potential to result in Resident 47 experiencing side effects of being administered Ibuprofen (Non-steroidal anti-inflammatory drugs (NSAIDs) are medicines that are widely used to relieve pain, reduce inflammation, and bring down a high temperature.) on an empty stomach. Findings: During a review of Resident 47's Admission Record (Face Sheet), the record indicated Resident 47 was admitted on [DATE] with the diagnosis of orthostatic hypotension (low blood pressure when standing after the person has been sitting or lying down) and syncope (fainting or passing out). During a review of Resident 47's Minimum Data Set ([MDS]- a standardized assessment and screening tool) dated 2/7/2024, the MDS indicated Resident 47's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was intact and required partial/moderate assistance (helper provides assistance through verbal cues and steadying) to complete activities of daily living (ADLs- toileting, bathing, eating and dressing). During a review of Resident 47's physician order dated 1/31/2024, the order indicated Ibuprofen oral tablet 400 miligrams (mg-unit of measurement) to be given one tablet orally every six hours as needed for pain mild to moderate (1-6 on the pain scale). During a review of Resident 47's consultant pharmacist's medication regimen review (examination of a resident's medication by a pharmacist) dated 3/1/2024, the review indicated to clarify the order for Ibuprofen to include to give the medication with food. During an interview on 4/14/2024 at 12:29 p.m. with the Assistant Director of Nursing (ADON) and the Director of Nursing (DON), the ADON stated the pharmacist's MRR order clarification for the Ibuprofen was not followed up with the physician. The ADON stated the purpose of the MRR was to see if orders needed to be clarified, if medication doses needed to be adjusted or if medications have black box warnings (alert health care providers to serious side effects, such as injury or death). The ADON stated if the medication regimen review recommendations are not completed it can affect the resident in various way dependent on the medication. During a review of the facility's policy titled Medication (Drug) Regimen Review (MRR) revised date 12/2023 indicated the report should be provided to the responsible physician by the facility within seven working days of review. The policy indicated communication and physician response will be documented in the clinical record, along with any new orders or changes to medication regimen.

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Shoreline Healthcare Center	4029 East Anaheim Street Long Beach, CA 90804

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45425 Based on observation, interview and record review, the facility staff failed to: 1. Properly store lentils and black beans according to the facility's policy and procedure. 2. Properly place thawing meat such as fish and chicken appropriately in the refrigerator when the thawing fish was placed on top of hard-boiled eggs and raw vegetables were placed next to thawing chicken. These deficient practices have the potential to place 62 residents who are served food from the facility's kitchen at risk for foodborne illness. Findings: During an observation on 4/13/2024 at 6:47 a.m. of the facility's dry food storage, there was one open bag of lentils and one open bag of black beans both closed with plastic ties. During an observation on 4/13/2024 at 7:05 a.m. of the facility's #1 refrigerator, there was chicken defrosting at the bottom of the refrigerator in red liquid at a metal tray next to a plastic bin of raw vegetables that has cabbage and zucchini. It was observed in the facility's #1 refrigerator, at the third shelf, there was raw fish on ice defrosting in a metal tray, the metal tray was on top of a box of hard-boiled eggs. During an interview on 4/13/2024 at 7:06 a.m. with the Cook, the Cook stated the raw chicken and fish should be on the bottom of the refrigerator to avoid cross contamination with other food such as the hard-boiled eggs and the raw vegetables. The Cook stated if the food gets contaminated, there is the potential the residents could be sick. During an interview on 4/13/2024 at 2:28 p.m. with Dietary Supervisor (DS), the DS stated defrosting meat should be stored on the bottom of the refrigerator next to other items that are defrosting to avoid any drippage from the raw meat causing cross contamination. The DS stated if there is cross contamination, it can make the residents sick. The DS stated dry goods such as beans and lentil should be stored in a container with a tight lid to ensure no pests can go in the dry goods. During a review of the facility's policy titled Thawing of Meat undated, the policy indicated thaw meat should be stored on the bottom shelf below prepared and ready to eat food. The policy indicated to avoid cross contamination from water dripping from food or splashing onto other foods. During a review of the facility's policy titled Storage of Food and Supplies undated, the policy indicated dry bulk food such as dry beans should be stored in seamless metal or plastic containers with tight covers.

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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** 45425 Based on interview and record review, the facility staff failed to maintain an accurate documentation of Restorative Nursing Assistant (RNA- nursing aide program that helps residents maintain their function and joint mobility) weekly progress report for one of two sampled residents (Resident 48) when the report dated 4/10/2024 was not complete. This deficient practice placed Resident 48 at risk for a decline or improvement in RNA progress to go undocumented. Findings: During a review of Resident 48's Admission Record, the record indicated Resident 48 was admitted on [DATE] with the diagnoses including difficulty walking and muscle weakness. During a review of Resident 48's Minimum Data Set ([MDS]-a standardized assessment and care screening tool) dated 1/31/2024 indicated Resident 48's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was intact. During a review of Resident 48's RNA weekly progress report dated 4/10/2024 was blank. During an interview on 4/14/2024 at 5:22 p.m. with the Director of Nursing (DON), the DON stated the medical record should be complete and accurate. The DON stated the progress report tracks and monitors if a resident has a decline, and if there is no documentation then the record is not accurate. During an interview on 4/14/2024 at 5:43 p.m. with the Director of Staff Development (DSD), the DSD stated the weekly progress report should be complete and accurate. The DSD stated if there is no documentation then the activity did not happen. During a review of facility's policy titled ROM and Contracture Prevention dated 5/2019, the policy indicated appropriate documentation should be completed to address goals of the

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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. 45425 Based on observation, interview and record review, the facility failed to ensure two of two sampled residents (Resident 164 and Resident 2) were free from risk of contracting infection when: a. the facility failed to properly store one of one sampled resident's (Resident 164) oxygen tubing (a device that provides additional oxygen through the nose) when Resident 164's oxygen tubing was found on the floor. b. Resident 2's foley catheter (a tube that is inserted into the bladder, allowing the urine to drain freely into a collection bag, which must be strapped and/ or secured) was not secured to prevent from touching the floor. These deficient practices have the potential to spread germs and bacteria from the floor to Resident 164 and Resident 2. Findings: A. During an observation on 4/13/2024 at 8:10 a.m., in Resident 164's room, Resident 164's oxygen tubing was found on the floor to the right of Resident 164's bed. During an interview on 4/13/2024 at 8:10 a.m., with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated the oxygen tubing should not be on the floor. LVN 1 stated the oxygen tubing should be stored curled up in a plastic bag and not be on the floor because there is a potential for the oxygen tubing to become exposed to infectious bacteria. During an interview on 4/14/2024 at 5:22p.m., with the Director of Nursing (DON), the DON stated an oxygen tubing should be stored in a plastic bag to prevent it from touching the floor. The DON stated if the oxygen tubing touches the floor, it is an infection control issue, which could expose the resident to harmful bacteria. During a review of the facility's policy and procedure (P/P) titled Oxygen, Use of revised in 5/2021, the P/P indicated the tubing should be kept off the floor. The P/P indicated labeled and dated bags should be provided for the tubing to be placed in when not in use. B. During an observation on 4/13/2024 at 7:21 a.m., Resident 2's foley catheter was found unsecured in a privacy bag and was touching the floor. During an interview on 4/13/2024 at 7:21 a.m., with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated the foley catheter should be secured inside the privacy and should not touch the floor because this could cause an infection to Resident 2. During an interview on 4/13/2024 at 7:30 a.m., with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated aside from privacy and/or dignity concerns, an unsecured foley catheter touching the floor is a risk of infection to Resident 2 because of germs and bacteria being present on the floor. (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 4/14/2024 at 3:07 p.m., with Registered Nurse 1 (RN 1), RN 1 stated if the foley catheter is on the floor, this could cause tension and/or discomfort to Resident 2 and Resident 2 will be exposed to germs and/or bacteria from the floor. During an interview on 4/14/2023 at 3:27 p.m., with Infection Control Nurse (IPN), the IPN stated the foley catheter must always be off the ground to ensure proper infection control procedures. During an interview on 4/14/2024 at 5:18 p.m., with the Director of Nursing Services (DON), the DON stated all staff must make sure the foley catheter of the residents must not touch the floor to prevent risks of infection that could be detrimental to their overall health and well-being. During a review of the facility's policy and procedure (P/P) titled Indwelling Urinary Catheter Care revised 12/2023, the P/P indicated the facility must ensure that each resident with an indwelling catheter will receive catheter care daily, secure the device and cover the drainage bag with a privacy bag to ensure hygiene, comfort and decrease the risk of infection. 45537

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45425 Based on interview and record review, the facility failed to implement the antibiotic stewardship program policy for three of three sampled residents (Resident 27, 59 and 164) by not completing the McGreer's Criteria (criteria used to determine appropriate use of antibiotics). This deficient practice had the potential to increase antibiotic resistance and provide antibiotics without justification. Findings: During a review of Resident 27's Admission Record, the record indicated Resident 27 was admitted on [DATE] with the diagnoses including urinary tract infection (bacterial infection of the bladder). During a review of Resident 27's Minimum Data Set ([MDS]-a standardized resident assessment and care screening tool) dated 4/2/2024 indicated Resident 27's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was intact and Resident 27 required supervision from facility staff to complete activities of daily living (ADLs- eating, drinking, dressing and toileting). During a review of Resident 27's physician order dated 4/1/2024, the order indicated Ceftriaxone sodium injection solution (medication for treatment of an infection) give 2 grams intravenously (IV-through access into the veins) one time a day for sepsis (a serious condition in which the body responds improperly to an infection) and UTI until 4/5/2024. During a review of Resident 27's Infection Surveillance report dated 4/1/2024, the report indicated under the Infection Preventionist Note section the neither the box next to meets criteria for infection and does not meet criteria was not marked. During a review of Resident 59's Admission Record, the record indicated Resident 59 was admitted on [DATE] with the diagnosis including pneumonia (an infection of the lungs that may be caused by bacteria, viruses, or fungi). During a review of Resident 59's MDS dated [DATE], the MDS indicated Resident 59's cognition was intact and Resident 59 required partial to moderate assistance (helper lifts, holds or supports trunk or limbs but provides less than half the effort) to complete ADLs. During a review of Resident 59's physician order dated 4/2/2024, the order indicated Piperacillin (medication for treatment of an infection) give 2.25 grams IV every 12 hours for infection for three days. During a review of Resident 59's physician order dated 4/2/2024, the order indicated Vancomycin (medication for treatment of an infection) give 1 gram IV every 12 hours for pneumonia for three days. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 59's Infection Surveillance report dated 4/2/2024 and signed 4/15/2024, the report indicated under the Infection Prevention Note section the box next to meets criteria for infection was marked. During a review of Resident 164's Admission Record, the record indicated Resident 164 was admitted on [DATE] with the diagnosis including UTI. During a review of Resident 164's MDS dated [DATE], the MDS indicated Resident 164's cognition was moderately impaired and Resident 164 required partial to moderate assistance in completing ADLs. During a review of Resident 164's physician order dated 4/3/2024, the order indicated Cefepime to give 2 grams IV two times a day for septic shock (a life-threatening condition that happens when your blood pressure drops to a dangerously low level after an infection) until 4/9/2024. During a review of Resident 164's Infection Surveillance report dated 4/8/2024, the report indicated under the Infection Preventionist Note section, neither box next to does not meet criteria and meets criteria for infection are marked. During an interview on 4/13/2024 at 3:40 p.m. and a subsequent interview on 4/14/2024 at 4:39 p.m. with the Infection Prevention Nurse (IP), the IP stated for Resident 164, she was not working when the antibiotic was ordered for Resident 164. The IP stated that she only works Monday to Wednesday, so she started the surveillance form when she returned to work on 4/8/2024. For Resident 59 and 27, the IP stated that for Resident 59 and 27 she was still trying to finish the surveillance forms for the residents. The IP stated the purpose of the surveillance form was to determine if the antibiotic meets the criteria and to decrease the growing numbers of antibiotic resistant organisms. The IP was not sure who follows up when antibiotics are ordered when she is not working. The IP stated if the surveillance is not completed timely, the resident might be getting an antibiotic when it is not indicated. During an interview on 4/14/2024 at 5:22 p.m. with the Director of Nursing (DON), the DON stated the purpose of the antibiotic stewardship program is to identify the right medication for the correct indication. The DON stated the antibiotic stewardship program is significant because of the increase of antibiotic resistant bacteria. During a review of the facility's policy titled Antibiotic Stewardship dated 12/2023, the policy indicated the team will assess residents for any infection using McGeer's criteria. The policy indicated the Infection Preventionist or designee will be responsible for infection surveillance.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. 45537 Based on observation, interview and record review, the facility failed to ensure the call lights of two of two sampled residents (Resident 53 and Resident 42) were fixed in a timely manner. This failure has the potential for delay of care and services to Resident 53 and Resident 42. Findings: A. During a review of Resident 53's Admission Record (face sheet) dated 2/26/2024, the face sheet indicated Resident 53 was admitted to the facility with diagnoses including cerebral infarction (also known as stroke- a medical condition that happens when there is a loss of blood flow to the part of the brain). During a review of Resident 53's Minimum Data Set ([MDS] a standardized assessment and care screening tool), dated 3/4/2024, the MDS indicated the MDS indicated Resident 53 was able to make independent decisions that were reasonable and consistent, requires one-person substantial/ maximal assist (helper does more than half the effort, the helper lifts or holds trunk or limbs and provides more than half the effort) to complete her activities of daily living ({ADLs} task such as bathing/ showering, dressing and mobility {chair/bed-to-chair transfer, repositioning in bed and walking in and out of the facility}) and was incontinent (has no control) of bladder and bowel functions. During a concurrent observation and interview on 4/13/2023 at 7:50 a.m., Resident 53 stated her call light is not working and it has been a while that it's nonfunctioning and she has not been helped to move in bed. Resident 53 stated she told the head nurse about the call light. During an observation on 4/13/2024 at 8:26 a.m.-8:36 a.m., Resident 53 pressed the button of her call light and observed the following: a. the call light indicator on top of her door did not light up, b. the call light panel in the nursing station did not light up, and c. there was no sound of a call light heard in the hallway. d. there was no staff assisting Resident 53. B. During a review of Resident 42's Admission Record (face sheet) dated 11/20/2023, the face sheet indicated Resident 42 was admitted to the facility with diagnosis including sepsis (a serious condition in which the body responds to an infection by causing the body organs to work poorly and eventually damaging the lungs, kidneys, liver and other organs), difficulty walking and diabetes mellitus (a disease that occurs when the blood glucose, also knows and blood sugar, is too high). (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 42's Minimum Data Set ([MDS] a standardized assessment and care screening tool), dated 3/29/2024, the MDS indicated the MDS indicated Resident 42 was able to make independent decisions that were reasonable and consistent, requires one-person substantial/ maximal assist (helper does more than half the effort, the helper lifts or holds trunk or limbs and provides more than half the effort) to complete her activities of daily living ({ADLs} task such as bathing/ showering, dressing and mobility {chair/bed-to-chair transfer, repositioning in bed and walking in and out of the facility}), had a foley catheter (a tube that is inserted into the bladder, allowing the urine to drain freely into a collection bag, which must be strapped and/ or secured) and was continent (has full control) of bowel functions. During an observation and interview on 4/13/2024 at 8:57 a.m., Resident 42 pressed the button of her call light and stated her call light was not working because she had been waiting for 2 hours for her nurse to assist her with toileting. Resident 42 stated she felt uncomfortable sitting on her feces (human body's waste left over from eating food) and she told the nurse supervisor a while back about the call light. During an observation on 4/13/2024 at 9:09 a.m.-9:20a.m., Resident 42 pressed the button of her call light and observed the following: a. the call light indicator on top of her door did not light up, b. the call light panel in the nursing station did not light up, c. there was no sound of a call light heard in the hallway, and d. there was no staff assisting Resident 42. During an observation and interview on 4/13/2024 at 9:45 a.m., the Director of Staff Development (DSD) tested the call lights of Resident 42 and Resident 53 and confirmed the call lights of Resident 42 and Resident 53 were not functioning properly. The DSD stated the staff are rounding and present in the facility 24 (twenty-four) hours and must not miss addressing a malfunctioning call light. During an interview on 4/13/2023 at 9:51 a.m., the Registered Nurse 1 (RN 1) stated Resident 42 and Resident 53 were both able to express their needs and require assistance with their ADLs. RNS 1 stated the maintenance crew should have been called to fix the malfunctioning call lights immediately. During an interview and record review on 4/13/2024 at 4:15 p.m., the Maintenance Supervisor (MS) stated the staff who identifies the malfunctioning call lights must inform their supervisor immediately so the maintenance team can fix the call lights immediately. During an interview on 4/14/2024 at 5:32 p.m., the Director of Nursing (DON) stated if call lights are not functioning properly the residents' needs are not attended promptly and is a safety risk to their well-being. During an interview on 4/15/2024 at 1:45 p.m., the Administrator (ADM) stated a malfunctioning call light is a major concern and the facility must acknowledge the problem and the call light should be fixed immediately. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P/P) titled, Call light/ Bell revised 5/ 2007, the P/P indicated the facility must provide each resident a means of communication with the (nursing) staff so their needs and/ or requests will be answered within a reasonable time. The P/P indicated if the call light is defective, the staff must immediately report this information to the unit supervisor.