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	04/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 45891 Based on observation, interview, and record review, the facility failed to ensure the protection and promotion of Resident Rights for one of six sampled residents (Resident 21) by not covering Resident 21's genital area and failing to close the privacy curtain during care. This failure had the potential to result in residents not being treated with dignity and respect, not receiving care in a manner that promotes quality of life. During a review of Resident 21's Admission Record, the Admission Record indicated the facility readmitted Resident 21 on 9/12/2024 with diagnoses including hemiplegia (a condition where one side of the body is completely paralyzed) and hemiparesis (a condition involves a weaker, less severe form of paralysis one side of the body) following cerebral infarction (an ischemic stroke) affecting right dominant side and cognitive communication deficit (someone has trouble communicating because they're struggling with thinking skills that are important for understanding and using language). During a review of Resident 21's Minimum Data Set (MDS- a resident assessment tool), dated 3/4/2025, the MDS indicated Resident 21's cognitive (ability to think, pay attention, process information, and remember things) skills were moderately impaired. The MDS indicated Resident 21 required maximal assistance (helper does more than half the effort to complete task) for oral hygiene, toileting hygiene, personal hygiene and was dependent (helper does all the effort) for showering. During a concurrent observation and interview on 4/14/2025 at 1:28 p.m., in Resident 21's room, Resident 21 was lying on his back in the bed with his genital area exposed. When Certified Nurse Aids (CNA) 1 and CNA 2 assisted Resident 21 in turning toward CNA 1, his back, including his buttocks, was exposed. After Resident 21 repositioned onto his back, his genital area remained uncovered. When Restorative Nursing Aide (RNA) 1 joined the care team and left to get a mechanical lift (a machine used to lift and move residents from one surface to another), Resident 21's genital area was still exposed until RNA 1 returned and assisted Resident 21 into a seated position and transferred him to a shower chair. At 1:35 p.m., Resident 21's bed and Resident 13's bed were positioned facing each other, and the privacy curtain between them remained open throughout the care for Resident 21. Resident 13 was awake and sitting upright in bed at 45-degree angle. CNA 1 and CNA 2 stated that they should have covered Resident 21's genital area and closed the curtain during the care to protect his privacy. CNA 1 stated that if he were the resident, he would have felt embarrassed. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Director of Nursing (DON) on 4/17/2025 at 8:26 a.m., the DON stated that residents should be covered to maintain dignity when not actively receiving care. The DON also stated that if a resident's genital area in exposed during care, privacy curtains should be closed to protect the resident's dignity and privacy. During a review of the facility's policy and procedure titled, Dignity and Respect, revised 5/2007, the P&P indicated that residents shall be treated in a manner that maintains the privacy of their body, a closed door or drawn curtain shields the resident from passers-by. The P&P also indicated that privacy of a Resident's body shall be maintained during toileting, bathing and other activities of personal hygiene. 50387

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50144 Based on interview and record review, the facility failed to ensure two (2) of four (4) sampled residents (Resident 22 and 325) had Interdisciplinary Team (IDT: group of professionals from different departments coordinate care and address the multifaceted needs of resident) meetings to discuss plan of care and discharge goals. This deficient practice had the potential to violate Resident 22 and 325's right to be an active participant in their plan of care and delay the services needed. Findings: a. During a review of Resident 22's Admission record (Face Sheet), the Face Sheet indicated Resident 22 was admitted to the facility on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), and Type II Diabetes Mellitus (DM: a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 22's Minimum Data Set [MDS] a resident assessment tool) dated 3/9/2025, the MDS indicated Resident 22's cognitive skills (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) were mildly impaired. The MDS indicated Resident 22 is dependent on toilet hygiene, required maximal assistance living for bathing, chair/bed-to-chair transfer, dressing lower (waist below) body, required moderate assistance dressing the upper (waist up) body, and required supervision for eating, oral hygiene, and personal hygiene. The MDS indicated Resident 22 did not have any impairments on both of the upper (arms/shoulders) and lower (hips/legs) extremities. During a review of the Interdisciplinary (IDT) Committee Meeting dated 3/26/2025, the IDT Committee Meeting indicated the Social Service Director 1 (SSD 1) and the Minimum Data Set Coordinator (MDSC) were present to do the initial care plan review with Resident 22's representative over the phone and discussions such as the Physician Orders for Life-Sustaining Treatment (POLST: medical form that allows individuals to specify their wishes regarding medical treatment at the end of life) status, psychotropic medication consent, psychiatrist referral, inventory list, and discharge planning were done. During a concurrent interview and record review on 4/18/2025 at 11:04a.m. with SSD 1, SSD 1 stated they do the social service assessment as soon as possible and do the IDT meeting upon admission. SSD 1 stated Resident 22 was admitted to the facility on [DATE] and indicated she never had the chance to put the IDT meeting that was gone over on 3/26/2025. SSD 1 stated the IDT meeting she did is not in the medical record as the document is exclusive to her and does not put in the chart. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. During a review of Resident 325's Face Sheet, the Face Sheet indicated Resident 325 was admitted to the facility on [DATE] with diagnoses including dementia fracture of the lower end of left radius (break in the radius bone near the wrist joint), assault by other bodily force, and traumatic subarachnoid hemorrhage (a type of bleeding in the brain that occurs in the space surrounding the brain due to head trauma). During a review of Resident 325's History and Physical (H&P), dated 4/11/2025, the H&P indicated Resident 325 is able to make her own medical decisions. During a review of Resident 325's MDS, dated [DATE], the MDS indicated Resident 325's cognitive skills were intact. The MDS indicated Resident 325 is dependent on toilet hygiene, bathing, required maximal assistance living for bathing, chair/bed-to-chair transfer, dressing lower body, required moderate assistance dressing the upper body, and required moderate assistance for eating, oral hygiene, and personal hygiene. The MDS indicated Resident 325 have impairments on one side of the upper and lower extremities. During an interview on 4/17/2025 at 4:10p.m. with SSD 1, SSD 1 stated IDT meetings are done within one (1) to three (3) days or within 72 hours (hrs.) SSD 1 stated they did not do an IDT meeting for Resident 325, but they were supposed to. SSD 1 stated IDT meetings are done to discuss plan of care, why they were admitted to the facility, discuss any concerns, medications, dietary preferences, who to contact, and discuss the discharge plans. During an interview on 4/18/2025 on 12:10p.m. with Director of Nursing (DON), DON stated IDT meetings are done to address residents plan of care to ensure the goal is met. DON stated when the resident is admitted , the initial IDT meeting is done within the first 72 hours. DON stated if there are no IDT meetings done, the residents problems would not be addressed and can cause a delay in treatment. During a review of the facility's policies and Procedures (P&P), titled Care and Treatment: Comprehensive Person-Centered Care Planning, revised 8/2017, the P&P indicated the facility IDT includes, but is not limited to the following professionals: A. Attending Physician of Non-Physician Practitioner (NPP) designee involved in resident's care; B. Registered Nurse responsible for the resident; C. Nurse aid responsible for the resident; D. Member of the Food and Nutrition services staff; E. To the extent practicable, resident and/or resident representative; F. Other appropriate staff or professions in disciplines as determined by the resident's needs or as requested by the resident.

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46415 Based on interview and record review, the facility failed to ensure two (2) of four (4) sampled residents (Resident 22 and 325) had Interdisciplinary Team (IDT: group of professionals from different departments coordinate care and address the multifaceted needs of resident) meetings to discuss plan of care and discharge goals. This deficient practice had the potential to violate Resident 22 and 325's right to be an active participant in their plan of care and delay the services needed. Findings: a. During a review of Resident 22's Admission record (Face Sheet), the Face Sheet indicated Resident 22 was admitted to the facility on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), and Type II Diabetes Mellitus (DM: a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 22's Minimum Data Set [MDS] a resident assessment tool) dated 3/9/2025, the MDS indicated Resident 22's cognitive skills (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) were mildly impaired. The MDS indicated Resident 22 is dependent on toilet hygiene, required maximal assistance living for bathing, chair/bed-to-chair transfer, dressing lower (waist below) body, required moderate assistance dressing the upper (waist up) body, and required supervision for eating, oral hygiene, and personal hygiene. The MDS indicated Resident 22 did not have any impairments on both of the upper (arms/shoulders) and lower (hips/legs) extremities. During a review of the Interdisciplinary (IDT) Committee Meeting dated 3/26/2025, the IDT Committee Meeting indicated the Social Service Director 1 (SSD 1) and the Minimum Data Set Coordinator (MDSC) were present to do the initial care plan review with Resident 22's representative over the phone and discussions such as the Physician Orders for Life-Sustaining Treatment (POLST: medical form that allows individuals to specify their wishes regarding medical treatment at the end of life) status, psychotropic medication consent, psychiatrist referral, inventory list, and discharge planning were done. During a concurrent interview and record review on 4/18/2025 at 11:04a.m. with SSD 1, SSD 1 stated they do the social service assessment as soon as possible and do the IDT meeting upon admission. SSD 1 stated Resident 22 was admitted to the facility on [DATE] and indicated she never had the chance to put the IDT meeting that was gone over on 3/26/2025. SSD 1 stated the IDT meeting she did is not in the medical record as the document is exclusive to her and does not put in the chart. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. During a review of Resident 325's Face Sheet, the Face Sheet indicated Resident 325 was admitted to the facility on [DATE] with diagnoses including dementia fracture of the lower end of left radius (break in the radius bone near the wrist joint), assault by other bodily force, and traumatic subarachnoid hemorrhage (a type of bleeding in the brain that occurs in the space surrounding the brain due to head trauma). During a review of Resident 325's History and Physical (H&P), dated 4/11/2025, the H&P indicated Resident 325 is able to make her own medical decisions. During a review of Resident 325's MDS, dated [DATE], the MDS indicated Resident 325's cognitive skills were intact. The MDS indicated Resident 325 is dependent on toilet hygiene, bathing, required maximal assistance living for bathing, chair/bed-to-chair transfer, dressing lower body, required moderate assistance dressing the upper body, and required moderate assistance for eating, oral hygiene, and personal hygiene. The MDS indicated Resident 325 have impairments on one side of the upper and lower extremities. During an interview on 4/17/2025 at 4:10p.m. with SSD 1, SSD 1 stated IDT meetings are done within one (1) to three (3) days or within 72 hours (hrs.) SSD 1 stated they did not do an IDT meeting for Resident 325, but they were supposed to. SSD 1 stated IDT meetings are done to discuss plan of care, why they were admitted to the facility, discuss any concerns, medications, dietary preferences, who to contact, and discuss the discharge plans. During an interview on 4/18/2025 on 12:10p.m. with Director of Nursing (DON), DON stated IDT meetings are done to address residents plan of care to ensure the goal is met. DON stated when the resident is admitted , the initial IDT meeting is done within the first 72 hours. DON stated if there are no IDT meetings done, the residents problems would not be addressed and can cause a delay in treatment. During a review of the facility's policies and Procedures (P&P), titled Care and Treatment: Comprehensive Person-Centered Care Planning, revised 8/2017, the P&P indicated the facility IDT includes, but is not limited to the following professionals: A. Attending Physician of Non-Physician Practitioner (NPP) designee involved in resident's care; B. Registered Nurse responsible for the resident; C. Nurse aid responsible for the resident; D. Member of the Food and Nutrition services staff; E. To the extent practicable, resident and/or resident representative; F. Other appropriate staff or professions in disciplines as determined by the resident's needs or as requested by the resident.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50387 Based on interview and record review, the facility failed to obtain a resident's Advance Directive (AD-a written document that tells your health care providers who should speak for you and what medical decisions they should make if you become unable to speak for yourself) upon admission for one of the four sampled residents (Resident 10). This deficient practice had the potential to cause conflict with the residents' wishes regarding health care decisions in cases where they are unable to make decisions for themselves. Findings: During a review of Resident 10's Admission Record, the Admission Record indicated the Resident 10 was admitted on [DATE] with diagnoses including cerebral infarction (an ischemic (blockage and loss of blood flow to the brain, causing tissue death) stroke, and metabolic encephalopathy (a change in how the brain works due to an underlying condition). During a review of Resident 10's Minimum Data Set (MDS- a resident assessment tool), dated 3/27/2025, the MDS indicated Resident 10's cognitive (functions the brain uses to think, pay attention, process information, and remember things) skills were moderately impaired. The MDS indicated Resident 10 required moderate assistance (helper does less than half the effort to complete the task) with toileting hygiene, showering, maximal assistance (helper does more than half the effort to complete task) with supervision assistance (helper provides verbal cues and/ or touching/ steading and/or contact guard assistance as resident completes activity) with eating, oral hygiene and personal hygiene. During a review of Resident 10's Advance Directive (AD) Notification, dated 3/24/2025, the AD Notification indicated, Resident 10 had an Advance Directive and needed to bring the copy. During an interview on 4/15/2025 at 4:50 p.m., with the Social Service Director (SSD), the SSD stated that the facility did not obtain the copy of Resident 10's AD. The SSD stated that the facility must obtain the Advance Directive Notification upon admission (on or around 3/21/2025). During an interview on 4/18/2025 at 10:27 a.m., with the Director of Nursing (DON), the DON stated that obtaining a resident's AD upon admission was important in order to know the resident's wishes in case of an emergency if the resident was unable to make their own decisions. The DON stated if there was an existing copy, it must be obtained upon admission. During a review of the facility's policy and procedure (P&P) titled, Advance Directives and Associated Documentation, revised 1/ 2021, indicated, the facility staff member shall provide the resident/ family or responsible agent written information regarding the right to formulate advance directives and document in the resident health record that the resident/ family has been provided with written information regarding advance directives. When an advance directive is completed, obtain copy of the Advance Directive and conservatorship (a legal arrangement where a court appoints someone to manage the financial and/or personal affairs of another person who is unable to do so themselves)/ guardianship documents and place in the resident health record.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45891 (Cross Reference F686 and F726) Based on observation, interview, and record review, the facility failed to notify the responsible parties, and the physician of a change of condition (COC) for two out of 16 sampled residents. The facility failed to inform: a. Resident 35's physician of a COC when Resident 35's left foot suspected deep tissue injury (SDTI, a form of pressure-induced damage to underlying tissues, including muscles, bones, and subcutaneous layers, while the skin surface might remain intact. It typically results from sustained pressure or shear forces that compromise blood flow, leading to subsequent tissue necrosis. Recognizing a suspected deep tissue injury is crucial for timely intervention to prevent progression to more severe wounds) was noted to have a foul (bad) odor, an area of eschar (dead tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like, usually firmly attached to the base sides, and/or edges of the wound), and slough (dead tissue that is usually yellow, tan, gray, or green in color, usually moist and stringy in texture) on 4/14/2025. b. Resident 57's family member/resident representative (FM7) of a COC when Resident 57 developed right buttock redness (on 1/7/2025), which progressed to moisture associated dermatitis (MASD - moisture associated skin damage caused from prolonged exposure to moisture) on 2/12/2025, which progressed to an unstageable (a wound where the depth of the wound cannot be determined because it is covered by slough or eschar) pressure injury) on 2/21/2025, requiring (on 2/27/2025) wound debridement (process of removing dead or damaged tissue and debris from a wound), which progressed to a stage four (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) pressure injury on the sacrum (the bony area at the base of the spine). This deficient practice had the potential to delay care and treatment of Resident 35's left heel wound and Resident 57's right buttock wound. Resident 35's left heel wound was reclassified as an unstageable pressure injury (when the stage is not clear. In these cases, the base of the wound is covered by a layer of dead tissue that may be yellow, grey, green, brown, or black) on 4/16/2025 and Resident 35 was sent to a general acute care hospital (GACH) for evaluation of the left heel unstageable pressure injury on 4/17/2025. Resident 57 was sent to a GACH on 4/16/2025 and is receiving treatment for diagnoses including sepsis (a life-threatening blood infection), and a pressure injury (referring to right buttock pressure injury). (Cross Reference F686 and F726) Findings: a. During a review of Resident 35's Admission Record, the Admission Record indicated Resident 35 was admitted to the facility on [DATE] with diagnoses of left femur fracture (broken leg bone), fall, muscle weakness, difficulty in walking, joint replacement surgery, and type 2 diabetes (happens when the body cannot use insulin correctly and sugar builds up in the blood). (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 35's Initial Admission Record dated 3/23/2025, the Initial admission Record indicated a skin integrity check was done by TXN 2, and the physician (unspecified) was notified of the left heel blister. During a review of the Admission Report- Skin Check (paper document) undated, the Admission Report skin check indicated Resident 35 had a 1.5 cm by 0.5 cm right heel DTI and a 3 cm by 6 cm left heel blister. During a review of Resident 35's history and physical (H&P) dated 3/24/2025, the H&P indicated Resident 35 was able to make her own medical decisions. The H&P indicated Resident 35 was sent to the facility after left hip surgery after sustaining a left hip fracture. The H&P indicated Resident 35 did not have any concerning rashes or lesions (wounds) at the time but did have a left hip surgical site. The H&P included a plan to monitor for wound per facility protocol and obtain a wound care evaluation as needed. The H&P indicated the facility's care staff was instructed to call the physician for any COC. During a review of Resident 35's care plan titled, Has actual impairment to skin integrity related to (r/t) left heel blister and left heel protector boot (cushioned boot that floats the heel to aid in healing of pressure injuries) initiated 3/25/2025, goals for Resident 35 included reducing the risk for impairment to skin integrity by positioning techniques, and adaptive equipment. Interventions included avoiding scratching, keeping body parts from excessive moisture, keeping fingernails short, educating resident/ family/ and caregivers of causative factors and measures to prevent skin injury, and encouraging good nutrition and hydration to promote healthier skin. On 4/15/2025 the care plan for the left heel blister was updated to include, on 3/26/2025: patient was reassessed by TXN 1, the left heel blister was clarified as SDTI with purple tissue. On 4/15/2025 the care plan interventions were updated to include left heel SDTI treatment as ordered, monitor/ document location, size and treatment of the skin injury, report abnormalities, failure to heal, signs and symptoms of infection to the physician, monitor for skin breakdown and off-load (minimizing or removing weight placed on the foot to help prevent and heal ulcers) as tolerated. During a review of Resident 35's Order Summary Report, the report indicated Resident 35 had the following wound care orders placed: - 3/25/2025 for left heel blister, cleanse with NS pat dry, apply antibacterial ointment then apply gauze and wrap with kerlix (type of dressing). Every day shift. The order was discontinued 3/26/2025. - 3/26/2025 for left heel SDTI: cleanse with NS, pat dry, apply sure prep (skin barrier ointment), apply abdominal (ABD) pad and cover with rolled gauze. Offload as tolerated, monitor for skin breakdown and notify the physician of any changes every day shift. The order was discontinued 4/14/2025.-4/14/2025 for left heel SDTI: cleanse with NS, pat dry, apply MediHoney (medical honey, hastens the healing of wounds through its anti-inflammatory effects), calcium alginate dressing (ideal for wounds with moderate to heavy exudate [fluid that leaks out of blood vessels into nearby tissues]), dry dressing and cover with rolled gauze. Offload as tolerated, monitor for skin breakdown and notify the physician of any changes every day shift. The order was discontinued 4/16/2025. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-4/16/2025 for left heel unstageable: cleanse with NS, pat dry, apply MediHoney, calcium alginate, dry dressing and cover with rolled gauze. Offload as tolerated, monitor for any signs for skin breakdown and notify the physician of any changes. During a review of Resident 35's Skin/ Wound Note dated 3/26/2025 (three days after admission), the note indicated Resident 35 was reassessed by TXN 1 and the left heel blister was clarified as an SDTI with purple tissue. The note did not indicate measurements or a complete wound assessment describing the characteristics of the wound. The note did not indicate the physician was notified of the clarified wound type or new treatment orders. Resident 35 did not have weekly Skin/Wound assessments documented in her medical record including all wounds and their progress as indicated in the facility's Wound Management and Prevention policy and procedure (P/P). During a review of Resident 35's minimum data set (MDS, a resident assessment tool) dated 3/28/2025, the MDS indicated Resident 35 had moderate cognitive impairment (having problems remembering things, concentrating, making decisions and solving problems) and required substantial/ maximal assistance (helper does more than half the effort) for bed mobility including rolling from left to right. The MDS indicated Resident 35 was at risk for pressure injuries and had two deep tissue injuries and zero unstageable pressure injuries with slough or eschar. During a review of Resident 35's COC evaluation dated 4/16/2025, the COC indicated Resident 35 had new pain of the bilateral heels. Resident 35's left heel SDTI was reclassified as an Unstageable pressure injury on 4/16/2025. The left heel unstageable pressure injury measured 6.5 cm by 7 cm with 75 percent (%) of wound covered in eschar, 20% slough, and 5% granulation tissue (new tissue) with medial (inside) ankle discoloration. During a review of Resident 35's nursing progress note dated 4/17/2025, the progress note indicated Resident 35 verbalized she was unable to sleep well the night prior due to left heel pain and had moderate pain at the time of evaluation on the left heel. Patient was offered to be transferred to the GACH for further evaluation of her heel wound and Resident 35 agreed to the transfer. During a review of Resident 35's skin/ wound note dated 4/17/2025, the skin/wound note indicated treatment was halted due to patient expressing pain. The note indicated wound care was not resumed due to Resident 35's condition and pain level and Resident 35 was transferred to the GACH. During a review of Resident 35's GACH Wound Care Consult dated 4/18/2025, the Wound Care Consult indicated Resident 35 was sent from the facility for worsening wounds to bilateral heels and bilateral heel pain. The consult indicated Resident 35 received medication to treat infection, pain medication and fluids in the Emergency Department. The consult indicated FM 2 reported Resident 35 had worsening wound to the left heel for one week with odor. The consult indicated Podiatry (the treatment of the feet and their ailments) was consulted for the left heel unstageable pressure injury. During an observation on 4/14/2025 at 10 a.m., Resident 35 was lying in bed with 1 pillow elevating her feet, there were no heel protector boots on, and no air loss mattress (LALM a specialized medical mattress designed to minimize moisture buildup and promote airflow around the patient's skin, primarily to prevent and treat pressure ulcers) was on Resident 35's bed. During an interview on 4/14/2025 at 10:11 a.m., FM 2 stated she was upset because Resident 35's left heel wound was getting worse. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 4/14/2025 at 1:44 p.m., TXN 1 was in Resident 35's room speaking to FM 3 at the bedside. Resident 35 was lying in bed crying in pain, saying her left foot hurt. Resident 35 was informing FM 3 she had chills (the feeling of being cold, though not necessarily in a cold environment, often accompanied by shivering or shaking). Resident 35's left heel was observed with the following and described by TXN 1 as: a large area of dark purple or black appearing eschar, surrounded by a pinkish red area of granulation tissue, and a small amount of yellowish white slough. During an interview on 9/15/2025 at 9:03 a.m., TXN 1 stated Resident 35 was not being seen by a wound care practitioner. TXN 1 stated she noticed a change in appearance to Resident 35's left heel wound and a little bit of odor on 4/14/2025. During an interview on 4/16/2025 at 8:04 a.m., FM 1 stated she was visiting Resident 35 on the evening of 4/13/2025, Resident 35 was complaining of pain to her left foot, and she noted a smell in Resident 35's room so she ripped off Resident 35's sock and bandage that was wrapped around the left heel. FM 1 stated she was shocked to see Resident 35's left heel wound looked worse, and the wound smelled. FM 1 stated she alerted staff (unknown) to the issue on 4/13/2025 and two staff came in to look at the wound and wrap it back up but she was unsure who the staff were. FM 1 stated the wound looked much worse than it did when Resident 35 was admitted . FM 1 stated a wound culture was taken the next day (4/14/2025) but she did not know the results yet. FM 1 stated Resident 35 was complaining of worsening left heel pain for a few days. During an interview on 4/16/2025 at 11:16 a.m., TXN 1 stated Resident 35's left heel wound had a change in status on 4/14/2025. The wound had some drainage and had a smell. TXN 1 stated she did not inform the physician of the change in appearance of the wound. TXN 1 stated Resident 35's left heel wound now had eschar or necrotic tissue which was not good for wound healing and usually needs to be debrided (removed) but that was not in her scope of practice so Resident 35 needed a wound care consultation. TXN 1 stated when a wound has eschar, they do not know how bad the wound really was underneath, and the wound could have been worse. TXN 1 stated DTIs could deteriorate rapidly with any pressure due to the fragility of the skin and it was important to be proactive with interventions and offload the heels for the best chance for wound healing. TXN 1 stated she was upset with herself because she did not perform a COC assessment and notify the physician of Resident 35's decline in wound appearance on 4/14/2025. TXN 1 stated there was a possibility of delay in care and treatment if the physician was not notified right away of a wound decline. TXN 1 stated she had not called Resident 1's physician to discuss Resident 35's wound status since she had been caring for Resident 35's wounds. During an interview on 4/16/2025 at 2:21 p.m. physician assistant (PA) 1 was in the facility and stated he had just been informed Resident 35 had worsening wounds. PA 1 stated he was going to put an order to be seen by a wound care consultant. PA 1 stated the physician or himself should have been notified right away of new or changing wounds. PA 1 stated it was important residents with eschar were seen by a wound care consultant so the appropriate interventions could be placed. During an interview on 4/16/2025 at 2:25 p.m., TXN 1 stated she was now staging Resident 35's left heel wound as an unstageable pressure injury due to the wound characteristics (slough and eschar). TXN 1 stated the definition of an unstageable pressure injury was the wound couldn't be staged. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 4/16/2025 at 2:42 p.m., TXN 1 measured the wound on Resident 35's left heel, the wound measured 6.5 cm by 7 cm with a separate discolored (redness) on the inner ankle. The wound had a large purplish black center, yellowish white area surrounding the dark area as well as a small area of granulation tissue (new pinkish red tissue). During an interview on 4/17/2025 at 2:33 p.m., the DON stated she was not aware of Resident 35's wounds until this interview. The DON stated it was important she was notified of wounds and the wound decline so she could review the chart and ensure the resident was receiving all appropriate interventions. The DON stated it was important the physician was aware of wound changes so they could order any necessary interventions. The DON stated there was no COC or notification of the physician documented in Resident 35's chart related to the wound appearance and decline on 4/14/2025. During an interview on 4/18/205 at 7:26 a.m., FM 1 stated Resident 35 had been transferred to the GACH the night prior and was receiving fluids, pain medication, and antibiotics. b. During a review of Resident 57's Admission record, the Admission record indicated Resident 57 was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (brain dysfunction caused by underlying metabolic disorders or conditions), cerebral infarction (stroke - loss of blood flow to a part of the brain), and wedge compression fracture wedge compression fracture (when the front part of the bones of the spine collapse, creating a wedge shape). The admission record indicated 57's Family member (FM 7) was the responsible party/resident's representative. During a review of Resident 57's History and Physical (H&P), dated 12/12/2024, the H&P indicated Resident 57 did not have the capacity to understand and make decisions. During a review of Resident 57's MDS, dated [DATE], the MDS indicated Resident 57 had moderate impairment to cognition, required supervision for eating and oral hygiene, required moderate assistance (helper does less than half the effort) for toileting, and required maximal assistance (helper does more than half the effort) for bathing. During an interview on 4/15/2025 at 11:24 a.m. with Resident 57's Family Member (FM7), FM7 stated Resident 57 did not have any bedsores in December 2024 and was notified on 4/8/2025 that Resident 57 had a bed sore when it had reached stage four. During a concurrent interview and record review on 4/16/2025 at 11:35 a.m. with the treatment nurse (TXN) 1, Resident 57's chart was reviewed. TXN 1 stated Resident 57 developed redness to the right buttock in 1/7/2025 and 2/8/2025 which progressed to MASD on 2/12/2025, which progressed to an unstageable injury requirement debridement on 2/21/2025. TXN 1 stated the wound was discussed with the FM7 on 3/13/2025 but should have been communicated to FM7 when the redness first appeared on 1/7/2025. TXN stated FM7 should have been informed every time the wound changed (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 4/18/2025 at 12:18 p.m. with the Director of Nursing (DON), Resident 57's chart was reviewed. The DON stated it is not normal for a resident with intact skin on admission to develop a stage four pressure injury. The DON stated she was informed of Resident 57's pressure injury on 4/8/2025 when it was reclassified to a stage four pressure injury. The DON stated she instructed the treatment nurse to inform FM7 the same day. The DON stated both herself and FM7 should have been informed every time the skin changed. The DON stated it is important that the responsible party is informed of the resident's care because it is their right to be informed of the plan of care. The DON stated the wound should have been escalated to the DON sooner. During a review of the facility's P/P titled Change of Condition Reporting dated 4/2021, the P/P indicated changes in resident condition were to be reported to the physician and it was to be documented in the eInteract Change of Condition and/ or in the nurse's progress notes, the plan of care was to be updated. The P/P indicated any attempts to contact the physician would be documented in the resident's medical record. During a review of the facility's P/P titled Wound Management and Prevention dated 8/1/2021, the P/P indicated it was the facility's policy to ensure any resident that entered the facility had appropriate preventative measure taken to ensure the resident did not develop pressure ulcers, or that residents admitted with wound did not develop signs and symptoms of infection. During a review of the facility's Job Description- Director of Nursing dated 10/2021, the job description indicated the DON was to review nursing personnel medical record documentation to ensure that it was appropriately and accurately descriptive of the nursing care provided. The DON was to manage and direct all aspects of the nursing services department. The DON was to assist in the development of preliminary and comprehensive assessments of the nursing needs of each resident. During a review of the facility's Job Description- Treatment Nurse dated 12/17/2021, the job description indicated the treatment nurse was to make written and oral reports/ recommendations to the attending physician, Medical Director, or the DON concerning the status and care of the residents. The treatment nurse was to examine the resident and or his/ her records and charts, and discriminate between normal and abnormal findings, to recognize when to refer the resident to a physician for evaluation, supervision, or directions. Initiate requests for consultation or referral. 50144

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45891 Based on observation, interview and record review the facility failed to: 1.Ensure one out of six sampled residents (Resident 2) was free from mental abuse (the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation). 2.Implement the facility Policy and Procedure (P&P) titled Abuse: Prevention of and Prohibition Against revised 12/2023, that indicated each resident had the right to be free of abuse. The P/P indicated the facility was to ensure the health and safety of each resident with regards to visitors, such as family members, friends, or other individuals subject to the resident's right to deny or withdraw consent at any time and to reasonable clinical and safety restrictions, by allowing Resident 2's alleged abuser, Family Member 4 (FM 4) access to Resident 2, when FM 4 came into the facility, and Resident 2's room and tried to force Resident 2 to talk to him (FM 4). As a result, Resident 2 suffered emotional distress requiring a new physician's order for Ativan (medication used to treat anxiety [a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities]) after Resident 2's alleged abuser, FM 4 gained access to the facility on [DATE], proceeded to Resident 2's room and tried opening Resident 2's bedside curtains while she was receiving perineal (peri) care (washing the genitals). (Cross reference F609 and F610) Findings: During a review of Resident 2's Admission Record, the Admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including confirmed physical abuse, major depressive disorder (a mental health condition that causes a persistently low or depressed mood and a loss of interest in activities that once brought joy), and anxiety disorder. During a review of Resident 2's History and Physical (H&P) dated 3/15/2025, the H&P indicated Resident 2 was admitted to the facility from a general acute care hospital (GACH) due to adult physical abuse causing traumatic ecchymosis (bruising). The H&P indicated Adult Protective Services (APS - a government agency that investigates allegations of a vulnerable adult being or having been abused, neglected, or exploited by their caregivers), and the police had been notified of the abuse by the GACH. The H&P indicated it was unclear if Resident 2 was able to make her own medical decisions and she was making medical decisions with the help of her sister (FM 5). The H&P indicated do not give any information to FM 4, in the plan of treatment. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 2's care plan titled, At risk for re-traumatization related to (r/t) history of physical abuse by a close family member initiated on 3/18/2025, the Care Plan goals included Resident 2 would have no evidence of emotional, physical, and psychological problems. The Care Plan interventions included encouraging Resident 2 to attend care conferences, to express preferences and participate in the care planning process. During a review of Resident 2's Interdisciplinary Team (IDT, brings together knowledge from different health care disciplines to help people receive the care they need)- Care Plan Review dated 3/18/2025, the IDT Care Plan Review indicated Resident 2 had an APS case against FM 4 for physical abuse. The IDT Care Plan Review indicated Resident 2 expressed that she did not want any calls or visits from FM 4. Resident 2 also expressed she felt threatened by FM 4, and FM 4 should also be banned from calling or visiting her. Resident 2 expressed she did not want to be discharged home with FM 4 because of the abuse. The IDT documentation indicated FM 4 was verbally, emotionally, financially, and physically abusive towards Resident 2 for years and multiple police reports were filed but Resident 2 always took FM 4 back in until the last event (date no specified) that led to her most recent hospitalization and she decided to press charges against FM 4 and not return to their apartment. During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool) dated 3/21/2025, the MDS indicated Resident 2's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was intact. The MDS indicated Resident 2 was not receiving any medications for anxiety. During a review of Resident 2's Case Manager (CM) Progress Notes dated 3/18/2025, the Case Manager Progress Notes indicated the CM was notified FM 4 was at the facility to visit Resident 2. The CM Progress Notes indicated the CM had been notified by Resident 2 that she did not want visits from FM 4. The CM Progress Notes indicated the CM notified FM 4 of Resident 2's wishes, and FM 4 proceeded to walk towards Resident 2's room stating, that is a lie! I was just there yesterday, and I took a train and two buses to get here. The CM Progress Notes indicated the CM asked FM 4 to wait in the lobby so she (CM) could confirm Resident 2's wishes, and Resident 2 again stated she did not want any calls or visits from FM 4. The CM Progress Notes indicated the CM relayed the message to FM 4, and he became agitated using profanity (bad words). The CM Progress Notes indicated the Police had to be called before FM 4 agreed to leave the facility. The CM Progress Notes indicated Resident 2's chart was updated, and staffing was made aware of Resident 2's wishes to not have visits from FM 4. During a review of Resident 2's Social Services Summary Note dated 3/21/2025, the Social Services Summary Note indicated Resident 2 was verbally responsive with capacity to understand and make decisions. The Social Services Summary Note indicated Resident 2 was unable to sleep well, had anxiety and worries about FM 4 who was physically abusive towards her. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 2's CM Note dated 4/8/2025, the CM Note indicated after lunch (lunch was served by 12:30 p.m.) on 4/8/2025 the CM was notified FM 4 was outside of Resident 2's room. The CM reminded FM 4 of Resident 2's wishes, and he became hostile and aggressive pushing past the CM and two other staff (unknown) to enter Resident 2's room. The CM Note indicated Resident 2's privacy curtain was pulled around Resident 2's bed for privacy and FM 4 proceeded to try and pull back the curtain as nursing staff (Licensed Vocational Nurse [LVN]3) was holding it shut. FM 4 was shouting to Resident 2, It's me FM 4, stop saying you do not want to see me. I came here to see you, tell them it is okay for me to see you, tell them it is okay for me to be here. The CM Note indicated Resident 2 was physically shaking her head No and Resident 2 was visually upset and tearful as she kept her eyes closed and continued shaking her head No. The CM Note indicated staff (unknown) intervened to prevent further interaction with Resident 2 and the police were called. FM 4 was escorted out of the building by two male staff (unknown) as FM 4 was verbally cursing profanities. During a review of Resident 2's Change in Condition (COC) evaluation dated 4/8/2025, the COC indicated Resident 2 was experiencing emotional distress. The COC indicated Resident 2 reported feeling anxious after the visit from FM 4 and emotional support was provided. MD 3 was notified and ordered; 1. monitor Resident 2 for emotional distress and 2. Ativan oral tablet 0.5 milligrams (mg) by mouth every eight hours as needed for anxiety manifested by verbalization of anxiousness with mild tremors for three days. 3. Psych consultation related to depression and anxiety. During a review of Resident 2's Care Plan titled Potential for psychosocial well-being problem related to family discord (disagreement, or difference in opinion) dated 4/8/2025, the Care Plan goals included for Resident 2 not having any further indications of psychosocial wellbeing problems. The Care Plan interventions included allowing Resident 2 time to answer questions and to verbalize feelings and fears, consultation with behavioral health, and when conflict arises removing Resident 2 to a calm, safe environment and allowing Resident 2 to vent and share her feelings. During a review of Resident 2's medication administration record (MAR), the MAR indicated Resident 2 was given Ativan 0.5 mg one time on 4/9/2025 for feeling anxious. During a review of Resident 2's Medication Administration Note dated 4/9/2025, the Medication Administration Note indicated Resident 2 was visibly shaken and anxious. Resident 2 was requesting anti-anxiety medications and Resident 2 was given Ativan 0.5 mg. During a review of Resident 2's COC (Condition) Follow-up dated 4/9/2025, the COC Follow-Up indicated Resident 2 had increased anxiety due to FM 4 and Resident 2 was calmer after receiving the Ativan 0.5 mg. During an observation and concurrent interview on 4/14/2025 at 9:50 a.m., Resident 2's name was displayed at the entrance of her door. Resident 2 stated her mind was always wandering, and did not work like it used to. During an interview on 4/15/2025 at 3:17 p.m., Resident 2 declined to elaborate on how FM 4 abused her prior to her admission to the facility. Resident 2 stated she was scared just hearing FM 4's voice when he got into the facility and the situation was mentally exhausting, but she prayed for FM 4 every day and just wanted to move forward with her life. Resident 2 stated the facility provided her with a number to call for therapy, but she had yet to set up an appointment. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 4/17/2025 at 10:20 a.m., with the CM, the CM stated Resident 2 had come to their facility after a stay in the GACH from sustaining injuries due to being physically assaulted by FM 4. The CM stated Resident 2 had an open APS case against FM 4 prior to her admission to the facility. The CM stated Resident 2 had been dealing with the abuse for several years until she decided to cut ties with FM 4 when she was admitted to the GACH. The CM stated FM 4 had snuck into the facility two times that they know of; on 3/18/2025 and 4/8/2025. The CM stated Resident 2 became visibly shaken up just by the mention of FM 4 being in the vicinity of the facility. The CM stated the first instance FM 4 entered the facility on 3/18/2025, she (the CM) was alerted a male was in Resident 2's room being disruptive so she went to investigate and informed FM 4 he was not welcome at the facility, Resident 2 did not wish to see him, and the police were called. The CM stated the second time he came back to the facility on [DATE], FM 4 was immediately spotted by staff, staff tried to stop him from entering Resident 2's room but he pushed his way into the room and was trying to pull the privacy curtain open, but LVN 3 was holding the privacy curtain shut. The CM stated Resident 2 was receiving peri care, and her privates were exposed while FM 4 was trying to pull the privacy curtain open. The CM stated FM 2's voice was very aggressive, very loud, caused a huge commotion and he was yelling to Resident 2, God dammit you know you want to see me, why are you telling them you do not want to see me! and Resident 2 was crying and very shaken up by the occurrence. The CM stated the way FM 4 was talking, acting, and the tone of voice he was using was verbally and emotionally abusive. The CM stated the abuse coordinator (administrator [ADM]) was aware of the situation that occurred on 4/8/2025. The CM stated she brought it up during a morning meeting with department heads that in GACHs, victims of violence do not have their names outside of their rooms for patient safety and the CM thought it would be a good idea to implement but she does not know what the facility did with that information. The CM stated she believed FM 4 found out what room Resident 2 was in by looking for and finding her name posted outside of her doorway. The CM stated they offered assistance to call a behavioral health self-referral number to set up an appointment for therapy, but the resident declined. During an interview on 4/17/2025 at 10:54 a.m., with the Social Services Director (SSD), the SSD stated Resident 2 became upset at the mention of FM 4's name so they had to respect her and not ask any questions because Resident 2 did not want to talk about any of the details. During an interview on 4/17/2025 at 1:42 p.m., with LVN 3, LVN 3 stated on 4/8/2025 FM 4 bypassed all the safety checks in the facility and snuck into the facility behind another resident's family member (unknown). LVN 3 stated she knew a Certified Nursing Assistant (CNA) (unknown) was providing peri care to Resident 2 at the time, so LVN 3 entered Resident 2's room to check on the resident before FM 4 abruptly made his way past the CM (who was at the doorway of Resident 2's room) and was trying to pull Resident 2's privacy curtain open. LVN 3 stated she was pleading with FM 4 to give Resident 2 some privacy and to let the staff get Resident 2 decent, but FM 4 was cussing at the staff, saying F (fuck), F the police and shouting at Resident 2 to let FM 4 in. LVN 3 stated FM 4 was shouting multiple things at Resident 2, but she couldn't exactly remember everything that was said. LVN 3 stated Resident 2 was visibly in fear, shaking, and traumatized. LVN 3 stated the interaction was verbal abuse and emotional abuse by the way he was talking to Resident 2 and the response Resident 2 had to the interaction. LVN 3 stated Resident 2 ended up needing Ativan because she was so shaken up. LVN 3 stated the abuse coordinator (ADM) was aware of the situation but was not sure if the incident was reported to necessary agencies other than the police because the police were called. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 4/18/2025 at 10:36 a.m., with the ADM, the ADM stated she was the abuse coordinator for the facility. The ADM stated the facility was informed an open APS case was filed against FM 4 for the abuse Resident 2 sustained. The ADM stated the police were called after the first incident 3/18/2025 and staff were notified not to let FM 4 in and to call the police if they saw him. The ADM stated the second incident on 4/8/2025 she was incorrectly informed after the incident had happened, that FM 4 did not enter Resident 2's room and staff were able to stop him from entering the room. The ADM stated from what she learned about the 4/8/2025 incident FM 4 was aggressive towards staff and just stated he wanted to see Resident 2, so she did not believe it was abuse but rather family dynamics. The ADM stated the incident was not reported to the state agency and a thorough investigation was not done but if she knew FM 4 entered the room and the details of the interaction she may have done things differently. The ADM read the details in Resident 2's medical record including the CM notes and COC dated 4/8/2025. The ADM stated she was not aware FM 4 entered Resident 2's room, was shouting towards Resident 2, and Resident 2 was shaking her head no and crying. The ADM stated it was important staff members reported accurate descriptions of events because that determined the course of action she takes and if an incident needed to be reported to the state agency. The ADM stated she unfortunately never spoke to Resident 2 herself regarding the situation. The ADM stated according to the facility's policy and procedure (P/P) titled Abuse: Prevention of and Prohibition Against definition of mental abuse, mental abuse included harassment. The ADM stated if there was an allegation of abuse, the incident needed to be thoroughly investigated and reported to the state agency right away. The ADM stated Resident 2 remained in the same room from the time of admission (3/16/2025) to the time of discharge (4/17/2025) and she could not find any evidence in Resident 2's chart she was offered a room change after the first incident on 3/18/2025, and the second incident on 4/8/2025 of FM 4 forcing his way into Resident 2's room for her safety. The ADM stated after the second incident on 4/8/2025, she (ADM) became worried about Resident 2's safety so she had the CM reach out to Resident 2's insurance to request a transfer to another facility but Resident 2's insurance declined. During a review of the facility's P/P titled Abuse: Prevention of and Prohibition Against revised 12/2023, the P/P indicated each resident had the right to be free of abuse. The P/P indicated abuse was the willful (the individual acted deliberately) infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain, or mental anguish. The P/P indicated the facility was to ensure the health and safety of each resident with regards to visitors, such as family members, friends, or other individuals subject to the resident's right to deny or withdraw consent at any time and to reasonable clinical and safety restrictions. The P/P indicated mental abuse included, but was not limited to humiliation, harassment, and threats of punishment or deprivation. The P/P indicated the facility was to protect the resident from further abuse by making room changes as needed.

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	04/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45891 Based on interview and record review, the facility failed to report immediately and not later than twenty-four hours after receiving an allegation of abuse to the state agency as indicated in the facility's policy and procedure (P/P) for one of six sampled residents (Resident 2). As a result of this deficient practice Resident 2 had the potential to experience additional mental abuse (the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation) from Resident 2's alleged abuser, family member (FM) 4 causing Resident 2 increased anxiety (a mental health disorder characterized by feelings of worry, or fear that are strong enough to interfere with one's daily activities). (cross reference F600 and F610) Findings: During a review of Resident 2's Admission Record, the Admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including confirmed physical abuse, major depressive disorder (a mental health condition that causes a persistently low or depressed mood and a loss of interest in activities that once brought joy), and anxiety disorder. During a review of Resident 2's History and Physical (H&P) dated 3/15/2025, the H&P indicated Resident 2 was admitted to the facility from a general acute care hospital (GACH) due to adult physical abuse causing traumatic ecchymosis (bruising). The H&P indicated Adult Protective Services (APS - a government agency that investigates allegations of a vulnerable adult being or having been abused, neglected, or exploited by their caregivers), and the police had been notified of the abuse by the GACH. The H&P indicated it was unclear if Resident 2 was able to make her own medical decisions and she was making medical decisions with the help of her sister (FM 5). The H&P indicated do not give any information to FM 4, in the plan of treatment. During a review of Resident 2's care plan titled, At risk for re-traumatization related to (r/t) history of physical abuse by a close family member initiated on 3/18/2025, the Care Plan goals included Resident 2 would have no evidence of emotional, physical, and psychological problems. The Care Plan interventions included encouraging Resident 2 to attend care conferences, to express preferences and participate in the care planning process. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2's Interdisciplinary Team (IDT, brings together knowledge from different health care disciplines to help people receive the care they need)- Care Plan Review dated 3/18/2025, the IDT Care Plan Review indicated Resident 2 had an APS case against FM 4 for physical abuse. The IDT Care Plan Review indicated Resident 2 expressed that she did not want any calls or visits from FM 4. Resident 2 also expressed she felt threatened by FM 4, and FM 4 should also be banned from calling or visiting her. Resident 2 expressed she did not want to be discharged home with FM 4 because of the abuse. The IDT documentation indicated FM 4 was verbally, emotionally, financially, and physically abusive towards Resident 2 for years and multiple police reports were filed but Resident 2 always took FM 4 back in until the last event (date no specified) that led to her most recent hospitalization and she decided to press charges against FM 4 and not return to their apartment. During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool) dated 3/21/2025, the MDS indicated Resident 2's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was intact. The MDS indicated Resident 2 was not receiving any medications for anxiety. During a review of Resident 2's Case Manager (CM) Progress Notes dated 3/18/2025, the Case Manager Progress Notes indicated the CM was notified FM 4 was at the facility to visit Resident 2. The CM Progress Notes indicated the CM had been notified by Resident 2 that she did not want visits from FM 4. The CM Progress Notes indicated the CM notified FM 4 of Resident 2's wishes, and FM 4 proceeded to walk towards Resident 2's room stating, that is a lie! I was just there yesterday, and I took a train and two buses to get here. The CM Progress Notes indicated the CM asked FM 4 to wait in the lobby so she (CM) could confirm Resident 2's wishes, and Resident 2 again stated she did not want any calls or visits from FM 4. The CM Progress Notes indicated the CM relayed the message to FM 4, and he became agitated using profanity (bad words). The CM Progress Notes indicated the Police had to be called before FM 4 agreed to leave the facility. The CM Progress Notes indicated Resident 2's chart was updated, and staffing was made aware of Resident 2's wishes to not have visits from FM 4. During a review of Resident 2's Social Services Summary Note dated 3/21/2025, the Social Services Summary Note indicated Resident 2 was verbally responsive with capacity to understand and make decisions. The Social Services Summary Note indicated Resident 2 was unable to sleep well, had anxiety and worries about FM 4 who was physically abusive towards her. During a review of Resident 2's CM Note dated 4/8/2025, the CM Note indicated after lunch (lunch was served by 12:30 p.m.) on 4/8/2025 the CM was notified FM 4 was outside of Resident 2's room. The CM reminded FM 4 of Resident 2's wishes, and he became hostile and aggressive pushing past the CM and two other staff (unknown) to enter Resident 2's room. The CM Note indicated Resident 2's privacy curtain was pulled around Resident 2's bed for privacy and FM 4 proceeded to try and pull back the curtain as nursing staff (Licensed Vocational Nurse [LVN]3) was holding it shut. FM 4 was shouting to Resident 2, It's me FM 4, stop saying you do not want to see me. I came here to see you, tell them it is okay for me to see you, tell them it is okay for me to be here. The CM Note indicated Resident 2 was physically shaking her head No and Resident 2 was visually upset and tearful as she kept her eyes closed and continued shaking her head No. The CM Note indicated staff (unknown) intervened to prevent further interaction with Resident 2 and the police were called. FM 4 was escorted out of the building by two male staff (unknown) as FM 4 was verbally cursing profanities. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2's Change in Condition (COC) evaluation dated 4/8/2025, the COC indicated Resident 2 was experiencing emotional distress. The COC indicated Resident 2 reported feeling anxious after the visit from FM 4 and emotional support was provided. MD 3 was notified and ordered; 1. monitor Resident 2 for emotional distress and 2. Ativan oral tablet 0.5 milligrams (mg) by mouth every eight hours as needed for anxiety manifested by verbalization of anxiousness with mild tremors for three days. 3. Psych consultation related to depression and anxiety. During a review of Resident 2's Care Plan titled Potential for psychosocial well-being problem related to family discord (disagreement, or difference in opinion) dated 4/8/2025, the Care Plan goals included for Resident 2 not having any further indications of psychosocial wellbeing problems. The Care Plan interventions included allowing Resident 2 time to answer questions and to verbalize feelings and fears, consultation with behavioral health, and when conflict arises removing Resident 2 to a calm, safe environment and allowing Resident 2 to vent and share her feelings. During a review of Resident 2's medication administration record (MAR), the MAR indicated Resident 2 was given Ativan 0.5 mg one time on 4/9/2025 for feeling anxious. During a review of Resident 2's Medication Administration Note dated 4/9/2025, the Medication Administration Note indicated Resident 2 was visibly shaken and anxious. Resident 2 was requesting anti-anxiety medications and Resident 2 was given Ativan 0.5 mg. During a review of Resident 2's COC (Condition) Follow-up dated 4/9/2025, the COC Follow-Up indicated Resident 2 had increased anxiety due to FM 4 and Resident 2 was calmer after receiving the Ativan 0.5 mg. During an observation and concurrent interview on 4/14/2025 at 9:50 a.m., Resident 2's name was displayed at the entrance of her door. Resident 2 stated her mind was always wandering, and did not work like it used to. During an interview on 4/15/2025 at 3:17 p.m., Resident 2 declined to elaborate on how FM 4 abused her prior to her admission to the facility. Resident 2 stated she was scared just hearing FM 4's voice when he got into the facility and the situation was mentally exhausting, but she prayed for FM 4 every day and just wanted to move forward with her life. Resident 2 stated the facility provided her with a number to call for therapy, but she had yet to set up an appointment. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/17/2025 at 10:20 a.m., with the CM, the CM stated Resident 2 had come to their facility after a stay in the GACH from sustaining injuries due to being physically assaulted by FM 4. The CM stated Resident 2 had an open APS case against FM 4 prior to her admission to the facility. The CM stated Resident 2 had been dealing with the abuse for several years until she decided to cut ties with FM 4 when she was admitted to the GACH. The CM stated FM 4 had snuck into the facility two times that they know of; on 3/18/2025 and 4/8/2025. The CM stated Resident 2 became visibly shaken up just by the mention of FM 4 being in the vicinity of the facility. The CM stated the first instance FM 4 entered the facility on 3/18/2025, she (the CM) was alerted a male was in Resident 2's room being disruptive so she went to investigate and informed FM 4 he was not welcome at the facility, Resident 2 did not wish to see him, and the police were called. The CM stated the second time he came back to the facility on [DATE], FM 4 was immediately spotted by staff, staff tried to stop him from entering Resident 2's room but he pushed his way into the room and was trying to pull the privacy curtain open, but LVN 3 was holding the privacy curtain shut. The CM stated Resident 2 was receiving peri care, and her privates were exposed while FM 4 was trying to pull the privacy curtain open. The CM stated FM 2's voice was very aggressive, very loud, caused a huge commotion and he was yelling to Resident 2, God dammit you know you want to see me, why are you telling them you do not want to see me! and Resident 2 was crying and very shaken up by the occurrence. The CM stated the way FM 4 was talking, acting, and the tone of voice he was using was verbally and emotionally abusive. The CM stated the abuse coordinator (administrator [ADM]) was aware of the situation that occurred on 4/8/2025. The CM stated she brought it up during a morning meeting with department heads that in GACHs, victims of violence do not have their names outside of their rooms for patient safety and the CM thought it would be a good idea to implement but she does not know what the facility did with that information. The CM stated she believed FM 4 found out what room Resident 2 was in by looking for and finding her name posted outside of her doorway. The CM stated they offered assistance to call a behavioral health self-referral number to set up an appointment for therapy, but the resident declined. During an interview on 4/17/2025 at 10:54 a.m., with the Social Services Director (SSD), the SSD stated Resident 2 became upset at the mention of FM 4's name so they had to respect her and not ask any questions because Resident 2 did not want to talk about any of the details. During an interview on 4/17/2025 at 1:42 p.m., with LVN 3, LVN 3 stated on 4/8/2025 FM 4 bypassed all the safety checks in the facility and snuck into the facility behind another resident's family member (unknown). LVN 3 stated she knew a Certified Nursing Assistant (CNA) (unknown) was providing peri care to Resident 2 at the time, so LVN 3 entered Resident 2's room to check on the resident before FM 4 abruptly made his way past the CM (who was at the doorway of Resident 2's room) and was trying to pull Resident 2's privacy curtain open. LVN 3 stated she was pleading with FM 4 to give Resident 2 some privacy and to let the staff get Resident 2 decent, but FM 4 was cussing at the staff, saying F (fuck), F the police and shouting at Resident 2 to let FM 4 in. LVN 3 stated FM 4 was shouting multiple things at Resident 2, but she couldn't exactly remember everything that was said. LVN 3 stated Resident 2 was visibly in fear, shaking, and traumatized. LVN 3 stated the interaction was verbal abuse and emotional abuse by the way he was talking to Resident 2 and the response Resident 2 had to the interaction. LVN 3 stated Resident 2 ended up needing Ativan because she was so shaken up. LVN 3 stated the abuse coordinator (ADM) was aware of the situation but was not sure if the incident was reported to necessary agencies other than the police because the police were called. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/18/2025 at 10:36 a.m., with the ADM, the ADM stated she was the abuse coordinator for the facility. The ADM stated the facility was informed an open APS case was filed against FM 4 for the abuse Resident 2 sustained. The ADM stated the police were called after the first incident 3/18/2025 and staff were notified not to let FM 4 in and to call the police if they saw him. The ADM stated the second incident on 4/8/2025 she was incorrectly informed after the incident had happened, that FM 4 did not enter Resident 2's room and staff were able to stop him from entering the room. The ADM stated from what she learned about the 4/8/2025 incident FM 4 was aggressive towards staff and just stated he wanted to see Resident 2, so she did not believe it was abuse but rather family dynamics. The ADM stated the incident was not reported to the state agency and a thorough investigation was not done but if she knew FM 4 entered the room and the details of the interaction she may have done things differently. The ADM read the details in Resident 2's medical record including the CM notes and COC dated 4/8/2025. The ADM stated she was not aware FM 4 entered Resident 2's room, was shouting towards Resident 2, and Resident 2 was shaking her head no and crying. The ADM stated it was important staff members reported accurate descriptions of events because that determined the course of action she takes and if an incident needed to be reported to the state agency. The ADM stated she unfortunately never spoke to Resident 2 herself regarding the situation. The ADM stated according to the facility's policy and procedure (P/P) titled Abuse: Prevention of and Prohibition Against definition of mental abuse, mental abuse included harassment. The ADM stated if there was an allegation of abuse, the incident needed to be thoroughly investigated and reported to the state agency right away. The ADM stated Resident 2 remained in the same room from the time of admission (3/16/2025) to the time of discharge (4/17/2025) and she could not find any evidence in Resident 2's chart she was offered a room change after the first incident on 3/18/2025, and the second incident on 4/8/2025 of FM 4 forcing his way into Resident 2's room for her safety. The ADM stated after the second incident on 4/8/2025, she (ADM) became worried about Resident 2's safety so she had the CM reach out to Resident 2's insurance to request a transfer to another facility but Resident 2's insurance declined. During a review of the facility's P/P titled Abuse: Prevention of and Prohibition Against revised 12/2023, the P/P indicated each resident had the right to be free of abuse. The P/P indicated abuse was the willful (the individual acted deliberately) infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain, or mental anguish. The P/P indicated the facility was to ensure the health and safety of each resident with regards to visitors, such as family members, friends, or other individuals subject to the resident's right to deny or withdraw consent at any time and to reasonable clinical and safety restrictions. The P/P indicated mental abuse included, but was not limited to humiliation, harassment, and threats of punishment or deprivation. The P/P indicated the facility was to protect the resident from further abuse by making room changes as needed. The P/P indicated allegations of abuse would be reported outside of the facility to appropriate State or Federal agencies in the applicable timeframes as per regulations.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45891 Based on interview and record review, the facility failed investigate an allegation of abuse as indicated in the facility's policy and procedure (P/P) for one of six sampled residents (Resident 2). As a result of this deficient practice Resident 2 had the potential to experience additional mental abuse (the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation) from Resident 2's alleged abuser, family member (FM) 4 causing Resident 2 increased anxiety (a mental health disorder characterized by feelings of worry, or fear that are strong enough to interfere with one's daily activities). (cross reference F600 and F609) Findings: During a review of Resident 2's Admission Record, the Admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including confirmed physical abuse, major depressive disorder (a mental health condition that causes a persistently low or depressed mood and a loss of interest in activities that once brought joy), and anxiety disorder. During a review of Resident 2's History and Physical (H&P) dated 3/15/2025, the H&P indicated Resident 2 was admitted to the facility from a general acute care hospital (GACH) due to adult physical abuse causing traumatic ecchymosis (bruising). The H&P indicated Adult Protective Services (APS - a government agency that investigates allegations of a vulnerable adult being or having been abused, neglected, or exploited by their caregivers), and the police had been notified of the abuse by the GACH. The H&P indicated it was unclear if Resident 2 was able to make her own medical decisions and she was making medical decisions with the help of her sister (FM 5). The H&P indicated do not give any information to FM 4, in the plan of treatment. During a review of Resident 2's care plan titled, At risk for re-traumatization related to (r/t) history of physical abuse by a close family member initiated on 3/18/2025, the Care Plan goals included Resident 2 would have no evidence of emotional, physical, and psychological problems. The Care Plan interventions included encouraging Resident 2 to attend care conferences, to express preferences and participate in the care planning process. During a review of Resident 2's Interdisciplinary Team (IDT, brings together knowledge from different health care disciplines to help people receive the care they need)- Care Plan Review dated 3/18/2025, the IDT Care Plan Review indicated Resident 2 had an APS case against FM 4 for physical abuse. The IDT Care Plan Review indicated Resident 2 expressed that she did not want any calls or visits from FM 4. Resident 2 also expressed she felt threatened by FM 4, and FM 4 should also be banned from calling or visiting her. Resident 2 expressed she did not want to be discharged home with FM 4 because of the abuse. The IDT documentation indicated FM 4 was verbally, emotionally, financially, and physically abusive towards Resident 2 for years and multiple police reports were filed but Resident 2 always took FM 4 back in until the last event (date no specified) that led to her most recent hospitalization and she decided to press charges against FM 4 and not return to their apartment. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool) dated 3/21/2025, the MDS indicated Resident 2's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was intact. The MDS indicated Resident 2 was not receiving any medications for anxiety. During a review of Resident 2's Case Manager (CM) Progress Notes dated 3/18/2025, the Case Manager Progress Notes indicated the CM was notified FM 4 was at the facility to visit Resident 2. The CM Progress Notes indicated the CM had been notified by Resident 2 that she did not want visits from FM 4. The CM Progress Notes indicated the CM notified FM 4 of Resident 2's wishes, and FM 4 proceeded to walk towards Resident 2's room stating, that is a lie! I was just there yesterday, and I took a train and two buses to get here. The CM Progress Notes indicated the CM asked FM 4 to wait in the lobby so she (CM) could confirm Resident 2's wishes, and Resident 2 again stated she did not want any calls or visits from FM 4. The CM Progress Notes indicated the CM relayed the message to FM 4, and he became agitated using profanity (bad words). The CM Progress Notes indicated the Police had to be called before FM 4 agreed to leave the facility. The CM Progress Notes indicated Resident 2's chart was updated, and staffing was made aware of Resident 2's wishes to not have visits from FM 4. During a review of Resident 2's Social Services Summary Note dated 3/21/2025, the Social Services Summary Note indicated Resident 2 was verbally responsive with capacity to understand and make decisions. The Social Services Summary Note indicated Resident 2 was unable to sleep well, had anxiety and worries about FM 4 who was physically abusive towards Resident 2. During a review of Resident 2's CM Note dated 4/8/2025, the CM Note indicated after lunch (lunch was served by 12:30 p.m.) on 4/8/2025 the CM was notified FM 4 was outside of Resident 2's room. The CM reminded FM 4 of Resident 2's wishes, and he became hostile and aggressive pushing past the CM and two other staff (unknown) to enter Resident 2's room. The CM Note indicated Resident 2's privacy curtain was pulled around Resident 2's bed for privacy and FM 4 proceeded to try and pull back the curtain as nursing staff (Licensed Vocational Nurse [LVN]3) was holding it shut. FM 4 was shouting to Resident 2, It's me FM 4, stop saying you do not want to see me. I came here to see you, tell them it is okay for me to see you, tell them it is okay for me to be here. The CM Note indicated Resident 2 was physically shaking her head No and Resident 2 was visually upset and tearful as she kept her eyes closed and continued shaking her head No. The CM Note indicated staff (unknown) intervened to prevent further interaction with Resident 2 and the police were called. FM 4 was escorted out of the building by two male staff (unknown) as FM 4 was verbally cursing profanities. During a review of Resident 2's Change in Condition (COC) evaluation dated 4/8/2025, the COC indicated Resident 2 was experiencing emotional distress. The COC indicated Resident 2 reported feeling anxious after the visit from FM 4 and emotional support was provided. MD 3 was notified and ordered; 1. monitor Resident 2 for emotional distress and 2. Ativan oral tablet 0.5 milligrams (mg) by mouth every eight hours as needed for anxiety manifested by verbalization of anxiousness with mild tremors for three days. 3. Psych consultation related to depression and anxiety. During a review of Resident 2's Care Plan titled Potential for psychosocial well-being problem related to family discord (disagreement, or difference in opinion) dated 4/8/2025, the Care Plan goals included for Resident 2 not having any further indications of psychosocial wellbeing problems. The Care Plan interventions included allowing Resident 2 time to answer questions and to verbalize feelings and fears, consultation with behavioral health, and when conflict arises removing Resident 2 to a calm, safe environment and allowing Resident 2 to vent and share her feelings. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2's medication administration record (MAR), the MAR indicated Resident 2 was given Ativan 0.5 mg one time on 4/9/2025 for feeling anxious. During a review of Resident 2's Medication Administration Note dated 4/9/2025, the Medication Administration Note indicated Resident 2 was visibly shaken and anxious. Resident 2 was requesting anti-anxiety medications and Resident 2 was given Ativan 0.5 mg. During a review of Resident 2's COC (Condition) Follow-up dated 4/9/2025, the COC Follow-Up indicated Resident 2 had increased anxiety due to FM 4 and Resident 2 was calmer after receiving the Ativan 0.5 mg. During an observation and concurrent interview on 4/14/2025 at 9:50 a.m., Resident 2's name was displayed at the entrance of her door. Resident 2 stated her mind was always wandering, and did not work like it used to. During an interview on 4/15/2025 at 3:17 p.m., Resident 2 declined to elaborate on how FM 4 abused her prior to her admission to the facility. Resident 2 stated she was scared just hearing FM 4's voice when he got into the facility and the situation was mentally exhausting, but she prayed for FM 4 every day and just wanted to move forward with her life. Resident 2 stated the facility provided her with a number to call for therapy, but she had yet to set up an appointment. During an interview on 4/17/2025 at 10:20 a.m., with the CM, the CM stated Resident 2 had come to their facility after a stay in the GACH from sustaining injuries due to being physically assaulted by FM 4. The CM stated Resident 2 had an open APS case against FM 4 prior to her admission to the facility. The CM stated Resident 2 had been dealing with the abuse for several years until she decided to cut ties with FM 4 when she was admitted to the GACH. The CM stated FM 4 had snuck into the facility two times that they know of; on 3/18/2025 and 4/8/2025. The CM stated Resident 2 became visibly shaken up just by the mention of FM 4 being in the vicinity of the facility. The CM stated the first instance FM 4 entered the facility on 3/18/2025, she (the CM) was alerted a male was in Resident 2's room being disruptive so she went to investigate and informed FM 4 he was not welcome at the facility, Resident 2 did not wish to see him, and the police were called. The CM stated the second time he came back to the facility on [DATE], FM 4 was immediately spotted by staff, staff tried to stop him from entering Resident 2's room but he pushed his way into the room and was trying to pull the privacy curtain open, but LVN 3 was holding the privacy curtain shut. The CM stated Resident 2 was receiving peri care, and her privates were exposed while FM 4 was trying to pull the privacy curtain open. The CM stated FM 2's voice was very aggressive, very loud, caused a huge commotion and he was yelling to Resident 2, God dammit you know you want to see me, why are you telling them you do not want to see me! and Resident 2 was crying and very shaken up by the occurrence. The CM stated the way FM 4 was talking, acting, and the tone of voice he was using was verbally and emotionally abusive. The CM stated the abuse coordinator (administrator [ADM]) was aware of the situation that occurred on 4/8/2025. The CM stated she brought it up during a morning meeting with department heads that in GACHs, victims of violence do not have their names outside of their rooms for patient safety and the CM thought it would be a good idea to implement but she does not know what the facility did with that information. The CM stated she believed FM 4 found out what room Resident 2 was in by looking for and finding her name posted outside of her doorway. The CM stated they offered assistance to call a behavioral health self-referral number to set up an appointment for therapy, but the resident declined. (continued on next page)

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/17/2025 at 10:54 a.m., with the Social Services Director (SSD), the SSD stated Resident 2 became upset at the mention of FM 4's name so they had to respect her and not ask any questions because Resident 2 did not want to talk about any of the details. During an interview on 4/17/2025 at 1:42 p.m., with LVN 3, LVN 3 stated on 4/8/2025 FM 4 bypassed all the safety checks in the facility and snuck into the facility behind another resident's family member (unknown). LVN 3 stated she knew a Certified Nursing Assistant (CNA) (unknown) was providing peri care to Resident 2 at the time, so LVN 3 entered Resident 2's room to check on the resident before FM 4 abruptly made his way past the CM (who was at the doorway of Resident 2's room) and was trying to pull Resident 2's privacy curtain open. LVN 3 stated she was pleading with FM 4 to give Resident 2 some privacy and to let the staff get Resident 2 decent, but FM 4 was cussing at the staff, saying F (fuck), F the police and shouting at Resident 2 to let FM 4 in. LVN 3 stated FM 4 was shouting multiple things at Resident 2, but she couldn't exactly remember everything that was said. LVN 3 stated Resident 2 was visibly in fear, shaking, and traumatized. LVN 3 stated the interaction was verbal abuse and emotional abuse by the way he was talking to Resident 2 and the response Resident 2 had to the interaction. LVN 3 stated Resident 2 ended up needing Ativan because she was so shaken up. LVN 3 stated the abuse coordinator (ADM) was aware of the situation but was not sure if the incident was reported to necessary agencies other than the police because the police were called. During an interview on 4/18/2025 at 10:36 a.m., with the ADM, the ADM stated she was the abuse coordinator for the facility. The ADM stated the facility was informed an open APS case was filed against FM 4 for the abuse Resident 2 sustained. The ADM stated the police were called after the first incident 3/18/2025 and staff were notified not to let FM 4 in and to call the police if they saw him. The ADM stated the second incident on 4/8/2025 she was incorrectly informed after the incident had happened, that FM 4 did not enter Resident 2's room and staff were able to stop him from entering the room. The ADM stated from what she learned about the 4/8/2025 incident FM 4 was aggressive towards staff and just stated he wanted to see Resident 2, so she did not believe it was abuse but rather family dynamics. The ADM stated the incident was not reported to the state agency and a thorough investigation was not done but if she knew FM 4 entered the room and the details of the interaction she may have done things differently. The ADM read the details in Resident 2's medical record including the CM notes and COC dated 4/8/2025. The ADM stated she was not aware FM 4 entered Resident 2's room, was shouting towards Resident 2, and Resident 2 was shaking her head no and crying. The ADM stated it was important staff members reported accurate descriptions of events because that determined the course of action she takes and if an incident needed to be reported to the state agency. The ADM stated she unfortunately never spoke to Resident 2 herself regarding the situation. The ADM stated according to the facility's policy and procedure (P/P) titled Abuse: Prevention of and Prohibition Against definition of mental abuse, mental abuse included harassment. The ADM stated if there was an allegation of abuse, the incident needed to be thoroughly investigated and reported to the state agency right away. The ADM stated Resident 2 remained in the same room from the time of admission (3/16/2025) to the time of discharge (4/17/2025) and she could not find any evidence in Resident 2's chart she was offered a room change after the first incident on 3/18/2025, and the second incident on 4/8/2025 of FM 4 forcing his way into Resident 2's room for her safety. The ADM stated after the second incident on 4/8/2025, she (ADM) became worried about Resident 2's safety so she had the CM reach out to Resident 2's insurance to request a transfer to another facility but Resident 2's insurance declined. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P/P titled Abuse: Prevention of and Prohibition Against revised 12/2023, the P/P indicated each resident had the right to be free of abuse. The P/P indicated abuse was the willful (the individual acted deliberately) infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain, or mental anguish. The P/P indicated the facility was to ensure the health and safety of each resident with regards to visitors, such as family members, friends, or other individuals subject to the resident's right to deny or withdraw consent at any time and to reasonable clinical and safety restrictions. The P/P indicated mental abuse included, but was not limited to humiliation, harassment, and threats of punishment or deprivation. The P/P indicated the facility was to protect the resident from further abuse by making room changes as needed. The P/P indicated allegations of abuse would be promptly and thoroughly investigated. The P/P indicated the investigation would include an interview with the resident, interviews of any witnesses, a review of the resident's record, interviews of other residents, and a review of the circumstances surrounding the incident. The P/P indicated the results of the investigation were to be documented.

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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** 45891 50144 Based on observation, interview, and record review, the facility failed to develop and implement comprehensive, person-centered care plans for three of 11 sampled residents (Resident 35, Resident 52 and Resident 57) when: a. Resident 35's care plan titled Has actual impairment to skin integrity related to (r/t) left heel blister (a painful skin condition where fluid fills a space between layers of skin)initiated [DATE] was not updated until [DATE] to indicate Resident 35 had a left heel suspected deep tissue pressure injury (SDTI, a form of unrelieved pressure-induced damage to underlying tissues, including muscles, bones, and subcutaneous layers, while the skin surface might remain intact. It typically results from sustained pressure or shear forces that compromise blood flow, leading to ischemia and subsequent tissue necrosis. Recognizing a suspected deep tissue injury is crucial for timely intervention to prevent progression to more severe wounds) and the facility failed to initiate and implement person-centered interventions for Resident 35's care plan for has actual impairment to skin integrity r/t left heel SDTI until [DATE]. b Resident 52 refused to get weighed for the past five months. c. Resident 57's care plan was not personalized to the resident appropriately upon admission on [DATE] and when right buttock redness developed on [DATE]. These failures had the potential to result in inadequate care, unmet needs, and compromised resident outcomes, placing residents at risk for avoidable decline in health, safety, and quality of life. Findings: a. During a review of Resident 35's Admission Record, the Admission Record indicated Resident 35 was admitted to the facility on [DATE] with diagnoses of left femur fracture (broken leg bone), fall, muscle weakness, difficulty in walking, joint replacement surgery, and type 2 diabetes (happens when the body cannot use insulin correctly and sugar builds up in the blood). During a review of Resident 35's general acute care hospital (GACH) clinical documents sent to the facility from the GACH, the Wound Care Consult dated [DATE] indicated Resident 35 had a 6 centimeter (cm, a unit of measurement) by 6 cm stage 2 (a partial skin thickness loss that may present as an intact blister)/ DTI with an intact fluid filled blister. The Wound Care Consult indicated Resident 35 required Pressure Injury Prevention Protocol including a waffle seat cushion (an air pressure redistribution cushion) or a low air loss mattress (LALM mattresses that are designed to distribute the patient's body weight over a broad surface area and help prevent skin breakdown. Air continually flows through tiny laser-made air holes in the top of the mattress surface so that the user floats on a soft cushion of air) to be turned and repositioned every 2 hours, and to offload (reducing or removing pressure) the heels over a pillow or heel protector boots. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 35's Licensed Nurse (LN)- Initial Admission Record dated [DATE], the Initial Admission Record indicated a skin integrity check was done by TXN 2, and the physician (unspecified) was notified of the left heel blister. During a review of the Admission Report- Skin Check (paper document) undated, the skin check indicated Resident 35 had a 3 cm by 6 cm left heel blister. During a review of Resident 35's care plan titled, Has actual impairment to skin integrity related to (r/t) left heel blister initiated [DATE], the goals for Resident 35 included reducing the risk for impairment to skin integrity by positioning techniques, and adaptive equipment. Interventions included avoiding scratching, keeping body parts from excessive moisture, keeping fingernails short, educating resident/ family/ and caregivers of causative factors and measures to prevent skin injury, and encouraging good nutrition and hydration to promote healthier skin. On [DATE] the care plan for the left heel blister was updated to include, on [DATE]: patient was reassessed by TXN 1, the left heel blister was clarified as SDTI with purple tissue. On [DATE] the care plan interventions were updated to include left heel SDTI treatment as ordered, monitor/ document location, size and treatment of the skin injury, report abnormalities, failure to heal, signs and symptoms of infection to the physician, monitor for skin breakdown and off-load (minimizing or removing weight placed on the foot to help prevent and heal ulcers) as tolerated. During a review of Resident 35's Skin/ Wound Note dated [DATE] (three days after admission), the Skin/ Wound Note indicated Resident 35 was reassessed by TXN 1 and the left heel blister was clarified as an SDTI with purple tissue. During a review of Resident 35's minimum data set (MDS, a resident assessment tool) dated [DATE], the MDS indicated Resident 35 had moderate cognitive impairment (having problems remembering things, concentrating, making decisions and solving problems) and required substantial/ maximal assistance (helper does more than half the effort) for bed mobility including rolling from left to right. The MDS indicated Resident 35 was at risk for pressure injuries and had two deep tissue injuries. During an interview on [DATE] at 11:16 a.m., treatment nurse (TXN 1) stated DTIs could deteriorate rapidly with any pressure due to the fragility of the skin and it was important to be proactive with interventions and offload the heels for the best chance for wound healing. TXN 1 stated wound interventions should be implemented immediately to keep the wound healthy, infection free, mitigate pain, and to promote healing. TXN 1 stated she reviewed Resident 35's care plans and the care plan was not updated until [DATE] to include the reclassified SDTI staging of the left heel wound and to offload the heels. TXN 1 stated a comprehensive person-centered care plan for each wound was important because the facility needed to identify the problem, assess the risk associated with the problem, and implement interventions to prevent a decline in the wound and to promote wound healing. During an interview on [DATE] at 2:33 p.m., the director of nursing (DON) stated person-centered care plans and interventions with wounds were important to implement immediately to start the healing process and to prevent a decline in wounds. The DON stated Resident 35's care plan should have been implemented as soon as the left heel wound was reclassified as an SDTI on [DATE] but according to her review of the care plan it was not updated until [DATE]. (continued on next page)

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F 0656 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 Comprehensive Person-Centered Care Planning dated ,d+[DATE], the P/P indicated the facility was to develop a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet the residents medical, nursing, mental and psychosocial needs. b. During a review of Resident 52's Admission Record, the Admission Record indicated the facility admitted Resident 52 on [DATE] and readmitted on [DATE] with diagnoses including dysphagia (swallowing difficulties), type 2 diabetes mellitus. During a review of Resident 52's MDS, dated [DATE], the MDS indicated Resident 52's cognitive skills were moderately impaired. The MDS indicated Resident 52 required setup or clean-up assistance (helper sets up or cleans up) with eating, oral hygiene, maximal assistance (helper does more than half the effort to complete task) with showering, was dependent (helper does all the effort) with toileting hygiene and personal hygiene. During a review of Resident 52's Order Summary Report, orders as of [DATE], the Order Summary Report indicated an order for Resident 52 to be seen by the Registered Dietitian (RD) consultant related to mini nutritional assessment (MNA-a validated screening tool used to identify older adults who are malnourished or at risk of malnutrition) score of 5.0 (score ,d+[DATE] indicates malnutrition) at risk for malnutrition on [DATE]. During a review of Resident 52's Weights and Vitals Summary (WVS), month of [DATE], [DATE], [DATE], February 2025, [DATE] and [DATE] were reviewed. The summary indicated that Resident 52's last recorded weight was on [DATE], which was 317.9 pounds (lbs-unit of weight), and the facility did not obtain or document his weight for the past five months after that date. During a review of Resident 52's interdisciplinary team (IDT-a gathering where healthcare professionals from different specialties come together to discuss a patient's care) progress note, dated [DATE], the Progress note indicated that the IDT held a meeting at the bedside to discuss the resident's refusal to be weighed. The IDT progress note indicated during the discussion, the resident stated that he would take it day by day and would let staff know if he wants to participate (in being weighed) or not. During a review of Resident 52's RD Note, dated [DATE] and [DATE], the RD Note indicated that Resident 52 refused to be weighed. The RD Note did not include the reason for Resident 52's refusal to be weighed, there was no documentation of the facility's attempts to encourage or support Resident 52 in completing the weight assessment. During a review of Resident 52's care plan for refusing to be weighed, dated [DATE], the care plan indicated that Resident 52 preferred not to be weighed with a full understanding of the risks. The care plan interventions included to offer getting weighed to Resident 52 at least every three months. The care plan did not include the reason for the refusal or interventions to encourage or support Resident 52 in completing the weight assessment. (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 [DATE] at 8:02 a.m., with Resident 52, Resident 52 stated that he did not refuse to be weighed, but that staff were unable to complete the weight check because the lift machine the facility used to weigh him with caused him pain on his knees. Resident 52 stated his knees hurt because when the staff try to weigh him with the lift machine, the sling used with the lift was not long enough to properly support his legs and that caused pain. During a concurrent observation and interview on [DATE] at 8:58 a.m., in Resident 52's room, Restorative Nursing Aide (RNA) 2 asked Resident 52 to get weighed, and the resident stated that it would not work. RNA 2 reported the refusal to the charge nurse. RNA 2 stated that the resident had previously refused to be weighed. During an observation on [DATE] at 9:03 a.m., in Resident 52's room, observed Resident 52 agreed to be weighed when assisted by Physical Therapy (PT) 1 with leg support, and the resident's weight was 251.3lbs. During an interview on [DATE] at 9:10 a.m., with Resident 52, Resident 52 stated he had been wanting to lose weight, and he was glad to see that he had. During a review of Resident 52's Weights and Vitals Summary, dated [DATE], the Weight and Vital Summary indicated Resident 52 had a 26.50 % weight loss compared to the last weight taken in November, indicating a significant change that had gone unmonitored for five months. During a concurrent interview and record review on [DATE] at 9:34 a.m., with Registered Nurse Supervisor (RNS)1, Resident 52's Weights and Vitals Summary, Progress notes, care plan, from ,d+[DATE] to , d+[DATE] were reviewed. RNS 1 stated that there had been no body weight records for the past five months until today, at which point they became aware of the weight loss. RNS 1 stated that monitoring residents' (in general) body weight was important because it was an indicator of the residents' nutritional status. RN 1 stated if a resident refused to be weighed, staff should assess the reason, accommodate their needs, and document it in the progress notes. The care plan should be updated to indicate the specific care required and the reason for the resident's refusal. During an interview on [DATE] at 2:27p.m., with the DON, the DON stated that there was no documentation reflecting any effort made to address Resident 52's needs related to being weighed. There was also no documentation showing that the reason for the refusal to be weighted was assessed, addressed, or accommodated. The DON state that when a resident refused to be weighed, staff should educate the resident, assess related reasons or concerns, attempt accommodations, and if the resident still refuses, they should document the refusals, and develop or update the care plan accordingly. During an interview on [DATE] at 9:43 a.m. with Resident 52's physician (MD) 2, MD 2 stated that Resident 52's weight loss for last five months was not planned, and he expected the facility weighed his weight. MD 2 also stated it was unusual when they did not weigh his weight for last five months. During a concurrent interview and record review on [DATE] at 10:27 a.m., with the DON, Resident 52's care plan for not to be weighed, initiated [DATE], was reviewed. The DON stated that the care plan was general, missing what the underlying issue was, and missing interventions to fix or to address the problem. The DON stated the care plan should be established for the issues, and the goal should be set up to accommodate the issues, and the intervention should include addressing the causes. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. During a review of Resident 57's Admission record, the Admission Record indicated the facility admitted the resident on [DATE] with diagnoses including metabolic encephalopathy (brain dysfunction caused by underlying metabolic disorders or conditions), cerebral infarction (stroke - loss of blood flow to a part of the brain), and wedge compression fracture (when the front part of the bones of the spine collapse, creating a wedge shape). During a review of Resident 57's Licensed Nurse (LN) Admission Evaluation dated [DATE], the LN Admission Evaluation indicated Resident 57 had a right and left heel pressure injury on admission, Left knee injury, discolorations on neck, and skin tags on back. During a review of Resident 57's History and Physical (H&P), dated [DATE], the H&P indicated Resident 57 did not have the capacity to understand and make decisions. During a review of Resident 57's MDS, dated [DATE], the MDS indicated Resident 57 had moderate cognitive impairment, required supervision for eating and oral hygiene, required moderate assistance (helper does less than half the effort) for toileting, and required maximal assistance (helper does more than half the effort) for bathing. During a review of Resident 57's care plan titled, Has potential for pressure ulcer development related to (r/t) recent hospitalization r/t right basal ganglia stroke, dementia, history (hx) of falls, hypertension (HTN - high blood pressure, hyperlipidemia (HLD-elevated lipids (fats) in the blood), osteopenia (lower than normal bone density), and rhabdomyolysis (condition where damaged muscle tissue releases into the bloodstream) initiated [DATE], the care plan indicated a goal will have intact skin, free of redness, blisters or discoloration. On [DATE], the care plan intervention was updated to include Turned and repositioned every 2 (Q2) hours as resident allows. During a review of Resident 57's care plan titled, Has actual impairment to skin integrity r/t skin discoloration - Right (R) buttock, redness, initiated on [DATE], the care plan indicated Resident 57 had R buttock redness. The care plan indicated the following interventions: encourage good nutrition and hydration in order to promote healthier skin, keep skin clean and dry. Use lotion on dry skin, provide treatment as ordered. During a review of Resident 57's care plan titled, Has pressure ulcer or potential for pressure ulcer development r/t immobility right buttock unstageable, initiated [DATE], the care plan indicated Resident 57 had an unstageable right buttock injury. The care plan indicated the following interventions: Administer treatments as ordered and monitor for effectiveness, educate resident, family/caregivers as to causes of skin breakdown including transfer/positioning requirements, importance of taking care during ambulating/mobility, good nutrition and frequent repositioning, requires pressure relieving/reducing device on bed/chair, and to turn and reposition as tolerated. During a review of Resident 57's order summary, the orders indicated a LALM due to (d/t) right buttock unstageable, left heel stage three ordered on [DATE]. During a review of the Skilled Nursing Facility (SNF) Wound Care documentation by the Nurse Practitioner (NP) from [DATE] to [DATE], the SNF Wound Care documentation indicated the following: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-[DATE]: Right buttock unstageable pressure-induced tissue damage which measured a length of 6.2 Centimeters (CM - unit of measurement), a width of 6.4 CM, to be determined(UTD-meaning the base of the wound was not fully visualized due to wound debris, slough or eschar so the measurement was unable to be determinedundermining (the destruction of tissue or ulcer extending under the skin edges so that the pressure ulcer is larger at its base than at the skin surface) or tunnelinga passageway of tissue destruction under the skin surface that has an opening at the skin level from the edge of the wound) was noted. Post (after) debridement (process of removing dead or damaged tissue and debris from a wound) measured a length of 6.2 CM, a width of 6.5 CM, and width was UTD. Procedure: Necrotic (dead tissue that is no longer function and cannot be revived) subcutaneous tissue debridement. Indications: Removal of dead subcutaneous (under top layer of skin) tissue to promote healing. Tissue type: 30% granulation (type of new connective tissue), 70% slough. -[DATE]: Right buttock unstageable pressure -induced tissue damage which measured a length of 6.0 CM, a width of 3.6 CM, and depth was UTD. Post debridement measured a length of 6.1 CM, a width of 3.6 CM, and a depth was UTD. Dead subcutaneous tissue debridement performed. Tissue type: 40% granulation, 60% slough -[DATE]: Right buttock unstageable pressure-induced damage which measured a length of 5.8 CM, a width of 3.5 CM, and depth was UTD. Post debridement measured a length of 5.9 CM, a width of 3.6 CM, and depth was UTD. Dead subcutaneous tissue debridement performed. Tissue type: 50% granulation, 50% slough [DATE]: Right buttock unstageable pressure -induced tissue damage, now reclassified as stage four which measured a length of 4.1 CM, a width of 2.6 CM, and a depth 0.4 CM. Post debridement measured a length of 4.2 CM, a width of 2.7 CM, and a depth of 0.5 CM. Dead subcutaneous tissue debridement performed. Tissue type: 90% granulation, 10% slough During a concurrent interview and record review on [DATE] at 11:35 a.m., with the treatment nurse (TXN) 1, Resident 57's chart was reviewed. TXN 1 stated Resident 57 developed redness to the right buttock in [DATE] and [DATE] which progressed to MASD on [DATE], which progressed to an unstageable injury requiring debridement on [DATE]. TXN 1 stated Resident 57 was at risk for developing pressure injuries on admission and should have had orders and a care plan to reposition the resident frequently. TXN 1 stated Resident 57 should have had an order for nutritional supplement support such as multivitamins, zinc sulfate, vitamin C, and prostat when the right buttock redness occurred. During a concurrent interview and record review on [DATE] at 12:18 p.m., with the Director of Nursing (DON), Resident 57's chart was reviewed. The DON stated it is not normal for a resident with intact skin on admission to develop a stage four pressure injury. The DON stated on admission, Resident 57's Braden Scale (tool used to determine resident's risk for developing pressure injuries), indicated a score of 19 - Low risk. The DON stated the Change of Condition dated [DATE] indicated Resident 57 had a decline in Restorative Nursing Assistant (RNA) ambulation. The DON stated the Braden Scale was not reassessed but should have been reassessed to reflect the resident's condition. The DON stated if the Braden scale was reassessed, Resident 57 could have been identified as a risk and care plan interventions could have been implemented such as repositioning more frequently and offloading. (continued on next page)

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F 0656 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, comprehensive resident centered care plan, revised ,d+[DATE], the P&P indicated the IDT shall develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The P&P also indicated that a summary of the IDT care plan review can include person centered comprehensive care planning and resident's response to the established plan of care. 50387

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50144 Based on interview and record review, the facility failed to ensure the following were completed for two of three sampled residents: a. Resident 57 was seen by a neurologist as ordered b. Resident 63's decision making capacity was determined. This failure resulted in Resident 57 not being assessed by a neurologist potentially missing diagnostic test or services and Resident 63 potentially losing their right to make their own health care decisions and/or delaying care or treatment. Findings: During a review of Resident 57's Admission record, the Admission record indicated Resident 57 was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (brain dysfunction caused by underlying metabolic disorders or conditions), cerebral infarction (stroke - loss of blood flow to a part of the brain), and a lower spinal cord compression fracture (break in the bone). The admission record indicated 57's Family member (FM 7) was the the residents responsible party/resident's representative. During a review of Resident 57's History and Physical (H&P), dated 12/12/2024, the H&P indicated Resident 57 did not have the capacity to understand and make decisions. During a review of Resident 57's Minimum Data Set (MDS - a resident assessment tool), dated 12/18/2024, the MDS indicated Resident 57 was moderetly cognitvly (ability to learn, reason, remember, understand, and make decisions) impaired, required supervision for eating and oral hygiene, required moderate assistance (helper does less than half the effort) for toileting, and required maximal assistance (helper does more than half the effort) for bathing. During a review of Resident 57's Physician Order Summary, the Order Summary indicated an order for: 1. Neurology in 2-4 weeks ordered on 12/12/2024 2. Neuro consult (dx: dementia) ordered on 2/7/2025 During an interview on 4/18/2025 at 2:34 p.m., with FM 7, FM 7 stated Resident 57 was supposed to be seen by a neurologist, but when she (FM 7) followed up with the Social Services Director (SSD) about the results, FM 7 was told the appointment did not happen and Resident 57 missed the appointment. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/18/2025 at 3:04 p.m., with the Assistant Director of Nursing (ADON), the ADON stated when physician or specialized consults are ordered (in general), the case manager (CM) arranges the appointment with the insurance. The ADON stated once the appointment is confirmed and the transportation arranged, the CM enters the confirmed appointment as an order so that it is communicated to the team and the resident resident's representative should be updated. The ADON stated there was no appointment confirmation in Resident 57's chart. During an interview on 4/18/2025 at 4:20 p.m, with the Director of Nursing (DON), the DON stated it is the responsibility of the CM to follow up on the appointment and communicate it to the team by entering it in the resident's record. The DON stated if the facility fails to follow up and schedule an appointment to a neurologist, it can delay treatment to the resident. b. During a review of Resident 63's Admission record , the Admission record indicated Resident 63 was admitted to the facility on [DATE] with diagnoses including encephalopathy (damage or disease that affects brain function) and cognitive communication deficit (difficulties with any aspect of communication that are caused by problems with cognitive processes, not speech or language.) During a review of Resident 63's History and Physical (H&P), dated 3/20/2025, the H&P indicated for Decision making capabilities: defer to psychiatry/neurology. During a review of Resident 63's MDS, dated [DATE], the MDS indicated Resident 63 had severe impairment to cognition (ability to learn, reason, remember, understand, and make decisions) and required supervision for eating, required moderate assistance (helper does less than half the effort) for oral and personal hygiene, required maximal assistance (helper does more than half the effort) for bathing, and was dependent (helper does all the effort) for toileting. During a concurrent interview and record review on 4/18/2025 at 9:19 a.m., with the ADON, Resident 63's medical record was reviewed. The ADON stated the H&P dated 3/20/2025 does not indicate if Resident 63 had the capacity to make decisions. The Psychiatry Visit summary dated 3/19/2025 was reviewed and indicated Resident 63 was seen by the Psychiatrist but the Visit Summary does not indicate if it was determined that Resident 63 had the capacity to make decisions. The ADON stated there is no section that clearly stated Resident's mental capacity. The ADON stated Resident 63 was not seen by neurology. The ADON stated it is important that capacity is determined to know whether a resident or resident representative makes decisions and gives informed consents. The ADON stated nursing should have followed up on Resident 63's decision making capacity. During a review of the facility's policy and procedure (P&P), titled Social Services, Provision of Medically-Related, revised 12/2023, the P&P indicated Social services is responsible for providing for the medially related social services needs of each resident. I is not required that the social worker provides these services by assures that they are provided. Examples of these services may include transportation and scheduling appointments. During a review of the facility's policy and procedure (P&P), titled Informed Consent - CA, revised 5/2019, the P&P indicated the resident's capacity level shall be determine by a court in accordance with state law or by the resident's physician unless the physician's determination is disputed by the resident or resident's representative. The P&P indicated the resident's surrogate decision maker shall be documented in the resident's health record when the resident does NOT have the capacity level or has fluctuating capacity level.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45891 50144 Based on observation, interview and record review the facility failed to ensure the resident who had a suspected deep tissue pressure injury (SDTI, suspected pressure injury where damage is occurring beneath the skin, but the surface skin may still appear intact. It's characterized by a purple or maroon localized area of discolored skin or a blood-filled blister due to damage to underlying soft tissues from pressure) to a right heel and left heel blister did not progress to unstageable (actual pressure injury covered by slough [(pale yellow, thick, tissue with fiber) and/or eschar [a piece of dead tissue that is cast off from the surface of the skin] pressure injury for one of 16 sampled residents (Resident 35). The facility failed to: 1. Ensure Resident 35's right heel SDTI did not decline to an unstageable pressure injury2. 2. Monitored and documented the presence of a left heel SDTI upon Resident 35's admission. 3. Documented weekly left heel SDTI wound assessments in Resident 35's medical record. 4. Referred Resident 35 to a wound care practitioner. 5. Provided Resident 35 with offload (minimizing or removing weight placed on the foot to help prevent and heal ulcer) measures including low air loss (LAL) mattrass and elevate heels over a pillow or heel protector boots, and provide supplements such as additional protein, Zinc, Vitamin C and a Multivitamin to promote left heel SDTI wound healing. 6. Notify Resident 35's physician when the left heel blister (a painful skin condition where fluid fills a space between layers of skin) was reclassified as a left heel SDTI on 3/26/2025. 7. Notify Resident 35's physician and complete a change of condition (COC) assessment when Resident 35's left heel SDTI was noted to have a foul (bad) odor, an area of eschar, and slough on 4/14/2025. 8. Ensure the interdisciplinary team (IDT, brings together knowledge from different health care disciplines to help people receive the care they need) including the Director of Nursing (DON), the treatment nurse (TXN) 1, and the registered dietician (RD) met and discussed interventions to promote Resident 35's left heel SDTI wound healing. These deficient practices resulted in Resident 35's left heel blister and right heel SDTI to progress to unstageable pressure injuries on 4/14/2025 and causing the resident pain. Resident 35 was admitted to a general acute care hospital (GACH) on 4/17/2025 with a chief complaint of heel pain and a primary diagnosis of a left heel unstageable pressure injury injury Resident 35 was treated with Vancomycin (medication to treat infection) intravenously (IV, into the vein) bacteria wound infections, Morphine for pain, and was given one liter of Normal Saline (medical grade saline solution) solution for hydration in the emergency department (ED) on 4/17/2025. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Findings: During a review of Resident 35's Admission Record, the Admission Record indicated Resident 35 was admitted to the facility on [DATE] from the GACH with diagnoses of left femur (thigh bone) fracture (broken leg bone), fall, muscle weakness, difficulty in walking, joint replacement surgery, and type 2 diabetes (happens when the body cannot use insulin correctly and sugar builds up in the blood). During a review of Resident 35's GACH's Wound Care Consult notes dated 3/23/2025 the Wound Care Consult notes indicated Resident 35 had Stage II (may present as an intact blister)/ DTI with an intact fluid filled blister) measured 6.0 cm in length by 6.0 cm in width and a right heel SDTI with erythema (redness) measured 3.0 cm in length by 3.0 cm in width. The Wound Care Consult notes indicated Resident 35 required Pressure Injury Prevention Protocol including a waffle seat cushion (an air pressure redistribution cushion), or a low air loss mattress, turning and repositioning every two hours, and offload the heels over a pillow or heel protector boots. During a review of Resident 35's Initial Admission Record dated 3/23/2025, the initial Admission Record indicated treatment nurse (TXN) 2 conducted a skin integrity check. The Admission Record indicated TXN 2 notified the physician (unspecified) of Resident 35's, left heel blister and right heel SDTI. Resident 35's Initial Admission Record did not indicate a description, including the appearance and measurements of the left heel blister and the right heel SDTI upon admission. During a review of the Admission Report- Skin Check (paper document) undated, the Skin Check document indicated Resident 35 had a right heel SDTI measured 1.5 cm in length by 0.5 cm in width and a 3.0 cm by 6. 0 cm left heel blister. During a review of Resident 35's H&P dated 3/24/2025, the H&P (a thorough medal history from the patient obtained by a physician during a physical examination) indicated Resident 35 was able to make her own medical decisions. The H&P indicated Resident 35 was sent to the facility status post (after) left hip surgery due to a left hip fracture. The H&P indicated Resident 35 did not have any concerning rashes or lesions (wounds) at the time but did have a left hip surgical site. The H&P included a plan to monitor the wound (surgical site) per facility protocol and obtain a wound care evaluation as needed. The H&P indicated the facility's care staff was instructed to call the physician for any COC. During a review of Resident 35's care plan titled, Actual impairment to skin integrity related to left heel blister and left heel protector boot (cushioned boot that floats the heel to aid in healing of pressure injuries) dated 3/25/2025, the care plan indicated the goals for Resident 35 included reducing the risk for impairment to skin integrity by (body) positioning techniques, and adaptive equipment. The care plan interventions included avoiding scratching, keeping body parts from excessive moisture, keeping fingernails short, educating resident/ family/ and caregivers of causative factors and measures to prevent skin injury, and encouraging good nutrition and hydration to promote healthier skin. On 4/15/2025 the care plan for the left heel blister was updated to include, on 3/26/2025: patient was reassessed by TXN 1, the left heel blister was classified as SDTI with purple tissue. On 4/15/2025 the care plan interventions were updated to include left heel SDTI treatment as ordered, monitor/ document location, size and treatment of the skin injury, report abnormalities, failure to heal and signs and symptoms of infection to the physician, monitor for skin breakdown and off-load (minimizing or removing weight placed on the foot to help prevent and heal ulcers) as tolerated. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 35's Order Summary Report, the report indicated the following physician's wound care orders: - On 3/25/2025 for left heel blister, cleanse with NS pat dry, apply antibacterial ointment then apply gauze and wrap with kerlix (type of dressing). Every day shift. The order was discontinued on 3/26/2025. - On 3/25/2025 for right heel SDTI cleanse with NS, pat dry, apply oil emulsion dressing wrap (gauze wound dressing impregnated with a blend of oil and water), in kerlix. Ever day shift. The order was discontinued on 4/16/2025. - On 3/25/2025 for bilateral (both) heel apply protector boots as tolerated or as patient allows. Every day shift. -On 3/26/2025 for left heel SDTI: cleanse with NS, pat dry, apply sure prep (skin barrier ointment), apply abdominal (ABD) pad and cover with rolled gauze. Offload as tolerated, monitor for skin breakdown and notify the physician of any changes every day shift. The order was discontinued on 4/14/2025. -On 4/14/2025 for left heel SDTI: cleanse with NS, pat dry, apply Medihoney, calcium alginate dressing (ideal for wounds with moderate to heavy exudate [fluid that leaks out of blood vessels into nearby tissues]), dry dressing and cover with rolled gauze. Offload as tolerated, monitor for skin breakdown and notify the physician of any changes every day shift. The order was discontinued 4/16/2025. - On 4/14/2025 wound culture of the left heel, one time only. -On 4/16/2025 wound care consult for SDTI. -On 4/16/2025 for left heel unstageable pressure injury: cleanse with NS, pat dry, apply Medihoney, calcium alginate, dry dressing and cover with rolled gauze. Offload as tolerated, monitor for any signs for skin breakdown and notify the physician of any changes. -On 4/16/2025 for right heel unstageable pressure injury: cleanse with NS, pat dry, apply Medihoney, calcium alginate, dry dressing and cover with rolled gauze. Offload as tolerated, monitor for any signs for skin breakdown and notify the physician of any changes. During a review of Resident 35's Skin/ Wound Note dated 3/26/2025 (three days after admission), the note indicated Resident 35 was reassessed by TXN 1 and the left heel blister was classified as an SDTI with purple tissue. The note did not indicate measurements or a complete wound assessment describing the characteristics of the wound. The note did not indicate the physician was notified of the classified wound type or new treatment orders. Resident 35 did not have weekly Skin/Wound assessments documented in her medical record including all wounds and their progress as indicated in the facility's Wound Management and Prevention policy and procedure (P/P). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 35's MDS, dated [DATE], the MDS indicated Resident 35 had moderate cognitive impairment and required substantial/ maximal assistance (helper does more than half the effort) for bed mobility including rolling from left to right. The MDS indicated Resident 35 was at risk for pressure injuries and had two deep tissue injuries and zero unstageable pressure injuries with slough or eschar. During an observation on 4/14/2025 at 10 a.m., Resident 35 was lying in bed with her feet elevated on one pillow. Resident 35 did not have heel protector boots on, Resident 35 was not lying on a low air loss mattress. During an interview on 4/14/2025 at 10:11 a.m., Family Member (FM) 2 stated she was upset because Resident 35's left heel wound was getting worse. During an observation on 4/14/2025 at 1:44 p.m., TXN 1 was in Resident 35's room speaking to FM 3 at the bedside. Resident 35 was lying in bed crying in pain, saying her left foot hurt. Resident 35 was informing FM 3 she had chills (the feeling of being cold, though not necessarily in a cold environment, often accompanied by shivering or shaking). TXN 1 was obtaining a wound culture swab of Resident 35's left foot wound due to the foul odor of the wound. Resident 35's left heel was observed with the following and described by TXN 1 as: a large area of dark purple or black appearing eschar, surrounded by a pinkish red area of granulation tissue, and a small amount of yellowish white slough. During a review of Resident 35's wound culture (medical test to determine the kind of infectious agent), obtained from left foot on 4/14/2025, the wound culture results indicated Resident 35 had moderate growth of Proteus Mirablis (a gram-negative bacteria that can cause wound infections). During an interview on 4/15/2025 at 9:03 a.m., TXN 1 stated Resident 35's wounds were not being treated by a wound care practitioner. TXN 1 stated she noticed a change in appearance to Resident 35's left heel wound and a little bit of odor, so she obtained the wound culture on 4/14/2025. TXN 1 reviewed her wound care binder at the nurse's station where she tracked residents' wound progress but there was no information about Resident 35 in her wound care binder. TXN 1 reviewed Resident 35's medical record and stated there were no weekly skin/ wound documentation in the chart including measurements and appearance of the wounds. TXN 1 reviewed Resident 35's LN-Initial Admission Assessment from 3/23/2025 and stated the documentation lacked a description of the wound appearance and the measurements of the wound. TXN 1 stated the initial assessment of the left heel wound indicated it was a left heel blister. TXN 1 stated when she assessed Resident 35 herself on 3/26/2025, she noted the wound to be a SDTI with 100% of the wound being purple boggy (a wound where the surrounding tissue feels soft, spongy, and possibly mushy to the touch, often due to increased fluid content) tissue. TXN 1 stated based on the documentation in the chart she did not have a good baseline (assessment of the wound upon admission) from admission to see if there had already been a decline in the wound status since admission because the documentation was lacking wound characteristics, so she reclassified the wound as an SDTI based on her assessment from 3/26/2025. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 4/16/2025 at 8:04 a.m., with FM 1, FM 1 stated when she was visiting Resident 35 on the evening of 4/13/2025, Resident 35 was complaining of pain to her left foot, and she noted a smell in Resident 35's room so she ripped off Resident 35's sock and bandage that was wrapped around the left heel. FM 1 stated she was shocked to see Resident 35's left heel wound looked worse, and the wound smelled. FM 1 stated she alerted staff (unknown) to the issue on 4/13/2025 and two staff came in to look at the wound and wrap it back up, but she was unsure who the staff were. FM 1 stated the wound looked much worse than it did when Resident 35 was admitted . FM 1 stated a wound culture was taken the next day (4/14/2025) but she did not know the results yet. FM 1 stated Resident 35 was complaining of worsening left heel pain for a few days. FM 1 stated Resident 1 was admitted from the GACH with heel protector boots and when she would go visit Resident 35, they would not be on and would be in Resident 35's closet and sometimes Resident 35's heels would be touching the bed. During an interview on 4/16/2025 at 11:16 a.m., TXN 1 stated Resident 35's left heel wound had a change in status on 4/14/2025. The wound had some drainage and had a smell, so the facility obtained an order for a wound culture. TXN 1 stated she did not inform the physician of the change in appearance of the wound; they just requested a wound culture due to the smell. TXN 1 stated Resident 35's left heel wound now had eschar or necrotic tissue which was not good for wound healing and usually needed to be debrided but debridement was not in her scope of practice so Resident 35 needed a wound care consultation. TXN 1 stated she had yet to request an order for a wound care consultation for Resident 35's wound because the results of the wound culture were not back yet. TXN 1 stated when a wound has eschar, they do not know how bad the wound really was underneath, and the wound could have been worse. TXN 1 stated DTIs could deteriorate rapidly with any pressure due to the fragility of the skin and it was important to be proactive with interventions and offload the heels for the best chance for wound healing. TXN 1 stated it was important to have accurate baseline assessments of wounds and wound interventions should be implemented immediately to keep the wound healthy, infection free, mitigate pain, and promote healing. TXN 1 stated it was the facility's policy to document weekly on the wound progress. TXN 1 stated it was important to have a description of the wound including all the wound characteristics and measurements upon baseline so the facility could have an accurate baseline to track the progress of the wound and to ensure the resident receives the proper interventions to prevent a decline in the wound. TXN 1 stated she reviewed Resident 35's care plans and the care plans were not updated until 4/15/2025 to include the reclassified SDTI staging of the left heel wound and to offload the heels. TXN 1 stated the care plan should have been updated when she reclassified the left heel wound as a SDTI on 3/26/2025. TXN 1 stated a comprehensive person-centered care plan for each wound was important because the facility needed to identify the problem, assess the risk associated with the problem, and implement interventions to prevent a decline in the wound and to promote wound healing. TXN 1 stated she was upset with herself because she did not perform a COC assessment and notify the physician of Resident 35's decline in wound appearance on 4/14/2025. TXN 1 stated there was a possibility of delay in care and treatment if the physician was not notified right away of a wound decline. TXN 1 stated she had not called Resident 1's physician to discuss Resident 35's wound status since she had been caring for Resident 35's wounds. During an interview on 4/16/2025 at 2:21 p.m., with the physician assistant (PA) 1 who was in the facility, PA 1 stated he had just been informed Resident 35 had worsening wounds. PA 1 stated he was going to put an order for Resident 35 to be seen by a wound care practitioner. PA 1 stated the physician or himself should have been notified right away of any new or changing wounds. PA 1 stated it was important residents with wounds that have eschar were seen by a wound care consultant so the appropriate interventions could be placed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 4/16/2025 at 2:25 p.m., TXN 1 stated she was now staging Resident 35's left heel wound as an unstageable pressure injury due to the wound characteristics (slough and eschar). TXN 1 stated the definition of an unstageable pressure injury was the wound couldn't be staged. During an observation on 4/16/2025 at 2:42 p.m., TXN 1 measured the wound on Resident 35's left heel, the wound measured 6.5 cm length by 7.0 cm in width with a separate discoloration (redness) on the inner ankle. The wound had a large purplish black center, yellowish white area surrounding the dark area as well as a small area of granulation tissue (new pinkish red tissue). TXN 1 removed the dressing from the right heel and revealed a 3.3 cm in length by 5.0 cm in width wound that was purple with a translucent center. TXN 1 indicated she would be reclassifying the right heel wound as an unstageable pressure injury as well completing a COC for bilateral heels. During a review of Resident 35's COC evaluation dated 4/16/2025, the COC indicated Resident 35 had developed pain in both heels. Resident 35's left and right hells SDTI were reclassified as Unstageable pressure injuries. The left heel unstageable pressure injury measured 6.5 cm in length by 7.0 cm in width with 75 percent (%) of wound covered in eschar, 20% slough, and 5% granulation tissue with medial (inside) ankle discoloration. The right heel unstageable pressure injury measured 3.3 cm in length by 5.0 cm in width with purple intact tissue. The COC indicated FM 2 was requesting an x-ray (a type of diagnostic test using radiation that creates a picture of the inside of the body) of both feet to rule out effects to the bone. During a review of Resident 35's Nursing Progress Note dated 4/17/2025, the Progress Note indicated Resident 35 verbalized she was unable to sleep well the night prior due to left heel pain and had moderate pain at the time of evaluation on the left heel. The Progress Note indicated nursing offered Resident 35 to be transferred to the GACH for further evaluation of her pressure injury wounds and Resident 35 agreed to the transfer. During a review of Resident 35's Skin/ Wound Note dated 4/17/2025, the Skin/ Wound Note indicated treatment was halted due to patient expressing pain. The note indicated wound care was not resumed due to Resident 35's condition and pain level and Resident 35 was transferred to the GACH. (continued on next page)

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	055353	A. Building B. Wing	04/18/2025

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 4/17/2025 at 2:33 p.m., the DON stated she was not aware of Resident 35's wounds until this interview. The DON stated it was important she was notified of wound and the wound decline so she could review the chart and ensure the resident was receiving all appropriate interventions. The DON stated wounds needed to be assessed upon admission, for any changes, and weekly and all assessments needed to be recorded in the resident's chart. The DON stated the IDT had not met to discuss Resident 35's wounds. The DON stated there was a possibility the wounds could decline if the IDT did not meet to discuss important interventions needed. The DON reviewed Resident 35's medical record and stated weekly skin/ wound assessments had not been completed. The DON stated the LN- initial admission assessment should have included a wound description and measurements, and the initial assessment indicated Resident 35 was admitted with a left heel blister. The DON stated the physician should have been notified that the left heel blister was reclassified as a SDTI on 3/26/2025 but there was no evidence in the chart that the physician was informed. The DON stated it was important the physician was aware of wound changes so they could order any necessary interventions. The DON stated there was no COC or notification of the physician documented in Resident 35's chart related to the wound appearance and decline on 4/14/2025. The DON stated the treatment nurses (TXN 1 and TXN 2) were not competent in wound documentation and tracking as evidenced by the lack of documentation in Resident 35's chart and the failure to complete a COC when a decline in the wound was noted on 4/14/2025. The DON stated Resident 35 did not have an order for an LAL mattress. The DON stated Resident 35 had not been seen by a wound care consult. The DON stated the importance of a wound care consultation was to ensure they followed the progression of the wound closely, performed any necessary debridement's, and implemented interventions to help prevent a decline in the wound. The DON stated there was no evidence in Resident 35's chart that registered dietician was aware of Resident 35's wounds. During an interview on 4/17/2025 at 2:25 p.m., the case manager (CM) stated she requested an authorization for a wound care consultation for Resident 35 for the first time on 4/16/2025 when the order was placed. During a review of Resident 35's Registered Dietician Note dated 4/18/2025, Registered Dietician Note indicated Resident 35 had bilateral heel unstageable pressure injuries. The note indicated a nurse (unknown) had received a new physicians order (4/17/2025) for multivitamins with minerals, Vitamin C 500 mg, and Zinc 220 mg for 14 days and RD 2 recommended ProStat (liquid protein) 30 ml twice a day for wound healing. During a review of Resident 35's GACH's Wound Care Consult dated 4/18/2025, the GACH Wound Care Consult indicated Resident 35 was sent from the facility for worsening wounds to bilateral heels and bilateral heel pain. The Wound Care Consult indicated Resident 35 received Vancomycin, Morphine 4.0 mg intravenously (IV-into the vein), and 1.0 liter of NS in the ED. The Wound Care Consult indicated FM 2 reported Resident 35 had worsening wound to the left heel for one week with odor. The Wound Care Consult indicated Podiatry (the treatment of the feet and their ailments) was consulted for the left heel unstageable pressure injury. During an interview on 4/18/2025 at 7:26 a.m., FM 1 stated Resident 35 had been transferred to the GACH the night prior due to her wounds and was receiving IV fluids, pain medication, and antibiotics. FM 1 stated they were waiting for a specialist to come and look at Resident 35's heels to discuss if surgery was required to treat the wounds. FM 1 stated Resident 35 was feeling very anxious and upset because she thought they might have to cut her left foot off due to the wound. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 4/18/2025 at 1:17 p.m., RD 2 stated she was just made aware of Resident 35's wounds and was not aware that Resident 35 had wounds upon admission. RD 2 stated nutritional consultation was important for residents with wounds because they require more protein to promote wound healing. RD 2 stated there is a nutritional regimen they usually implement for wound healing that includes Vitamin C, Zinc, Multivitamins with minerals and ProStat (liquid protein) but it was not added for Resident 35 until 4/18/2025. During a review of the facility's P/P titled Change of Condition Reporting dated 4/2021, the P/P indicated changes in resident condition were to be reported to the physician and it was to be documented in the eInteract Change of Condition and/ or in the nurse's progress notes, the plan of care was to be updated. The P/P indicated any attempts to contact the physician would be documented in the resident's medical record. During a review of the facility's P/P titled Wound Management and Prevention dated 8/1/2021, the P/P indicated it was the facility's policy to ensure any resident that entered the facility had appropriate preventative measure taken to ensure the resident did not develop pressure ulcers, or that residents admitted with wound did not develop signs and symptoms of infection. The P/P indicated a plan of care was to be initiated to address areas of actual skin breakdown and the care plan was to be reviewed and revised as needed. The P/P indicated a report of all the wounds and their progress would be updated by the treatment nurse weekly. The P/P indicated the RD was to provide nutritional support when appropriate. During a review of the facility's Job Description- Director of Nursing dated 10/2021, the job description indicated the DON was to review nursing personnel medical record documentation to ensure that it was appropriately and accurately descriptive of the nursing care provided. The DON was to manage and direct all aspects of the nursing services department. The DON was to assist in the development of preliminary and comprehensive assessments of the nursing needs of each resident. During a review of the facility's Job Description- Treatment Nurse dated 12/17/2021, the job description indicated the treatment nurse was to make written and oral reports/ recommendations to the attending physician, Medical Director, or the DON concerning the status and care of the residents. The treatment nurse was to work with the IDT to develop a comprehensive assessment and care plan for all assigned residents. Examine the resident and or his/ her records and charts, and discriminate between normal and abnormal findings, to recognize when to refer the resident to a physician for evaluation, supervision, or directions. Initiate requests for consultation or referral.

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F 0688 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36943 Based on observation, interview, and record review, the facility failed to provide services to improve or maintain range of motion ([ROM] full movement potential of a joint) and mobility (ability to move) for three of five sampled residents (Resident 40, 4, and 34) with ROM and mobility concerns by failing to: 1. Provide Resident 40 with a Physical Therapy ([PT] profession aimed in the restoration, maintenance, and promotion of optimal physical function) screening or evaluation in accordance with the PT Job Description when the facility identified Resident 40's decline in ability to perform sit-to-stand (ability to come to a standing position from sitting) transfers on 10/4/2024. 2. Provide Resident 40 with interventions to improve the ability to perform sit-to-stand transfers on 10/4/2024 in accordance with facility's policy and procedure (P&P) for Quality of Care titled, ROM and Contracture (a stiffening/shortening at any joint that reduces the joint's range of motion) Prevention. 3. Provide Resident 40 with active assistive range of motion ([AAROM] use of muscles surrounding the joint to perform the exercise but requires some help from a person or equipment) to both arms and legs on 4/15/2025 in accordance with the physician order for Restorative Nursing Aide ([RNA] nursing aide program that helps residents to maintain their function and joint mobility), dated 10/4/2024. 4. Provide Resident 40 with a right-hand splint (material used to restrict, protect, or immobilize a part of the body to support function, assist and/or increase range of motion) to prevent further ROM decline in accordance with the facility's P&P for Quality of Care titled, ROM and Contracture Prevention. 5. Accurately assess Resident 4's right-hand during the Joint Mobility Evaluation ([JME] brief assessment of a resident's range of motion in both arms and both legs), dated 4/14/25. 6. Provide Resident 4 with passive range of motion ([PROM] movement of a joint through the ROM with no effort from person) exercises to both wrists during the Restorative Nursing Aide ([RNA] nursing aide program that helps residents to maintain their function and joint mobility) session on 4/15/25 in accordance with the physician's order, dated 10/25/2023. 7. Provide Resident 34 with ROM exercises to both wrists, hands, and ankles during the RNA session on 4/15/25 in accordance with the physician's order, dated 12/9/2024. These failures resulted in Resident 40 losing the ability to stand and had the potential for Resident 40 to experience further ROM decline in the right hand, causing Resident 40 to feel frustrated and debilitated. These failures also had the potential for Resident 4 and 34 to experience a ROM decline in both arms and legs. Findings: (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 40's Admission Record, the Admission Record indicated Resident 40 was initially admitted on [DATE] and readmitted on [DATE] with diagnoses including muscle weakness, diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing), peripheral vascular disease ([PVD] a slow progressive narrowing of the blood flow to the arms and legs), and difficulty walking. During a review of Resident 40's physician order, dated 12/16/2023, the physician order indicated for the RNA to provide Resident 40 with AAROM to both arms and legs, four times a week as tolerated. During a review of Resident 40's physician order, dated 1/27/2024 and revised 4/10/2024, the physician order indicated for the RNA to provide Resident 40 with sit-to-stand transfers using the front wheeled walker ([FWW] an assistive device with two front wheels used for stability when walking), four times per week as tolerated. During a review of Resident 40's Restorative Nursing records (record of daily RNA sessions) from 4/10/2024 to 10/4/2024, the RNA records indicated Resident 40 received AAROM to both arms and legs, four times per week, and sit-to-stand with the FWW, four times per week as tolerated. During a review of Resident 40's RNA Weekly Progress Report (summary of RNA sessions for the given week with written narrative comments), dated 5/2/2024, the RNA Weekly Progress Report comments indicated Resident 40 performed sit-to-stand transfers with two-person assistance and held a standing position for 20-35 seconds. During a review of Resident 40's RNA Weekly Progress Report, dated 5/9/2024, the RNA Weekly Progress Report comments indicated Resident 40 performed sit-to-stand transfers using a FWW and held a standing position for 10 seconds. During a review of Resident 40's RNA Weekly Progress Report, dated 5/16/2024, the RNA Weekly Progress Report comments indicated Resident 40 performed sit-to-stand transfers two-person assistance and held a standing position for 30-60 seconds. During a review of Resident 40's RNA Weekly Progress Report, dated 6/6/2024, the RNA Weekly Progress Report indicated Resident 40 performed two repetitions of sit-to-stand transfers using a FWW with two-person assistance. During a review of Resident 40's quarterly Joint Mobility Evaluation ([JME] brief assessment of a resident's range of motion in both arms and both legs), dated 6/28/2024, the JME indicated Resident 40's current intervention included RNA for AAROM of both arms and legs, four times per week, and sit-to-stand, four times per week. The JME indicated Resident 40 had moderate ROM limitations (50-75 percent [%] ROM intact; 25-50% ROM loss) in both shoulders for flexion (raising arms upward in front of the body), the right shoulder for abduction (raising arm upward at the side of the body), the right fingers, and both hips. The JME indicated Resident 40 had minimum ROM limitations (75-100% ROM intact; 0-25% ROM loss) in the left shoulder for abduction, the right elbow, the left fingers, and both knees. During a review of Resident 40's RNA Weekly Progress Report, dated 7/4/2024, 7/11/2024, 7/18/2024, and 7/25/2024, the RNA Weekly Progress Reports indicated Resident 40 performed three repetitions of sit-to-stand transfers using a FWW and two-person assistance. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 40's RNA Weekly Progress Report, dated 8/1/2024, 8/8/2024, 8/15/2024, 8/22/2024, and 8/29/2024, the RNA Weekly Progress Reports indicated Resident 40 performed three repetitions of sit-to-stand transfers using a FWW and two-person assistance. During a review of Resident 40's RNA Weekly Progress Report, dated 9/5/2024 and 9/19/2024, the RNA Weekly Progress Report indicated Resident 40 performed two to three repetitions of sit-to-stand transfers using a FWW. During a review of Resident 40's RNA Weekly Progress Report, dated 9/26/2024, the RNA Weekly Progress Report indicated Resident 40 performed three sets of sit-to-stand transfers using a FWW. During a review of Resident 40's quarterly JME, dated 10/1/2024, the JME indicated Resident 40's current intervention included RNA for AAROM of both arms and legs, four times per week, and sit-to-stand, four times per week. The JME indicated Resident 40 had moderate ROM limitations in both shoulders for flexion, the right shoulder for abduction, the right fingers, and both hips. The JME indicated Resident 40 had minimum ROM limitations in the left shoulder into abduction, the right elbow, the left fingers, and both knees. The JME indicated Resident 40 did not have any changes in ROM since the last assessment on 6/28/2024. During a review of Resident 40's Progress Notes, a late entry Progress Note, dated 10/4/2024 at 11:08 a.m. by the Assistant Director of Rehabilitation (ADOR), the Progress Notes indicated Resident 40 had decreased strength and stability during two-person transfers with the Certified Nursing Assistants (CNAs). The Progress Note indicated the ADOR educated Resident 40 on the benefits and safety with the use of a mechanical lift (device used to lift and/or transfer a person's entire body from one surface to another surface) and/or sit-to-stand mechanical lift (device used to lift a person from a sitting position to a standing position to transfer from one surface to another surface) to reduce risk for fall and/or injury to Resident 40 or staff. During a review of Resident 40's physician order, dated 10/4/2024 at 11:10 a.m. by Physical Therapist 1 (PT 1), the physician order indicated to discontinue Resident 40's RNA to perform sit-to-stand transfers with a FWW, four times per week as tolerated. During a review of Resident 40's Change in Condition (CIC) Evaluation, dated 10/4/2024 at 11:34 a.m. entered by Licensed Vocational Nurse 4 (LVN 4), the CIC Evaluation indicated Resident 40 had a decline with RNA for sit-to-stand transfers. The CIC Evaluation indicated Resident 40 was unable to perform the sit-to-stand transfer and safely put back to bed. The CIC Evaluation indicated Resident 40's family member (FM 1) was notified on 10/4/2024 at 11:53 a.m. The CIC Evaluation also indicated Resident 40's Nurse Practitioner (NP) 1 was notified of the decline in sit-to-stand transfers on 10/4/2024 at 11:34 a.m. The CIC Evaluation indicated NP 1 provided recommendations to continue to monitor and did not provide any new orders. During a review of Resident 40's Progress Notes, a late entry Progress Note, dated 10/4/2024 at 11:35 AM (entered on 10/11/2024 at 1:03 p.m.) by the Assistant Director of Nursing (ADON), the Progress note indicated NP 1 provided a new RNA order to provide Resident 40 with AAROM to both arms and legs, every day, five days per week as tolerated. During a review of Resident 40's physician's order, dated 10/4/2024, the physician's order indicated for RNA to provide AAROM to both arms and legs, every day, five times per week as tolerated. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 40's Interdisciplinary Team ([IDT] group of individuals from different professional disciplines who collaborate to address a shared problem or goal for a resident) Care Plan Review, dated 12/17/2024, the IDT-Care Plan Review was not completed. During a review of Resident 40's quarterly JME, dated 1/1/2025, the JME indicated Resident 40's current intervention indicated RNA for AAROM of both arms and legs, four times per week, and sit-to-stand, four times per week. The JME indicated Resident 40 had moderate ROM limitations in both shoulders for flexion, both shoulders for abduction, and the right fingers. The JME indicated Resident 40 had minimum ROM limitations in the right elbow, the left fingers, both hips, and both knees. The JME indicated Resident 40 had improvement in both hips and a decline in the left shoulder for abduction. The JME indicated for Resident 40 to continue with the RNA program for ROM and monitor (unspecified). During a review of Resident 40's Minimum Data Set ([MDS] a resident assessment tool), dated 2/7/2025, the MDS indicated Resident 40 had clear speech, expressed ideas and wants, understood verbal content, and had intact cognition (clear ability to think, understand, learn, and remember). The MDS indicated Resident 40 had functional ROM limitations (limited ability to move a joint that interferes with daily functioning or places the resident at risk of injury) in one arm and both legs. The MDS indicated Resident 40 required setup or clean-up assistance for eating, substantial/maximal assistance (helper does more than half the effort) for bathing, dressing, rolling to either side in bed, and moving from lying in bed to sitting at the side of the bed, and dependent (helper does all the effort, resident does none of the effort to complete the activity, or the assistance of two or more helpers is required to complete the activity) for chair/bed-to-chair transfers. During an interview on 4/14/2025 at 9:42 a.m., with the Director of Rehabilitation (DOR), the DOR stated the purpose of PT (in general) included returning residents to their prior level of function with therapeutic exercises (movement prescribed to correct impairments and restore muscle function), gait (manner of walking) training, and strengthening. The DOR stated RNA was a maintenance program to maintain a resident's level of mobility which included the provision of ROM exercises, ambulation (the act of walking), and application of splints. The DOR stated maintaining a resident's mobility (in general) provided the resident with dignity (quality of being worthy of honor or respect) and quality of life. During a review of Resident 40's quarterly JME, dated 4/14/2025 at 2:31 p.m., the JME indicated Resident 40's current intervention included RNA for AAROM of both arms and legs, five times per week. The JME indicated Resident 40 had moderate ROM limitations in the right shoulder for flexion, both shoulders for abduction, and the right fingers. The JME indicated Resident 40 had minimum ROM limitations in the left shoulder into flexion, the right elbow, the left fingers, both hips, and both knees. The JME indicated Resident 40 had improvement in left shoulder flexion from moderate limitations to minimum ROM limitations since the last assessment on 1/1/2025. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	During a concurrent observation and interview on 4/15/2025 at 9:01 a.m. with Resident 40 in the bedroom, Resident 40 was lying awake in bed with the head-of-bed (HOB) elevated and had fluent speech. Resident 40 moved both arms at the shoulder, elbow, and wrist joints without any assistance. Resident 40 stated both hands used to look normal and constantly felt cold. The large knuckles of each finger on Resident 40's right-hand was observed in a bent position and unable to fully straighten. The middle joint of each finger on Resident 40s right-hand were hyperextended (excessive backward bending), which caused the tip joints of each finger to slightly bend. Resident 40 bent the right-hand fingers but was unable to make a full fist. Resident 40 stated both hands were normal until about one year ago when both hands started feeling cold. Resident 40 stated the facility has never provided any splints to the right-hand. Resident 40 was observed with more active movement in the left-hand than the right-hand. Resident 40 moved the left-hand into a fist and extended the fingers. Resident 40's left-hand had minimal ROM limitations when extending the fingers, which included hyperextension of the large knuckles of the index and ring fingers, a slight bend in the middle joints of each finger, and abduction (movement away from the other fingers) of the small finger. Resident 40 stated both hands made him feel handicapped. Resident 40 stated the RNAs performed exercises to both hips, knees, ankles, shoulders, elbows, and hands. A folded-up manual wheelchair was observed on the right side of Resident 40's bed. A FWW was also observed leaning against the wall next to Resident 40's nightstand. Resident 40 stated the facility transferred him to the wheelchair during the weekdays using a sit-to-stand mechanical lift. Resident 40 stated he used to walk with the therapists from the therapy room and down the hallway using the FWW but stated the facility had not attempted to walk with him anymore for over one year. During an observation on 4/15/2025 at 9:54 a.m. with Restorative Nursing Aide 2 (RNA 2), Resident 40's RNA session was observed. Resident 40 was lying awake in bed with the HOB elevated. RNA 2 lowered the HOB to place Resident 40's bed in a flat position. RNA 2 performed ROM exercises to both legs, including hip flexion (bending the leg at the hip joint toward the body) with the knee extended (straight), hip abduction (moving the leg at the hip joint away from the body), hip flexion with knee flexion, and right ankle dorsiflexion (bending the ankle toward the body). RNA 2 performed ROM exercises to Resident 40's right arm, including shoulder flexion, elbow flexion and extension, wrist rotation, thumb extension and flexion, and right-hand flexion. RNA 2 was unable to completely extend Resident 40's right elbow and the right fingers at the large knuckles. RNA 2 performed ROM exercises to Resident 40's left arm, including shoulder flexion, elbow flexion and extension, wrist rotation, and thumb extension and flexion. RNA 2 encouraged Resident 40 to perform active range of motion ([AROM] performance of ROM of a joint without any assistance or effort of another person) of the left hand into complete finger extension and flexion. During an interview on 4/15/2025 at 10:16 a.m., with RNA 2, RNA 2 stated she provided passive range of motion ([PROM] movement of a joint through the ROM with no effort from person) to both of Resident 40's arms and legs and AROM the left hand during the RNA session. RNA 2 stated she used to perform sit-to-stand transfers with Resident 40, but the therapist (unspecified) changed Resident 40's RNA program to ROM since it was unsafe for Resident 40 to perform sit-to-stand. During an interview on 4/15/2025 at 2:27 p.m., with the DOR, the DOR described PROM exercises as ROM provided to residents who did not have the physical ability to perform ROM exercises. The DOR stated AAROM exercises were when the resident can perform the ROM exercises but required assistance to finish or initiate the motion. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 4/15/2025 at 3:29 p.m., with the DOR, Resident 40's physician's orders for RNA were reviewed. The DOR stated Resident 40 had a physician's order, dated 1/26/2024 and re-ordered on 4/10/2024, for the RNA to perform sit-to-stand transfers, four times per week. The DOR stated Resident 40's physician's order for RNA to perform sit-to-stand transfers was discontinued on 10/4/2024. The DOR stated the physician's order, dated 10/4/2024, indicated for RNA to provide Resident 40 with AAROM to both arms and legs, five times per week. During an interview and record review on 4/15/2025 at 4:15 p.m., with the DOR, Resident 40's CIC Evaluation, dated 10/4/2024, was reviewed. The DOR stated LVN 4 completed the CIC Evaluation but no longer worked at the facility. The DOR stated the CIC Evaluation indicated Resident 40 had a decline due to the resident's inability to perform sit-to-stand transfers. The DOR stated the CIC Evaluation indicated NP 1 was notified, did not provide any new orders, and continue to monitor Resident 40. The DOR stated Resident 40 did not receive a Rehab Screen (brief assessment to determine if a therapy evaluation was needed) on 10/4/2024. During an interview on 4/16/2025 at 10:57 a.m., with Resident 40, Resident 40 stated the facility did not inform him when they stopped RNA for sit-to-stand transfers. Resident 40 did not recall performing sit-to-stand transfers with the RNAs that often. Resident 40 stated he did not ask any questions and went along with the RNA program. Resident 40 stated there was one occurrence (unspecified date) when the RNAs thought the resident was going to fall. Resident 40 stated PT 1, who did not work at the facility anymore, observed the RNAs assist the resident with the sit-to-stand transfer, told Resident 40 that he was not strong enough to do the transfer, and told Resident 40 the sit-to-stand mechanical lift would be used for transfers. Resident 40 stated he did not discuss stopping RNA for sit-to-stand transfers with NP 1 and did not receive any additional therapy to maintain his ability to stand. During a telephone interview on 4/16/2025 at 11:19 a.m., with FM 1, FM 1 stated Resident 40's right-hand had limited motion for at least one year. FM 1 stated Resident 40 was left-handed and constantly felt cold in both hands. FM 1 stated Resident 40 used the left-hand more often and kept the right-hand clenched in a fist under the blanket. FM 1 was aware that the facility stopped physically transferring Resident 40 to the wheelchair and used the sit-to-stand mechanical lift for transfers. FM 1 stated she was not aware the facility stopped the RNA program for Resident 40 to perform sit-to-stand transfers. During an interview on 4/16/2025 at 12:49 p.m., with RNA 2, RNA 2 stated Resident 40 used to require two-person assistance during RNA for sit-to-stand transfers. RNA 2 stated Resident 40's ability to maintain his standing balance would vary. RNA 2 stated Resident 40's inability to stand during RNA sessions was reported to the charge nurse (unable to recall which nurse) and the DOR. RNA 2 stated either PT 1 (no longer worked at the facility) or Occupational Therapist 1 ([OT] professional aimed to increase or maintain a person's capability of participating in everyday life activities [occupations]) changed Resident 40's RNA program to discontinue sit-to-stand transfers. (continued on next page)

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

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F 0688 Level of Harm - Actual harm Residents Affected - Few	During an observation on 4/16/2025 at 1:25 p.m., with Certified Nursing Assistant 4 (CNA 4) and RNA 2 in Resident 40's room, Resident 40's transfer from the bed to the wheelchair using the sit-to-stand mechanical lift was observed. RNA 2 stood on the right side of the bed while CNA 4 stood on the left side of the bed. Both CNA 4 and RNA 2 assisted Resident 40 from lying in bed to sitting on the right side of the bed. RNA 2 and CNA 4 placed and fastened a cloth sling around Resident 40's waist. Cloth loops were sewn onto the cloth sling. RNA 2 fastened the loop to a right-sided hook on the sit-to-stand mechanical lift and then attached another loop to a left-sided hook on the sit-to-stand mechanical lift. RNA 2 used a controller to lift Resident 40 from a seated position at the edge of the bed to a standing position. Resident 40's knees were extended but Resident 40 did not stand upright. Both of Resident 40's hips were bent and positioned behind Resident 40's torso (main part of the body comprised of the chest, abdomen, pelvis, and back) and legs. RNA 2 turned the sit-to-stand mechanical lift toward Resident 40's wheelchair. CNA 4 secured Resident 40's wheelchair as RNA 2 lowered Resident 40 into a seated position. During an interview on 4/16/2025 at 1:47 p.m., with Occupational Therapist 2 (OT 2), OT 2 stated ROM loss could be prevented with ROM exercises and application of splints. OT 2 stated splints prevented the development of contractures (a stiffening/shortening at any joint that reduces the joint's range of motion) and prevented further contractures if a resident already had contractures. During an observation and interview on 4/16/2025 at 2:04 p.m., with OT 2, Resident 40's hands were observed while Resident 40 sat in the wheelchair. OT 2 stated the large knuckles of Resident 40's right-hand were in a bent position to approximately 60 degrees (normal 0-90 degrees), the middle joints of each finger were hyperextended, and the tip joints of each finger were bent. OT 2 asked Resident 40 to make a fist with the right-hand. OT 2 stated Resident 40's right-hand fingers slightly bent with the thumb having the most motion. OT 2 asked Resident 40 to move the left-hand into a fist and to touch the thumb to the tip of each finger. OT 2 stated Resident 40's left-hand motion was within functional limits (sufficient joint movement without significant limitation). During an interview on 4/16/2025 at 2:12 p.m., with OT 2, OT 2 stated Resident 40's right hand was not normal due to significant limitation in the large knuckles and hyperextension of the middle joints. OT 2 stated Resident 40 would benefit from a splint to prevent further contractures in the right hand. During a telephone interview on 4/16/2025 at 4:06 p.m., with Resident 40's physician (MD 1), MD 1 stated he would try to determine the reason for a resident's decline (in general) to perform sit-to-stand transfers with RNA and usually recommended additional therapy to improve mobility after a discussion with the resident if the facility notified MD 1 of a decline. MD 1 stated he would absolutely recommend additional therapy for Resident 40 if Resident 40 experienced a decline in the ability to perform sit-to-stand transfers with RNA. MD 1 stated the therapists usually contacted MD 1 directly for additional therapy orders but did not contact MD 1 regarding Resident 40. MD 1 stated NP 1 usually assessed the residents at the facility. During an interview on 4/17/2025 at 10:06 a.m., with Resident 40, Resident 40 stated he felt frustrated that he could not stand anymore. Resident 40 stated he did not have a choice and would find a way to stand by himself even if it was not safe. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	During an interview on 4/17/2025 at 10:18 a.m., with the Director of Nursing (DON) and the DOR, the DON stated the DON, and the Director of Staff Development (DSD) oversaw the RNA program. The DON stated the RNA program maintained a resident's mobility after a resident's discharge from therapy services. The DOR stated maintaining a resident's mobility (in general) was important to a resident's quality of life. The DOR stated the facility needed to perform an assessment if a resident experienced a decline in mobility while on RNA to determine the reason for the decline. The DON stated the assessment of a resident's decline would include an interview with the resident, an interview with the RNA, and a discussion during the IDT meeting to determine if there was a true decline. During an interview and record review on 4/17/2025 at 10:42 a.m., with the DON, ADON, and DOR, Resident 40's discontinued physician's order for RNA to perform sit-to-stand, dated 10/4/2024, CIC Evaluation, dated 10/4/2024, physician order for RNA to perform AAROM to both arms and legs, dated 10/4/2024, physician (MD) progress notes from 10/2024, and nurse practitioner (NP) progress notes from 10/2024 and 11/5/2024, were reviewed. The ADON stated Resident 40's decline in performing sit-to-stand transfers with RNA was reported to LVN 4, who no longer worked at the facility. The ADON stated NP 1 was notified of Resident 40's decline with RNA and NP 1 recommended to monitor Resident 40. The DON reviewed Resident 40's discontinued physician order for RNA and stated PT 1 discontinued the RNA order for sit-to-stand in the electronic medical record. The ADON stated she spoke to NP 1 in-person on 10/4/2024 (unspecified time) and the conversation with NP 1 was documented on 10/11/2024 as a late entry. The ADON stated NP 1 recommended to discontinue Resident 40's RNA for sit-to-stand transfers after NP 1 spoke with Resident 40. The ADON stated NP 1 recommended for Resident 40 to receive RNA for AAROM to both arms and legs. The ADON reviewed Resident 40's NP progress notes, including all of NP 1's progress notes, and did not locate any documentation from 10/2024 regarding Resident 40's decline with sit-to-stand transfers. The ADON reviewed Resident 40's NP 1's progress note, dated 11/5/2024, which did not include Resident 40's decline with RNA for sit-to-stand transfers. The ADON reviewed Resident 40's MD progress notes and did not locate any documentation from 10/2024 regarding Resident 40's decline with sit-to-stand transfers. During an interview and record review on 4/17/2025 at 11:05 a.m., with the DON and the DOR, Resident 40's Rehab Screen documentation was reviewed. The DOR stated Resident 40 experienced a decline in mobility since the RNA program was changed from sit-to-stand transfers to AAROM to both arms and legs. The DOR stated Resident 40 did not receive a Rehab Screen when the decline in mobility was identified on 10/4/2024. The DON stated the facility did not provide any intervention after Resident 40's decline on 10/4/2024 to maintain Resident 40's ability to perform sit-to-stand transfers. During an interview and record review on 4/17/2025 at 11:18 a.m., with the DON and the DOR, Resident 40's IDT meeting notes, including the IDT-Care Plan Review dated 12/17/2024, were reviewed. The DON stated there was no documentation the IDT discussed Resident 40's decline in mobility when the decline was identified on 10/4/2024. The DON stated Resident 40's IDT-Care Plan Review, dated 12/17/2024, was not completed. During an interview on 4/17/2025 at 11:39 a.m., with the DON, the DON stated PT 1 discontinued Resident 40's RNA order for sit-to-stand transfer (on 10/4/2024). The DON stated the PT would be the best person to maintain Resident 40's mobility. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	During an interview on 4/17/2025 at 11:59 a.m., with the DON and the DOR, the facility's P&P for Quality of Care titled, ROM and Contracture Prevention, was reviewed which indicated the facility ensured residents received services, care and equipment to maintain and/or improve their highest level of ROM and mobility unless a reduction is clinical unavoidable. The DON stated Resident 40's highest practicable level of mobility was to perform sit-to-stand. The DON declined to answer the question regarding whether Resident 40's decline in mobility was preventable. During a concurrent observation and interview on 4/17/2025 at 1:07 p.m. with RNA 2 and the DOR, Resident 40 sat in the wheelchair while RNA 2 wheeled Resident 40 into the hallway facing the hallway's siderail. The DOR placed a vinyl gait belt (assistive device placed around a person's waist to assist with safe transferring between surfaces or while walking) around Resident 40's waist. The DOR was standing on the left side of Resident 40 while RNA 2 was on the right side. Resident 40 extended both arms and grabbed the hallway siderail as the DOR and RNA 2 physically assisted Resident 40 upward toward standing. Resident 40's hips were bent and positioned behind Resident 40's torso and legs in a squatting position. The DOR attempted to physically push both of Resident 40's hips upward and forward but Resident 40 did not stand upright. The DOR and RNA 2 assisted Resident 40 back to sitting in the wheelchair and appeared physically tired. The DOR and RNA 2 stated Resident 40 required complete physical assistance to attempt to stand. RNA 2 stated Resident 40 used to stand before with maximum assistance of two-persons. Resident 40 stated, That's the perfect word, 'before,' because I have not stood in a while. During a telephone interview on 4/17/2025 at 1:57 p.m. with NP 1, NP 1 stated she did not recall the facility reporting Resident 40's inability to perform sit-to-stand with RNA. NP 1 stated the facility would typically request a therapy evaluation if a resident (in general) had decline in mobility. NP 1 stated a therapy evaluation would have been approved if the facility requested it for Resident 40's decline in ability to perform sit-to-stand. During a concurrent interview and record review with Restorative Nursing Aide 1 (RNA 1) and RNA 2 on 4/17/2025 at 2:20 p.m., Resident 40's RNA Weekly Progress Reports from 5/2024 to 10/2024 were reviewed. RNA 2 stated Resident 40 used to require full physical assistance to perform sit-to-stand, stood upright, and required physical assistance to maintain the standing position. RNA 1 stated Resident 40's ability to perform sit-to-stand changed every session. RNA 1 reviewed Resident 40's RNA Weekly Progress Report, dated 5/2/2024, which indicated Resident 40 stood for 20-35 seconds. RNA 1 stated Resident 40 stood upright for 20-35 seconds with full physical assistance from both RNAs. RNA 1 reviewed Resident 40's RNA Weekly Progress Report, dated 5/9/2024, which indicated Resident 40 stood for 10 seconds with good balance. RNA 1 stated Resident 40 had good balance because he stood more upright than usual and did not need as much assistance from RNAs. RNA 1 reviewed Resident 40's RNA Weekly Progress Report, dated 5/16/2024, and stated Resident 40 required two-person assistance for the sit-to-stand transfer and assistance to maintain standing for 30-60 seconds. Both RNA 1 and RNA 2 reviewed Resident 40's RNA Weekly Progress Reports from 6/2024 to 9/2024 and stated Resident 40 required two-person assistance to perform sit-to-stand transfers and to maintain standing. RNA 1 stated Resident 40 was unable to stand fully on 10/4/2024 which was reported to the charge nurse, the DOR, and the PT (unspecified). RNA 1 and RNA 2 stated the therapists would usually do a screen and determined the next steps. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	b. During a review of Resident 4's Admission Record (AR), the AR indicated Resident 4 was admitted on [DATE] with diagnoses including vascular dementia (impaired supply of blood to the brain causing progressive state of decline in mental abilities), dysphagia (difficulty swallowing), and difficulty in walki [TRUNCATED]

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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** 50387 Based on observation, interview, and record review, the facility failed to follow the facility's policy and procedure (P&P) titled, Falling Star Program, dated 3/20/2024, that indicated, if the resident has fallen in the last 30days, staff would place a falling star sticker on their door tag to ensure one of one sampled resident (Resident 11) remained free of accident by not placing a star sticker on resident's door post. Resident 11 had four times falls in the past four months. This failure had the potential for Resident 11 to sustain injuries from falling, due to lack of proper supervision that would be indicated by a falling star sticker. Findings: During a review of Resident 11's Admission Record, the Admission Record indicated the facility Resident 11 admitted Resident 11 on 8/17/2022 with diagnoses including Dementia (Progressive loss of mental abilities like memory, thinking, and reasoning, so severe that it interferers with daily [NAME]) and history of transient ischemic attack (a temporary interruption of blood flow to the brain, leading to symptoms similar to a stroke but resolving within 24 hours) and cerebral infraction (an ischemic stroke). During a review of Resident 11's History and Physical (H&P), dated 3/24/2025, the H&P indicated, Resident 11 did not have the capacity to understand and make decisions. During a review of Resident 11's Minimum Data Set (MDS- a resident assessment tool), dated 03/23/2025, the MDS indicated Resident 11' cognitive (functions your brain uses to think, pay attention, process information, and remember things) skills were severely impaired. The MDS indicated Resident 11 required supervision assistance (helper provides verbal cues and/ or touching/ steading and/or contact guard assistance as resident completes activity) with eating, moderate assistance (helper does less than half the effort to complete the task) with oral hygiene, maximal assistance (helper does more than half the effort to complete task) with upper body dressing and was totally dependent with toileting hygiene, showering, lower body dressing, putting on and taking off footwear. During a review of Resident 11's Change in Condition (COC) Evaluation, for the month of December 2024, January 2025, and March 2025, the COC evaluation indicated, Resident 11 had fallen four times in the past four months, on 12/18/2024, on 12/24/2024, on 1/15/2025, and on 3/17/2024. During a review of Resident 11's fall risk assessment, dated 2/7/2025 and 3/23/2025, the fall risk assessments indicated, Resident 11 was a high risk for falls. During an observation on 4/14/2025 at 1:20 p.m., Resident 11's room, no star sticker as an indicator for fall risk was observed at the resident's door post. During an interview on 4/15/2025 at 8:28 a.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated that Resident 11 was not a fall risk because there was no falling star sticker on the entrance to his room, and residents who are fall risks have a falling star sticker on their door. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 4/17/2025 at 10:30 a.m., with LVN 1 at the door of Resident 11's room, there was still no star sticker observed on the door post to indicate high risk for falls. LVN 1 stated that she was not aware that Resident 11 was at a high risk for falls because there was no falling star sign next to his name on the door post, which indicated that he was not considered a fall risk. LVN 1 stated that if she had known the resident was at high risk for falls, she would have approached him like a high fall risk resident. During an interview on 4/17/2025 at 12:31 p.m., with Certified Nurse Assistant (CNA) 1, CNA 1 stated Resident 11 did not have a reminder in his room to ask for help. During an interview on 4/17/2025 at 1:40 p.m., with the Assistant Director of Nursing (ADON), the ADON stated that Resident 11 was a high risk for falls, and a falling star sticker should have been placed for staff to be aware that he had fallen multiple times in the last 90 days. The ADON stated that the facility wanted to prevent or eliminate the risk of reoccurring falls. The ADON stated the facility followed the falling star program as an intervention, and putting a falling star sticker after a fall was extremely important communication with all staff to monitor the resident, and also to place a reminder sign at bedside to ask for help. During an interview on 4/18/2025 at 10:27 a.m. with the Director of Nursing (DON), the DON stated that it was important to follow the falling star program for a fall risk resident to prevent a fall from reoccurring. During a review of the facility's policy and procedure (P&P) titled, Falling Star Program, dated 3/20/2024, the P&P indicated, if the resident has fallen in the last 30days, the DSD/ Designee will place a star sticker on their door tag.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50387 Based on observation, interview, and record review, the facility failed to follow its own policy and procedure (P&P) titled, Oxygen, Use of, revised 5/2021, that indicated, the oxygen cannula or mask, and the disposable humidifier would be changed at least every seven days, by not replacing the nasal canula after being used more than seven days for one of one sampled resident (Resident 52). This failure has the potential to compromise the resident's safety and well-being and spread of infection. Findings: During a review of Resident 52's Admission Record, the Admission Record indicated the facility admitted Resident 52 on 4/17/2024 and readmitted on [DATE] with diagnoses including acute respiratory failure (difficulty breathing) with hypoxia (a condition where there is not enough oxygen [life sustaining element of air] to supply the body) and chronic obstructive pulmonary disease (COPD-a progressive lung disease that makes it hard to breathe due to damaged airways and lung tissue). During a review of Resident 52's Minimum Data Set (MDS- a resident assessment tool), dated 1/16/2025, the MDS indicated Resident 52's cognitive (to think, pay attention, process information, and remember things) skills were moderately impaired. The MDS indicated Resident 52 required setup or clean-up assistance (helper sets up or cleans up) with eating, oral hygiene, maximal assistance (helper does more than half the effort to complete task) with showering, was dependent (helper does all the effort) with toileting hygiene and personal hygiene. During a review of Resident 52's Order Summary Report, orders as of 4/16/2025, the Order Summary Report indicated orders to administer oxygen at 3 liters per min (l/min-a unit that expresses flow rate) via nasal cannular (NC- a simple medical device used to deliver supplemental oxygen through the nose) continuous on 1/22/2025, change humidifier every Sunday on 1/26/2025, and change nasal cannula every Sunday on 1/26/2025. During an observation on 4/14/2025 at 10:45 a.m., in Resident 52's room, Resident 52 was observed lying in his bed on room air. There was a nasal cannula hanging on the right upper siderail of the bed and dated 4/6/2025. During a concurrent observation and interview on 4/14/2025 at 11:00 a.m., in Resident 52's room, the Director of Staff Development (DSD) entered the room and confirmed that the nasal cannula hanging on the side rail, dated 4/6/2025 was more than seven days old. The DSD stated that the nasal cannula should be changed on weekly basis to prevent of infections. During a concurrent interview and record review on 4/17/2025 at 10:52 a.m., with Licensed Vocational Nurse (LVN) 1, Resident 52's order summary Report, active as of 4/15/2025 was reviewed. LVN 1 stated that Resident 52's oxygen order was a continuous order, and on Monday (4/14/2025) morning and staff should have changed the nasal cannula every seven days. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/18/2025 at 10:27 a.m. with the Director of Nursing (DON), the DON stated that the nasal cannular goes directly to the lungs, so staff should have changed the nasal cannular every seven days to prevent infection, usually on every Sunday. During a review of the facility's policy and procedure (P&P) titled, Oxygen, Use of, revised 5/2021, the P&P indicated, the oxygen cannular or mask will be changed at least every seven days, as well as the disposable humidifier.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46415 Based on interview and record review, the facility failed to ensure the physician face-to-face visit was made by a physician at least once every 60 days for one of three sampled residents (Resident 49). This deficient practice had the potential to result in an undetected decline in medical, health or psychosocial condition and can lead to a delay in necessary care, treatment and services. Findings: During a review of Resident 49's Admission record (Face Sheet), the Face Sheet indicated Resident 49 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including Type II Diabetes Mellitus (DM: a disorder characterized by difficulty in blood sugar control and poor wound healing), heart failure (heart unable to pump enough blood to meet the body's needs), and HTN. During a review of Resident 49's Minimum Data Set [MDS] a resident assessment tool), dated 4/1/2025, the MDS indicated Resident 49's cognitive skills (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) were severely impaired. The MDS indicated Resident 49 is dependent on all aspects of activities of daily living (ADL: bathing, chair/bed-to-chair transfer, personal hygiene, toileting hygiene, oral hygiene). The MDS indicated Resident 49 does not have any impairments on both the upper (arms/shoulders) and lower extremities. During a review of the physician progress notes for Resident 49, Resident 49's last physician notes is 1/28/2025. During a concurrent interview and record review on 4/18/2025 at 2:58p.m. with Assistant Director of Nursing (ADON), ADON stated physicians come within two to three days upon admission to come and assess the residents and are present at the facility at least monthly. ADON stated Resident 49 has left the facility since 1/28/2025 and indicated there are no notes in PointClickCare (PCC: electronic medical record) nor on the physician progress notes in the chart. ADON stated Resident 49 is a custodial resident and is seen once every 2 months. During an interview on 4/18/2025 at 4:18p.m. with ADON, ADON stated Resident 49 should have been seen by a physician since 1/28/2025. ADON stated if the resident is not seen by the physician, it can affect the residents as they would not have the opportunity to talk to them face to face or ask questions. ADON stated the physician should come and see the residents so they can do a physical assessment. During a review of the facility's policies and Procedures (P&P), titled Physician Visits, revised 6/2015, the P&P indicated it is the policy of this facility that residents must be seen by a physician at least once every thirty (30) days for the first ninety (90) days after admission, and at least once every sixty (60) thereafter.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45891 Based on interview, and record review the facility failed to ensure facility staff were competent when caring for two out of 16 sampled residents (Resident 35 and Resident 57) with pressure injuries (areas of damaged skin and tissue caused by sustained pressure) by failing to: a. Ensure treatment nurse (TXN 1) was competent in performing and documenting weekly wound assessments per the facility's Wound Management and Prevention Policy and Procedure (P/P) for Resident 35. b. Ensure TXN 1 was competent in completing a change of condition (COC) assessment and notifying the physician when a change in Resident 35's left heel suspected deep tissue pressure injury (SDTI, a form of pressure-induced damage to underlying tissues, including muscles, bones, and subcutaneous layers, while the skin surface might remain intact. It typically results from sustained pressure or shear forces that compromise blood flow, leading to ischemia and subsequent tissue necrosis. Recognizing a suspected deep tissue injury is crucial for timely intervention to prevent progression to more severe wounds) noted on [DATE]. c. Ensure the Director of Nursing (DON) was monitoring all residents with pressure injuries including Resident 57 As a result of this deficient practice accurate progress or lack thereof for Resident 35's left heel SDTI was not recorded in the medical record and there was a possibility for delay in care and treatment for Resident 35's left heel wound. Resident 35's left heel SDTI declined and was reclassified as an unstageable pressure injury (when the stage is not clear. In these cases, the base of the wound is covered by a layer of dead tissue that may be yellow, grey, green, brown, or black. The doctor cannot see the base of the wound to determine the stage) on [DATE]. Resident 57 did not receive clinical oversight from the DON until Resident 57's right buttock redness first seen on [DATE] had developed into a stage four (Full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) pressure injury on [DATE]. (Cross reference: F580 and F686) Findings: a.b.During a review of Resident 35's Admission Record, the Admission Record indicated Resident 35 was admitted to the facility [DATE] with diagnoses of left femur fracture (broken leg bone), fall, muscle weakness, difficulty in walking, joint replacement surgery, and type 2 diabetes (happens when the body cannot use insulin correctly and sugar builds up in the blood). During a review of Resident 35's general acute care hospital (GACH) clinicals sent to the facility from the GACH, the Wound Care Consult dated [DATE] indicated Resident 35 had a 6 centimeter (cm, a unit of measurement) by 6 cm stage 2 (may present as an intact blister)/ SDTI with an intact fluid filled blister. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 35's Initial Admission Record dated [DATE], the Initial Admission Record indicated a skin integrity check indicated Resident 35 had a left heel blister. The Intitial Admission Record did not indicate there was no description of the appearance of the wounds upon admission. During a review of the Admission Report- Skin Check (paper document) undated, the skin check indicated Resident 35 had a 3 cm by 6 cm left heel blister. During a review of Resident 35's history and physical (H&P) dated [DATE], the H&P indicated Resident 35 was able to make her own medical decisions. The H&P indicated Resident 35 was sent to the facility after left hip surgery after sustaining a left hip fracture. The H&P indicated Resident 35 did not have any concerning rashes or lesions (wounds) at the time but did have a left hip surgical site. The H&P included a plan to monitor for wound per facility protocol and obtain a wound care evaluation as needed. The H&P indicated the facility's care staff was instructed to call the physician for any COC. During a review of Resident 35's care plan titled Has actual impairment to skin integrity related to (r/t) left heel blister and left heel protector boot (cushioned boot that floats the heel to aid in healing of pressure injuries) initiated [DATE], goals for Resident 35 included reducing the risk for impairment to skin integrity by positioning techniques, and adaptive equipment. Interventions included avoiding scratching, keeping body parts from excessive moisture, keeping fingernails short, educating resident/ family/ and caregivers of causative factors and measures to prevent skin injury, and encouraging good nutrition and hydration to promote healthier skin. On [DATE] the care plan for the left heel blister was updated to include, on [DATE]: patient was reassessed by TXN 1, the left heel blister was clarified as SDTI with purple tissue. On [DATE] the care plan interventions were updated to include left heel SDTI treatment as ordered, monitor/ document location, size and treatment of the skin injury, report abnormalities, failure to heal, signs and symptoms of infection to the physician, monitor for skin breakdown and off-load (minimizing or removing weight placed on the foot to help prevent and heal ulcers) as tolerated. During a review of Resident 35's Order Summary Report, the report indicated Resident 35 had the following wound care orders were placed: - [DATE] for left heel blister, cleanse with NS pat dry, apply antibacterial ointment then apply gauze and wrap with kerlix (type of dressing). Every day shift. The order was discontinued [DATE]. - [DATE] for bilateral (both) heel apply protector boots as tolerated or as patient allows. Every day shift. - [DATE] for left heel SDTI: cleanse with NS, pat dry, apply sure prep (skin barrier ointment), apply abdominal (ABD) pad and cover with rolled gauze. Offload as tolerated, monitor for skin breakdown and notify the physician of any changes every day shift. The order was discontinued [DATE]. -[DATE] for left heel SDTI: cleanse with NS, pat dry, apply MediHoney (medical honey, hastens the healing of wounds through its anti-inflammatory effects), calcium alginate dressing (ideal for wounds with moderate to heavy exudate [fluid that leaks out of blood vessels into nearby tissues]), dry dressing and cover with rolled gauze. Offload as tolerated, monitor for skin breakdown and notify the physician of any changes every day shift. The order was discontinued [DATE]. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- [DATE] wound culture of the left heel, one time only -[DATE] wound care consult for DTI -[DATE] for left heel unstageable: cleanse with NS, pat dry, apply MediHoney, calcium alginate, dry dressing and cover with rolled gauze. Offload as tolerated, monitor for any signs for skin breakdown and notify the physician of any changes. During a review of Resident 35's Skin/ Wound Note dated [DATE] (three days after admission), the note indicated Resident 35 was reassessed by TXN 1 and the left heel blister was clarified as an SDTI with purple tissue. The note did not indicate measurements or a complete wound assessment describing the characteristics of the wound. The note did not indicate the physician was notified of the clarified wound type or new treatment orders. Resident 35 did not have weekly Skin/Wound assessments documented in her medical record including all wounds and their progress as indicated in the facility's Wound Management and Prevention policy and procedure (P/P). During a review of Resident 35's minimum data set (MDS, a resident assessment tool) dated [DATE], the MDS indicated Resident 35 had moderate cognitive impairment (having problems remembering things, concentrating, making decisions and solving problems) and required substantial/ maximal assistance (helper does more than half the effort) for bed mobility including rolling from left to right. The MDS indicated Resident 35 was at risk for pressure injuries and had two deep tissue injuries and zero unstageable pressure injuries with slough or eschar. During a review of Resident 35's wound culture, source left foot obtained [DATE], the wound culture results indicated Resident 35 had moderate growth of Proteus Mirablis (a gram-negative bacteria that can cause wound infections). During a review of Resident 35's COC evaluation dated [DATE], the COC indicated Resident 35 had new pain of the left and right heels. The COC indicated Resident 35's left heel SDTI was reclassified as Unstageable pressure injury. The left heel unstageable pressure injury measured 6.5 cm by 7 cm with 75 percent (%) of wound covered in eschar, 20% slough, and 5% granulation tissue (new tissue) with medial (inside) ankle discoloration. The COC indicated family member (FM) 2 was requesting an x-ray (a type of radiation that creates a picture of the inside of the body) of both feet to rule out effects to the bone. During a review of Resident 35's Registered Dietician Note dated [DATE], the note indicated Resident 35 had bilateral heel unstageable pressure injuries. The note indicated a nurse (unknown) had received a new physicians order ([DATE]) for multivitamins with minerals, Vitamin C 500 mg, and Zinc 220 mg for 14 days and RD 2 recommended ProStat (liquid protein) 30 ml twice a day for wound healing. During a review of Resident 35's GACH Wound Care Consult dated [DATE], the consult indicated Resident 35 was sent to the GACH from the facility for worsening wounds to bilateral heels and bilateral heel pain. The consult indicated Resident 35 received Vancomycin, morphine 4mg IV, and 1 L NS in the ED. The consult indicated FM 2 reported Resident 35 had worsening wound to the left heel for one week with odor. The consult indicated Podiatry (the treatment of the feet and their ailments) was consulted for the left heel unstageable pressure injury. During an interview on [DATE] at 10:11 a.m., FM 2 stated she was upset because Resident 35's left heel wound was getting worse. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on [DATE] at 1:44 p.m., TXN 1 was in Resident 35's room speaking to FM 3 at the bedside. Resident 35 was lying in bed crying in pain, saying her left foot hurt. Resident 35 was informing FM 3 she had chills (the feeling of being cold, though not necessarily in a cold environment, often accompanied by shivering or shaking). Resident 35's left heel was observed with the following and described by TXN 1 as: a large area of dark purple or black appearing eschar, surrounded by a pinkish red area of granulation tissue, and a small amount of yellowish white slough. During an interview on [DATE] at 9:03 a.m., TXN 1 stated she noticed a change in appearance to Resident 35's left heel wound and a little bit of odor. TXN 1 reviewed Resident 35's medical record and stated there were no weekly skin/ wound documentation in the chart including measurements. During an interview on [DATE] at 11:16 a.m., TXN 1 stated Resident 35's left heel wound had a change in status on [DATE]. The wound had some drainage and had a smell. TXN 1 stated she did not inform the physician of the change in appearance of the wound on [DATE]. TXN 1 stated Resident 35's left heel wound now had eschar or necrotic tissue which was not good for wound healing and usually needs to be debrided (removed) but that was not in her scope of practice so Resident 35 needed a wound care consultation. TXN 1 stated when a wound has eschar, they do not know how bad the wound really was underneath, and the wound could have been worse. TXN 1 stated it was the facility's policy to document weekly on the wound progress. TXN 1 stated she was upset with herself because she did not perform a COC assessment and notify the physician of Resident 35's decline in wound appearance on [DATE]. TXN 1 stated there was a possibility of delay in care and treatment if the physician was not notified right away of a wound decline. TXN 1 stated she had not called Resident 1's physician to discuss Resident 35's wound status since she had been caring for Resident 35's wounds. During an interview on [DATE] at 2:21 p.m. physician assistant (PA) 1 was in the facility and stated he had just been informed Resident 35 had worsening wounds. PA 1 stated he was going to put an order to be seen by a wound care consultant. PA 1 stated the physician or himself should have been notified right away of new or changing wounds. PA 1 stated it was important residents with eschar were seen by a wound care consultant so the appropriate interventions could be placed. During an interview on [DATE] at 2:25 p.m., TXN 1 stated she was now staging Resident 35's left heel wound as an unstageable pressure injury due to the wound characteristics (slough and eschar). TXN 1 stated the definition of an unstageable pressure injury was the wound couldn't be staged. During an observation on [DATE] at 2:42 p.m., TXN 1 measured the wound on Resident 35's left heel, the wound measured 6.5 cm by 7 cm with a separate discolored (redness) on the inner ankle. The wound had a large purplish black center, yellowish white area surrounding the dark area as well as a small area of granulation tissue (new pinkish red tissue). (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 2:33 p.m., the DON stated she was not aware of Resident 35's wounds until this interview. The DON stated it was important she was notified of wound and the wound decline so she could review the chart and ensure the resident was receiving all appropriate interventions. The DON stated wounds needed to be assessed upon admission, for any changes, and weekly and all assessments needed to be recorded in the resident's chart. The DON stated the IDT had not met to discuss Resident 35's wounds. The DON stated there was a possibility the wounds could decline if the IDT did not meet to discuss important interventions needed. The DON reviewed Resident 35's medical record and stated weekly skin/ wound assessments had not been completed. The DON stated it was important the physician was aware of wound changes so they could order any necessary interventions. The DON stated there was no COC or notification of the physician documented in Resident 35's chart related to the wound appearance and decline on [DATE]. The DON stated TXN 1 was not competent in wound documentation and tracking as evidenced by the lack of documentation in Resident 35's chart and the failure to complete a COC when a decline in the wound was noted on [DATE]. c. During a review of Resident 57's Admission record, the Admission record indicated Resident 57 was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (brain dysfunction caused by underlying metabolic disorders or conditions), cerebral infarction (stroke - loss of blood flow to a part of the brain), and wedge compression fracture (when the front part of the vertebral body collapses, creating a wedge shape) of T11-T12 vertebra (lower two bones of the thoracic (middle section) spine). During a review of Resident 57's Licensed Nurse (LN) Admission evaluation dated [DATE], the LN Admission evaluation indicated Resident 57 had a right and left heel pressure injury on admission. Left knee injury, discolorations on neck, and skin tags on back. During a review of Resident 57's H&P, dated [DATE], the H&P indicated Resident 57 did not have the capacity to understand and make decisions. During a review of Resident 57's Minimum Data Set (MDS - a resident assessment tool), dated [DATE], the MDS indicated Resident 57 had moderate impairment to cognition (ability to learn, reason, remember, understand, and make decisions), required supervision for eating and oral hygiene, required moderate assistance (helper does less than half the effort) for toileting, and required maximal assistance (helper does more than half the effort) for bathing. During a review of Resident 57's care plan titled, Has actual impairment to skin integrity r/t skin discoloration - Right (R) buttock, redness, initiated [DATE], the care plan indicated Resident 57 had R buttock redness. The care plan indicated the following interventions: encourage good nutrition and hydration in order to promote healthier skin, keep skin clean and dry. Use lotion on dry skin, provide treatment (tx) as ordered. During a review of the Treatment Administration Record (TAR) for [DATE] to February 2025, the TAR indicated Resident 57 had the following orders and administrations: -[DATE] to [DATE]: Right buttock redness: cleanse with normal saline (NS), pat dry, apply zinc oxide cream, leave open to air every day and evening shift from -[DATE] to [DATE]: Right buttock redness: cleanse with NS, pat dry & apply barrier cream. Monitor for skin breakdown & notify MD of any changes. Every day shift. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-[DATE] to [DATE] Sacrococcyx: apply barrier cream daily & during perineal care for skin maintenance & integrity. Monitor for skin breakdown & notify MD of any changes every shift. -[DATE] to [DATE]: Right buttock Moisture associate skin dermatitis (MASD-moisture associated skin damage caused from prolonged exposure to moisture) with erosions & excoriations (A scrape or scratch to the skin): cleanse with NS, pat dry, apply triad wound cream (wound paste to create a moist healing environment for wounds) & cover with dry dressing. Monitor for skin breakdown & notify MD of nay changes. Every day shift. During a review of Resident 57's order summary, the orders indicated a low air loss (LALM) mattress due to (d/t) right buttock unstageable, left heel stage three ordered on [DATE]. During a review of the Treatment Administration Record (TAR) for February 2025 to [DATE], the TAR indicated Resident 57 had the following orders and administrations: -[DATE] to [DATE]: Right buttock unstageable: cleanse with NS, pat dry, apply medihoney (medical-grade honey used in wound care), calcium alginate (type of dressing to create a moist environment that supports wound healing and absorbs excess fluid) & cover with dry dressing. Monitor for skin breakdown & notify MD of any changes. -[DATE] to [DATE]: Right buttock Stage four: Cleanse with NS, pat dry, apply medihoney, collagen powder, calcium alginate & cover with dry dressing. Monitor for skin breakdown & notify MD of any changes. During a review of the Skilled Nursing Facility (SNF) Wound Care documentation by the Nurse Practitioner (NP) from [DATE] to [DATE], the SNF Wound Care documentation indicated the following: -[DATE]: Right buttock unstageable pressure-induced tissue damage. Measurement 6.2 x 6.4 centimeters (CM - unit of measurement), unable to determine (UTD). No undermining or tunneling was noted. Post debridement (process of removing dead or damaged tissue and debris from a wound) measure measurement: 6.2 x 6.5 CM, UTD. Procedure: Necrotic (dead tissue that is no longer function and cannot be revived) subcutaneous tissue debridement. Indications: Removal of devitalized necrotic subcutaneous tissue to promote healing. Tissue type: 30% granulation (type of new connective tissue), 70% slough (dead tissue that is usually yellow, tan, gray, or green in color, usually moist and stringy in texture, that may be found in wounds) -[DATE]: Right buttock unstageable pressure -induced tissue damage. Measurement: 6.0 x 3.6 CM, UTD. Post debridement measurement: 6.1 x 3.6 CM, UTD. Necrotic subcutaneous tissue debridement performed. Tissue type: 40% granulation, 60% slough -[DATE] : Right buttock unstageable pressure-induced damage. Measurement 5.8 x 3.5 CM, UTD. Post debridement measurement: 5.9 x 3.6 CM, UTD. Necrotic subcutaneous tissue debridement performed. Tissue type: 50% granulation, 50% slough [DATE]: Right buttock unstageable pressure -induced tissue damage, now reclassified as stage IV. Measurement: 4.1 x 2.6 x 0.4 CM. Post debridement measurement: 4.2 x 2.7 x 0.5 CM. Necrotic subcutaneous tissue debridement performed. Tissue type: 90% granulation, 10% slough (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 11:24 a.m. with Resident 57's Family Member (FM7), FM7 stated Resident 57 did not have any bedsores in [DATE], and was notified on [DATE] that Resident 57 had a bed sore when it had reached stage four. During a concurrent interview and record review on [DATE] at 11:35 a.m. with the treatment nurse (TXN) 1, Resident 57's chart was reviewed. TXN 1 stated Resident 57 developed redness to the right buttock in [DATE] and [DATE] which progressed to MASD on [DATE], which progressed to an unstageable injury requirement debridement on [DATE]. During a review of Resident 57's GACH Clinical record titled Wound Care Note, dated [DATE], the Wound Care Note indicated Resident 57 had a Stage four pressure injury on the coccyx measuring 4 x 3.2 x 2 CM, undermining (the destruction of tissue or ulcer extending under the skin edges so that the pressure ulcer is larger at its base than at the skin surface) ,d+[DATE] o'clock, deepest 2.8 CM at 9 o'clock, wound bed 90% non-granular tissue and 10% adherent slough on wound edge, wound exudate (fluid that leaks out of blood vessels due to inflammation) is moderate sanguineous (bright red, fresh blood). During a concurrent interview and record review on [DATE] at 12:18 p.m., the DON, Resident 57's chart was reviewed. The DON stated it is not normal for a resident with intact skin on admission to develop a stage four pressure injury. The DON stated she was not informed of Resident 57's pressure injury until [DATE] when it was reclassified to a stage four pressure injury. The DON stated she should have been informed every time the skin changed and be aware of all pressure injuries in the facility. The DON stated the wound should have been escalated to the DON sooner and stated Resident 57 could have been identified as a risk sooner and interventions could have been implemented such as repositioning more frequently and offloading. During a review of the facility's P/P titled Change of Condition Reporting dated ,d+[DATE], the P/P indicated changes in resident condition were to be reported to the physician and it was to be documented in the eInteract Change of Condition and/ or in the nurse's progress notes, the plan of care was to be updated. The P/P indicated any attempts to contact the physician would be documented in the resident's medical record. During a review of the facility's P/P titled Wound Management and Prevention dated [DATE], the P/P indicated it was the facility's policy to ensure any resident that entered the facility had appropriate preventative measure taken to ensure the resident did not develop pressure ulcers, or that residents admitted with wound did not develop signs and symptoms of infection. The P/P indicated a report of all the wounds and their progress would be updated by the treatment nurse weekly. During a review of the facility's Job Description- Director of Nursing dated ,d+[DATE], the job description indicated the DON was to review nursing personnel medical record documentation to ensure that it was appropriately and accurately descriptive of the nursing care provided. The DON was to manage and direct all aspects of the nursing services department. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46415 Based on interview and record review, the facility failed to provide social services to two (2) out of four sampled residents (Resident 15 and 325) by failing to assess the resident's psychosocial needs and trauma screening upon admission. This deficient practice had the potential for delay in the delivery of care and services. Findings: a. During a review of Resident 15's Admission record , the Admission record indicated Resident 15 was admitted to the facility on [DATE] with diagnoses including influenza (also known as the flu - a contagious respiratory illness caused by influenza viruses, post-traumatic stress disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event), and anxiety disorders (persistent and excessive worry that interferes with daily activities). During a review of Resident 15's History and Physical (H&P), dated 1/21/2025, the H&P indicated Resident 15 had the capacity to understand and make decisions. During a review of Resident 15's Minimum Data Set (MDS - a resident assessment tool), 1/24/2025, the MDS indicated Resident 15 required setup for eating and oral and personal hygiene and maximal assistance (helper does more than half the effort) for toileting, bathing and dressing. During a concurrent interview on 4/18/2025 at 11:04 a.m. with the Social Services Director (SSD)and record review Resident 15's medical record. The SSD stated Resident 15 did not have a trauma assessment or social services assessment completed on admission. The SSD stated all residents should be screened for trauma on admission to ensure that the resident receives proper treatment and resources if needed. During an interview on 4/18/2025 at 12:18 p.m. with the Director of Nursing (DON), the DON every resident should have a psychosocial assessment on admission and screened for trauma to identify if residents have PTSD or specific triggers and to ensure they receive appropriate resources like a psychiatry consult. b. During a review of Resident 325's Admission, the Admission Record indicated Resident 325 was admitted to the facility on [DATE] with diagnoses including dementia fracture of the lower end of left radius (break in the radius bone near the wrist joint), assault by other bodily force, and traumatic subarachnoid hemorrhage (a type of bleeding in the brain that occurs in the space surrounding the brain due to head trauma). During a review of Resident 325's H&P, dated 4/11/2025, the H&P indicated Resident 325 is able to make her own medical decisions. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 325's MDS, dated [DATE], the MDS indicated Resident 325's cognitive skills were intact. The MDS indicated Resident 325 is dependent on toilet hygiene, bathing, required maximal assistance for bathing, chair/bed-to-chair transfer, dressing lower body, required moderate assistance dressing the upper body, and required moderate assistance for eating, oral hygiene, and personal hygiene. During an interview on 4/17/2025 at 3:48p.m. with SSD 1, SSD 1 stated upon admission, they will do a trauma assessment if the resident has a diagnosis of Post Traumatic Stress Disorder (PTSD. SSD 1 stated Resident 325 was assaulted but would not do a trauma assessment since she does not have a diagnosis of PTSD. SSD 1 stated during a trauma assessment, she would ask if there were anything bothering the resident or if she visibly sees the resident is crying, but indicated when she spoke to Resident 325, she did not show any signs of distress. SSD 1 stated Resident 325 does not have a trauma assessment and did not do a social service assessment since she has seven (7) to eight (8) days to complete it. SSD 1 stated all social service assessments for admission has questions related to trauma. SSD 1 stated trauma questions are asked to identify any triggers or if there is anything that traumatized them, and even if the resident does not have a diagnosis of PTSD would still ask trauma questions as it is a part of the assessment. During an interview on 4/18/2025 at 12:13p.m. with Director of Nursing (DON), DON stated trauma assessments can be physical or emotional and is initiated upon admission. DON stated they will review the resident's history and diagnosis to identify if there is anything that needs to be addressed and indicated the resident does not have to have a diagnosis for a resident to have trauma. DON stated is a resident verbalized they were assaulted, that would be a part of the trauma assessment. DON stated it is addressed to ensure residents receive a customized care as they may require additional support and services and identify any triggers that may need to be addressed. DON stated if they did not do trauma assessments, the facility will not be able to provide the proper care and will delay the progression of the resident's overall being. DON stated there should be a trauma assessment and social service assessment for every resident. During a review of the facility's policies and Procedures (P&P), titled Social Services, Provision of Medically-Related revised 12/2023, the P&P indicated it is the policy of this facility to provide medical-related social services to attain or maintain the highest practicable physical, mental, or psychosocial well-being of each resident. social services complete a social history and social services admission evaluation for new admissions within the first week and initiates the discharge planning process. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P, titled Behavioral Health Services revised 4/2019, the P&P indicated it is the policy of this facility to provide residents with necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being .behavior health encompasses a resident's whole emotional and mental well-being, which includes the prevention and treatment of mental and substance use disorders, as well as psychosocial adjustment difficulty, or those with history of trauma and/or post traumatic stress disorder. Trauma survivors will receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. The Social Service designee will also meet with resident and/or resident representative and attempt to identify possible psychosocial issues and needs that may be causing the behaviors or having an impact on resident's function, mood, and cognition. The Inter-Disciplinary Team (IDT) will ensure that resident who display or is diagnosed with history of trauma, or post-traumatic stress disorder (PTSD) receives the appropriate treatment and services to attain the highest practicable mental or psychosocial well-being.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 28851 Based on interview and record review, the facility failed to provide pharmaceutical services that meet the needs of its residents, as evidenced by: 1. Failed to keep a separate record of emergency drug usage for drugs retrieved from the Cubex (a computer-controlled system that automates drug dispensing in a health facility). 2. Failed to ensure there were signatures of the licensed nurses who witnessed the non-controlled drugs disposition performed on 3/13/25. 3. Failed to ensure nurses checked the medications against the orders for accuracy when receiving medication delivered by the pharmacy, for Residents 377 and 429. (See also F-759, 760) 4. Failed to ensure nurses would consult with MD for an order to crush medications before crushing medications (Resident 67). These deficient practices had the potential for medication errors, adverse effects, and drug diversion. Findings: 1. During an interview on 4/15/25 at 12:03 PM, the director of nursing (DON) stated the pharmacy did not send Cubex transaction daily, During an interview on 4/15/25 at 12:43 PM, DON presented discrepancy summary reports and stated the pharmacy sent these reports daily; however, the reports did not have residents' names and other details. DON stated the emergency kit (E-kit, an emergency drug supplies) logbook is for the intravenous (IV, into the view) e-kit. DON stated the Cubex replaced the oral E-kits for emergency use and first doses of antibiotics (medications to treat infections). DON stated the facility did not keep records for emergency drug usage retrieved from the Cubex. During a review of the facility policy and procedures, Emergency Pharmacy Servie and Emergency Kits (dated August 2020), the policy indicated . Emergency needs for medication are met by using the facility's approved emergency medication supply . in compliance with applicable state regulations . During a review of the California Code of Regulations Title 22 section 72377(b)(5), the state regulation indicated Separate records of use shall be maintained for drugs administered from the supply. Such records shall include the name and dose of the drug administered, name of the patient, the date and time of administration and the signature of the person administering the dose. 2. During an interview on 4/15/25 at 3:56 PM, and a concurrent review of the facility's drug disposition records, DON stated one (1) licensed nurse performed non-controlled drug disposition. During a concurrent review of the facility's Medication Disposition Log - Non Controlled Medications (dated 3/13/25), the column signature of Licensed Nurse 2 was blank. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/15/25 at 4:01 PM, DON confirmed the disposition records shall have the signature of the licensed nurse who performed the destruction and the signature of one other person. During a review of the facility policy and procedure, Medication - Storage and Reconciliation (dated 1/2022), indicated . the following information is entered on the medication disposition form: . Signature of witnesses. 3. During a medication administration (or med pass) observation on 4/16/25 at 9:10 AM, the licensed vocational nurse (LVN 2) prepared and administered a tablet of benazepril (generic for Lotensin, a type of medication to treat high blood pressure) 40 milligrams (mg, unit to measure mass) to Resident 429. During a review of Resident 429's physician order dated 4/13/25 at 7:16 PM, the physician order indicated benazepril 20 mg 1 tablet orally one time a day for hypertension. During an interview on 4/16/25 at 11:10 AM, DON stated the nurses receiving the delivery should check the medications against the receipts and the residents' medication administration records, when pharmacy delivered medications. During an interview on 4/16/25 at 12:24 PM DON stated the pharmacy admitted they had made a mistake and sent the wrong medication for Resident 429. During an interview on 4/16/25 at 2:05 PM, DON stated Medical Record could not find the delivery receipt for Resident 429's benazepril. During a med pass observation on 4/17/25 at 9 AM, LVN 1 prepared and administered a tablet of morphine (a potent opioid for pain management) immediate release (IR, release drug into the body right away) 15 mg to Resident 377. During an interview on 4/17/25 at 10:20 AM, LVN 1 stated Resident 377's bubble pack label read morphine IR 15 mg; however, Resident 377's physician order read morphine ER (extended release, release drug slowly into the body over an extended period of time), not IR. During an interview on 4/17/25 at 10:37 AM, the registered nurse supervisor (RNS) stated morphine IR is not on Resident 377's physician order. During a concurrent review of Resident 377's progress notes, RNS stated there was no note on Resident 377's morphine order being changed from ER to IR. During an interview on 4/17/25 at 12:35 PM, DON stated the nurse who received the medication should have checked the medication against the order. DON acknowledged no one noticed the medication labels (for Resident 377's morphine and Resident 429's benazepril) were not the same as the corresponding orders, nor their electronic medication administration records. During a review of the facility policy and procedure, Medication Ordering and Receiving from Pharmacy (dated 2/2020), the policy indicated . A licensed nurse . verifies medications received and directions for use with the medication order form . 4. During a medication administration (med pass) observation on 4/17/25 at 8:50 AM, LVN 3 prepared Resident 67's following medications, crushed and kept in separate medicine cups: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. Metoprolol 100 mg 1 tablet b. Memantine 10 mg 1 tablet c. Hydralazine 50 mg 1 tablet During an interview on 4/17/25 at 10:15 AM, LVN 3 stated that Resident 67 had an order for puree (blended) diet, and asked the Resident if resident would like the medications crushed. LVN 3 reviewed Resident 67's physician orders and stated the resident did not have an order to crush medications. LVN 3 stated should check if medications were crushable before crushing medication. During an interview on 4/17/25 at 1:46 PM, the speech therapist (ST) stated Resident 67 can swallow solids and thin liquids. ST stated Resident 67 is on puree diet because the family stated the resident would be less picky about food when the food is blended. During an interview on 4/18/25 at 11:54 AM, the administrator (ADM) and corporate consultant stated the facility did not have a policy on medication administration guidance, but nurses should follow nursing standard of practice for medication administration.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28851 Based on observation, interviews, and record review, the facility failed to ensure its medication error rate was less than five (5) percents (%). Three medication errors out of 31 total opportunities yielded a medication error rate of 9.68%, in 2 of 4 sampled residents (Residents 429 and 377) observed during medication administration (med pass). This deficient practice of med pass error rate at 9.68% exceeded the 5 % threshold and had the potential of adversely affecting residents' health condition. Findings: During a review of Resident 429's admission record, the admission record indicated Resident 429 was admitted to the facility on [DATE] with diagnoses included hypertension (high blood pressure) and heart failure. During a review of Resident 429's physician order dated 4/13/25 at 7:16 PM, the physician order indicated benazepril 20 mg 1 tablet orally one time a day for hypertension. A further review of Resident 429's physician orders did not reveal an order for vitamin C 500mg; however, there was a physician order dated on 4/13/25 at 7:54 PM for calcium (a vital mineral for the human body, primarily known for its role in building and maintaining strong bones and teeth. 500 mg 1 tablet orally one time a day for supplement. During a medication administration (med pass) observation on 4/16/25 at 9:10 a.m. The Licensed Vocational Nurse (LVN 2) was preparing medications for Resident 429. In total, LVN 2 administered 11 medications to Resident 429. Those 11 medications included a tablet of benazepril (generic for Lotensin, a medication that lowers blood pressure and treats other heart conditions) 40 milligrams (mg, unit to measure mass) and a tablet of vitamin C 500 mg (also known as ascorbic acid, is a water-soluble vitamin essential for various bodily functions, including immune system support, wound healing, and collagen formation). During a review of Resident 429's physician order dated 4/13/25 at 7:54 PM, the physician order indicated to take calcium 500 mg 1 tablet orally one time a day for supplement. During a concurrent interview on 4/16/25 at 10:56 a.m. with LVN 2 and record review of , Resident 429's benazepril bubble pack (a card that packages doses of medication within small, clear plastic bubbles or blisters), LVN 2 stated Resident 429's bubble pack indicated benazepril 40mg. LVN 2 stated Resident 429's physician orders and electronic medication administration record (eMAR) indicated Resident 429's order and the eMAR benazepril 20 mg. During a subsequent interview on 4/16/25 at 10:57 a.m. with LVN2 about Resident 429 who received calcium 500 mg tablet this morning, LVN 2 stated she pulled out a bottle of vitamin C 500 mg and acknowledged she gave vitamin C, instead of the calcium. LVN 2 reviewed Resident 429's physician orders and stated Resident 429 did not have an order for vitamin C. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview on 4/16/25 at 1:12 PM, with the Director of Nursing (DON) and record review of Resident 429's physician orders, the DON stated Resident 429 did not have an order for vitamin C. B. During a review of Resident 377's admission record, the admission record indicated Resident 377 was admitted to the facility on [DATE] with diagnoses included surgical aftercare following surgery on the genitourinary system (urinary and reproductive systems) and chronic lymphocytic leukemia (a type of blood cancer that affects white blood cells). During a review of Resident 377's physician order dated 4/11/25 at 10:56 PM, the order indicated morphine sulfate ER (extended release, which releases drug slowly into the body over an extended period of time) 15 mg 1 tablet by mouth every 12 hours for pain management. During a med pass observation on 4/17/25 at 9 a.m., at Resident 377's room, . LVN 1 prepared 10 medications for Resident 377. One of the 10 medications was a tablet of morphine (a potent opioid used in pain management) IR (immediate release, which releases drug into the body right away) 15 mg. During a concurrent interview on 4/17/25 at 10:20a.m.with LVN 1 and record review of Resident 377's bubble pack , LVN 1 stated Resident 377's bubble pack label read morphine IR 15 mg; however, Resident 377's physician order read morphine ER, not IR. (refer to F-755 and F-760)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28851 (refer to F-755 and 759) Based on observation, interview, and record review, the facility failed to ensure two (2) of 4 sampled residents (Residents 377 and 429) were free of significant medication errors. The facility failed to ensure: 1.Resident 377 received morphine sulfate (a potent opioid for pain management) ER (extended release, release drug slowly into the body over an extended period of time) tablet 15 milligrams (mg, unit to measure mass) as per order; instead, Resident 377 received morphine sulfate immediate release (IR, release drug into the body right away). 2.Resident 429 received benazepril (generic for Lotensin, a type of medication to treat high blood pressure) 20 mg as per ordered. Instead, Resident 429 received benazepril 40 mg. These failures led to significant medication errors that let to insufficient pain relief for Resident 377 and resulted in Resident 377 requested and received additional pain relief more frequently for breakthrough pain and had the potential to cause hypotension (a health condition when the blood pressure is too low resulting in feeling weak and increased risk for falls) for Resident 429. Findings: 1. During a med pass observation on 4/17/2025 at 9 AM, the surveyor observed the licensed vocational nurse (LVN 1) prepared and administered 1 tablet of morphine sulfate IR 15 mg to Resident 377. During a review of Resident 377's admission record, the admission record indicated Resident 377 was admitted to the facility on [DATE] with diagnoses included surgical aftercare following surgery on the genitourinary system (urinary and reproductive systems) and chronic lymphocytic leukemia (a type of blood cancer that affects white blood cells). During a review of Resident 377's medication order dated 4/11/2025 at 10:56 PM, the order indicated morphine sulfate ER 15 mg, give 1 tablet by mouth every 12 hours for pain management. Resident 377 did not have an order for morphine sulfate IR 15 mg. During a concurrent interview and record review on 4/17/2025 at 10:20 AM with LVN 1, LVN 1 reviewed Resident 377's medication bubble pack (a card that packages doses of medication within small, clear plastic bubbles or blisters) and the medication order dated 4/11/2025. LVN 1 stated the label on the morphine sulfate bubble pack read IR 15 mg, which did not match Resident 377's medication order that read morphine sulfate ER 15 mg. During a review of Resident 377's eMAR for April 2025, the eMAR indicated morphine sulfate ER 15 mg, reflecting the medication order and did not indicate the morphine sulfate IR 15 mg delivered by the pharmacy. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 377's eMAR for April 2025, the eMAR indicated Resident 377 received 16 doses of Norco (or hydrocodone-acetaminophen) 7.5-325 mg at 3 times a day since 4/12/25. During an interview on 4/17/2025 at 10:25 AM with Resident 377 in the dining room, Resident 377 stated she recently arrived to the facility after a surgery. When asked about the pain medications, Resident 377 stated she been taking morphine sulfate long acting (extended release) every 12 hours, however, it had not been relieving the pain and she had to ask for Norco a few times a day. During a review of Resident 377's morphine IR 15 mg bubble pack (a card that packages doses of medication within small, clear plastic bubbles or blisters), the pharmacy label on the bubble pack indicated the morphine IR was dispensed on 4/12/2025. During an interview on 4/17/2025 at 10:35 AM, the registered nurse supervisor (RNS 1) stated Resident 377's Norco was not in the admission order; Norco was added to the day after resident was complaining of pain and requesting extra pain medication. During a review of Resident 377's physician orders, the physician orders indicated the following Norco or hydrocodone-acetaminophen orders: a.Norco 7.5-325 mg one (1) tablet every 8 hours as needed for breakthrough pain (a sudden onset of pain that breaks through the long-acting pain medication prescribed to treat moderate to severe pain), dated 4/12/2025 at 2:14 PM, discontinued on 4/12/2025 at 7:12 PM. b.Hydrocodone-acetaminophen (Norco) 7.5-325 mg, 1 tablet one time only for breakthrough pain, dated 4/12/2025 at 7:13 PM. c.Hydrocodone-acetaminophen 7.5-325 mg 1 tablet every 6 hours as needed for breakthrough . dated 4/12/2025 at 7:13 PM. During a review of Resident 377's eMAR for April 2025, Resident 377's pain levels (from a scale 1 to 10 with 10 being the highest, most severe level) after the twice daily doses of morphine sulfate and before Norco for breakthrough pain were as followed: on 4/13/2025, Pain level 8 at 2:17 AM; pain level 8 at 12:15 PM, pain level 7 at 6:46 PM. On 4/14/2025, pain levels: 9 at 3:02 AM, 9 at 10:54 AM, and 8 at 5:44 PM On 4/15/2025, pain levels: 8 at 1:40 AM, 9 at 9:50 AM, and 8 at 6:34 PM On 4/16/2025, pain levels: 8 at 4:14 AM, 9 at 11:12 AM, and 7 at 6:12 PM On 4/17/2025, pain levels: 7 at 12:59 AM, and 10 at 11:24 AM. During an interview on 4/17/25 at 12:35 PM, the director of nursing (DON) stated ER and IR were not the same medication, in which, extended-release (ER) provides longer coverage of pain relief than immediate-release (IR). (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a medication pass observation on 4/16/2025 at 9:10 AM, LVN 2 prepared and administered a tablet of benazepril 40 mg to Resident 429. During a review of Resident 429's admission record, the admission record indicated Resident 429 was admitted to the facility on [DATE] with diagnoses included hypertension (high blood pressure) and heart failure. During a review of Resident 429's medication order dated 4/13/2025 at 7:16 PM, the order indicated benazepril 20 mg one (1) tablet orally one time a day for hypertension. During an interview on 4/16/2025 at 12:24 PM with the DON, the DON stated the pharmacy made a mistake and sent the wrong medication for Resident 429 (the pharmacy sent benazepril 40 mg tablets in place of benazepril 20 mg as indicated in the aforementioned medication order). During an interview on 4/16/2025 at 1:08 PM with the DON, the DON stated during medication administration, nurses should check for the right resident, right drug, right dose, . and to check against the eMAR. DON stated Resident 429 was a newly admitted on [DATE] and Resident 429's benazepril 40 mg tablets should have been identified as the wrong dose before administration. During an interview on 4/16/2025 at 4:50 PM with the DON, the DON stated the potential risk for receiving higher dosage of benazepril would be hypotension. During a review of the facility policy and procedures (P&P), titled Six Rights of Medication Administration (dated 2007), the P&P indicated . in order to ensure safety and accuracy of administration . Medications are checked against the order before they are given .

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 38740 Based on observation, interview and record review, the facility failed to ensure the standardized recipes and portion sizes for lunch menu was followed on 4/15/25 when: 1.cook used small scoop size to serve Barbeque (BBQ) chicken for residents who were on ground texture modified diet. Four residents on ground texture diet received 2 2/3 ounces (oz.) of chicken instead of 3 oz. per the menu. 2.15 residents on mechanical soft diet (diet for residents who experience chewing or swallowing limitations, food texture is modified by chopping or grinding), received bbq chicken cut into inconsistent sizes instead of ground bbq chicken per menu and spreadsheet (food portion and serving guide) 3.Facility failed to ensure staff followed food production recipes for the puree diet (food that is blended to a pudding consistency, no chewing required). Ten residents on pureed diet received plain pureed chicken and bbq sauce on top instead of pureed chicken with bbq sauce mixed in per the recipe. These deficient practices have the potential to result in meal dissatisfaction, decreased nutritional intake and weight loss in residents who received less food. Findings: During a record review of the facility lunch menu for regular and mechanical soft diet on 4/15/2025, the following items will be served on regular diet: BBQ chicken 3 ounces (oz.); potato salad 1/2 cup; fresh carrots 1/2 cup; bread roll, margarin, strawberry gelatin and milk beverage. Mechanical soft diet (ground): BBQ chicken Ground 3oz.; potato salad (soft/chop 1/2 inch); Fresh carrots soft 1/2 cup; wheat roll margarine; strawberry gelatin and milk. During an observation on 4/15/2025 at 11:30 AM in the kitchen residents who were on mechanical soft ground diet the cook served bbq chicken using the #12 scoop yielding 2 2/3 ounces instead of using #10 scoop yielding 3oz per menu. During an interview on 4/15/2025 at 12:30PM, with cook (cook1) and dietary supervisor (DS) cook1 stated he didn't look at the spreadsheet (food portion and serving guide), cook1 stated he used the wrong scoop and served less chicken to residents. During an interview on 4/16/2025 at 10:45 AM with DS, DS stated cook1 made a mistake and used the wrong scoop. DS stated residents on ground diet received less food than the residents on regular diet. DS stated cook1 should follow the menu and the spreadsheet. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2.During an observation on 4/15/2025, at 12:00PM of the tray line service for lunch (a system of food preparation, in which trays move along an assembly line), residents who were on mechanical soft diet the cook served BBQ chicken that was cut into pieces instead of ground per spreadsheet (food portion and menu serving guide). the mechanical soft chicken and the regular chicken were in the same serving tray. The mechanical soft chicken was cut into inconsistent sizes, varying in length. During a concurrent review on 4/15/2025, at 12:30PM of the spreadsheet and interview with cook (Cook1), cook1 stated he made a mistake and didn't review the spreadsheet. Cook1 stated the mechanical soft chicken should be ground per the recipe and not cut into pieces. During an interview on 4/15/2025 at 12:35PM with Registered Dietitian (RD1), RD1 stated the mechanical soft chicken is cooked very soft and residents can tolerate it. RD1 verified that the recipe indicates to serve ground chicken. RD1 stated cooks should follow the menu as written, RD stated there is potential for choking if served the wrong texture. During a concurrent interview on 4/16/2025 at 10:45AM with DS and RD2, DS stated the mechanical soft chicken should be grind instead of cut. DS stated if we serve big pieces, it could be potential risk for residents choking. During an interview on 4/16/2025 at 11:20AM with Speech Therapist (ST), ST stated the mechanical soft diet is for residents who have some chewing or swallowing difficulties. ST stated the food can be either chopped to 1/2 inch pieces or grind. ST stated kitchen staff should follow the recipe and the diet menu to prepare the correct texture. ST stated some residents can't tolerate chopped and the order is ground to make sure they always receive ground food. ST stated the kitchen should have a guideline of what and how to provide the food on a mechanical soft diet. 3. During the same observation on 4/15/2025 at 11:30AM of the tray line service for lunch the pureed chicken looked plain with no BBQ sauce and white in color. During a concurrent observation on 4/15/2025 at 11:30AM and interview with Cook1, cook1 stated the pureed chicken is plain chicken only pureed. Cook1 stated the bbq sauce is poured over it as gravy. During a concurrent review on 4/15/2025 at 11:30AM of the bbq chicken recipe and interview with cook1, he stated he didn't blend bbq sauce with the chicken. Cook1 stated he didn't follow the recipe to make the pureed chicken. During an interview with DS on 4/16/2025 at 11:00AM, DS stated cooks should follow the recipe, when the pureed is not prepared correctly as the recipe it can be potential for meal dissatisfaction. Pureed chicken should have bbq sauce mixed in it to have same taste as the chicken on the regular diet. During a review of the recipe for BBQ Chicken indicated for mechanical soft diets, grind chicken and serve with #10 scoop (yield 3oz) with BBQ sauce; For pureed: pureed chicken with the BBQ sauce and serve 1/2 cup. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review of facility policy titled Menu Planning (dated 2023) indicated, The menus are planned to meet nutritional needs of residents with established national guidelines, physician's orders .the menus provide a variety of foods in adequate amount each meal .Menus are written for regular and therapeutic diets in compliance with the die manual .Standardized recipes adjusted to appropriate yield shall be maintained and used in food preparation. During a record review of facility policy titled Mechanical or Dental Soft (dated 2018) indicated, The mechanically altered diet provides foods that are easily chewed. It is appropriate for individuals who have chewing problems, poor dentition, and minor swallowing problems, but can tolerate more than a pureed texture or blenderized diet. The foods are modified in texture by chopping (food size 1/4-1/2 inch pieces, dicing (food size is 1/8-1/4 inch pieces and grinding(1/8 inch or less consistency of ground meat). During a review of cook's job description (dated 12/2021) indicated, essential duties and responsibilities: Serve food in accordance with established portion control procedures, prepare food for therapeutic diets in accordance with planned menus, prepare food in accordance with standardized recipes and special diet orders.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 38740 Based on observation, interview and record review, the facility failed to ensure one of 24 sampled resident (Resident 44) food preferences were honored when strawberry Flavored Gelatin was placed on Resident 44's lunch tray, despite Strawberry being listed as a allergy and disklike on Resident 44's meal tray ticket. This failure had the potential to result in decreased meal satisfaction and consumption and negatively affect Resident 44 nutritional status. Findings: During a review of Resident 44's Nutrition-Quarterly Evaluation dated 1/31/2025 indicated resident food dislikes includes strawberries allergy. During an observation of lunch service in the kitchen on 4/15/2025 at 11:30AM, DA1 served strawberry Gelatin to resident 44. During a dining observation on 4/15/2025 at 1:00PM, Resident 44 was eating lunch in the room. Resident 44 stated today's desert is strawberry gelatin and I am allergic to strawberries but they still put the strawberry gelatin on my tray. Resident 44 stated kitchen staff know I am allergic, but they still served the strawberry gelatin. Resident 44 stated I am not going to eat it. During review of Resident 44's meal ticket on the lunch tray (lists resident diet order and food preferences) indicated allergy to strawberries During an interview with Dietary Supervisor (DS) on 4/16/2025 at 10:00AM, DS stated she is aware of resident 44s allergy to strawberry. During a concurrent review of the gelatin package and interview with DS, DS stated the ingredients in the strawberry gelatin indicates artificial flavorings. DS stated even though the ingredients are not real strawberries we should have served something different or another color and flavor of gelatin. DS stated when residents receive something they don't like they become upset. DS stated will speak to resident 44 to offer other desert choices. During a review of facility policy and procedure titled Food Preferences not dated, indicated, Policy; Resident's food preferences will be adhered to within reason .Procedure .Food preferences can be obtained from the resident, family, or staff members. Updating of food preferences will be done as resident's needs change and/or during the quarterly review.

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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** 36943 Based on observation, interview, and record review, the facility failed to ensure one of five sampled residents (Resident 40) with range of motion ([ROM] full movement potential of a joint) and mobility (ability to move) concerns had complete and accurate medical records by failing to: 1. Accurately indicate the Restorative Nursing Aide ([RNA] nursing aide program that helps residents to maintain their function and joint mobility) providing Resident 40's RNA services for active assistive range of motion ([AAROM] use of muscles surrounding the joint to perform the exercise but requires some help from a person or equipment) to both arms and legs and sit to stand transfers (ability to come to a standing position from sitting) on 7/2/2024, 7/3/2024, 7/4/2024, 7/15/2024, 7/16/2024, 7/17/2024, 7/18/2024, 7/22/2024, and 7/25/2024. 2. Accurately indicate the RNA providing Resident 40's RNA services for AAROM to both arms and legs on 4/15/2025. These failures resulted in inaccurate medical records for the provision of Resident 40's RNA services, which placed Resident 40 at increased risk for developing a decline in mobility. Cross reference F688. Findings: During a review of Resident 40's Admission Record, the Admission Record indicated Resident 40 was initially admitted on [DATE] and readmitted on [DATE] with diagnoses including muscle weakness, diabetes mellitus (disorder characterized by difficulty in blood sugar control and poor wound healing), peripheral vascular disease (a slow progressive narrowing of the blood flow to the arms and legs), and difficulty walking. During a review of Resident 40's physician order, dated 12/16/2023, the physician order indicated for the RNA to provide Resident 40 with AAROM to both arms and legs, four times a week as tolerated. During a review of Resident 40's physician order, dated 1/27/2024 and revised 4/10/2024, the physician order indicated for the RNA to provide Resident 40 with sit to stand transfers using the front wheeled walker ([FWW] an assistive device with two front wheels used for stability when walking), four times per week as tolerated. During a review of Resident 40's Restorative Nursing records (record of daily RNA sessions) from 4/10/2024 to 10/4/2024, the RNA records indicated Resident 40 received AAROM to both arms and legs, four times per week, and sit to stand with the FWW, four times per week as tolerated. During a review of Resident 40's physician order, dated 10/4/2024, the physician order discontinued Resident 40's RNA to perform sit to stand transfers with the FWW, four times per week as tolerated. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 40's Change in Condition (CIC) Evaluation, dated 10/4/2024 at 11:34 a.m., the CIC Evaluation indicated Resident 40 had a decline with RNA for sit to stand transfers. The CIC Evaluation indicated Resident 40 was unable to perform the sit to stand transfer and safely put back to bed. During a review of Resident 40's Progress Notes, a late entry Progress Note, dated 10/4/2024 at 11:35 AM (entered on 10/11/2024 at 1:03 p.m.) by the Assistant Director of Nursing (ADON), indicated Resident 40's Nurse Practitioner (NP 1) provided a new RNA order to provide Resident 40 with AAROM to both arms and legs, five days per week as tolerated. During a review of Resident 40's physician order, dated 10/4/2024, the physician order indicated for RNA to provide AAROM to both arms and legs, every day, five times per week as tolerated. During a review of Resident 40's Minimum Data Set ([MDS] a federally mandated resident assessment tool), dated 2/7/2025, the MDS indicated Resident 40 had clear speech, expressed ideas and wants, understood verbal content, and had intact cognition (clear ability to think, understand, learn, and remember). The MDS indicated Resident 40 had functional ROM limitations (limited ability to move a joint that interferes with daily functioning or places the resident at risk of injury) in one arm and both legs. The MDS indicated Resident 40 required setup or clean-up assistance for eating, substantial/maximal assistance (helper does more than half the effort) for bathing, dressing, rolling to either side in bed, and moving from lying in bed to sitting at the side of the bed, and dependent (helper does all the effort, resident does none of the effort to complete the activity, or the assistance of two or more helpers is required to complete the activity) for chair/bed-to-chair transfers. During a concurrent observation and interview on 4/15/2025 at 9:01 a.m. with Resident 40 in the bedroom, Resident 40 was lying awake in bed with the head-of-bed (HOB) elevated and had fluent speech. Resident 40 moved both arms at the shoulder, elbow, and wrist joints without any assistance. Resident 40 stated both hands used to look normal and constantly felt cold. The large knuckles of each finger on Resident 40's right-hand were observed in a bent position and unable to fully straighten. The middle joint of each finger on Resident 40s right-hand were hyperextended (joint bent inward), which caused the tip joints of each finger to slightly bend. Resident 40 bent the right-hand fingers but was unable to make a full fist. Resident 40 was observed with more active movement in the left-hand than the right-hand. Resident 40 moved the left-hand into a fist and extended the fingers. Resident 40's left-hand had minimal ROM limitations when extending the fingers, which included hyperextension of the large knuckles of the index and ring fingers, a slight bend in the middle joints of each finger, and abduction (movement away from midline) of the small finger. Resident 40 stated both hands made him feel handicapped. Resident 40 stated the RNAs performed exercises to both hips, knees, ankles, shoulders, elbows, and hands. A folded-up manual wheelchair was observed on the right side of Resident 40's bed. A FWW was also observed leaning against the wall next to Resident 40's nightstand. Resident 40 stated the facility transferred him to the wheelchair during the weekdays using a sit-to-stand mechanical lift (device used to lift a person from a sitting position to a standing position to transfer from one surface to another surface). Resident 40 stated he used to walk with the therapists from the therapy room and down the hallway using the FWW but stated the facility did not attempt to walk with him anymore for over one year. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 4/15/2025 at 9:54 a.m. with Restorative Nursing Aide 2 (RNA 2), Resident 40's RNA session was observed. Resident 40 was lying awake in bed with the HOB elevated. RNA 2 lowered the HOB to place Resident 40's bed in a flat position. RNA 2 performed ROM exercises to both legs at the hip, knee, and ankle joints. RNA 2 performed ROM exercises to Resident 40's right arm at the shoulder, elbow, wrist, and fingers. RNA 2 was unable to completely extend Resident 40's right elbow and the right fingers at the large knuckles. RNA 2 performed ROM exercises to Resident 40's left arm at the shoulder, elbow, and wrist joints. RNA 2 encouraged Resident 40 to perform active range of motion ([AROM] performance of ROM of a joint without any assistance or effort of another person) of the left hand into complete finger extension (straightening) and flexion (bending). During an interview on 4/15/2025 at 10:16 a.m. with RNA 2, RNA 2 stated she provided ROM to both of Resident 40's arms and legs. RNA 2 stated she used to perform sit to stand transfers with Resident 40 but the therapist (unspecified) changed Resident 40's RNA program to ROM since it was unsafe for Resident 40 to perform sit to stand. During a review of Resident 40's Restorative Nursing record for 4/2025, the Restorative Nursing record indicated for the RNA to provide AAROM on both arms and legs, five times per week as tolerated, with a start date of 10/5/2024. The Restorative Nursing record, dated 4/15/2025, indicated Restorative Nursing Aide 1 (RNA 1) signed for the provision of Resident 40's RNA services. During an interview on 4/16/2025 at 10:57 a.m. with Resident 40, Resident 40 stated the facility did not inform him when they stopped RNA for sit to stand transfers. Resident 40 did not recall performing sit to stand transfers with the RNAs that often. During a review of Resident 40's Restorative Nursing records for 7/2024 (RNA Record A), which the facility provided on 4/16/2025, RNA Record A indicated Resident 40 received RNA for AAROM to both arms and legs and sit to stand transfers using the FWW, four times per week. RNA Record A indicated Restorative Nursing Aide 1 (RNA 1) and RNA 2 provided Resident 40 with the RNA services. RNA Record A indicated Resident 40's RNA for AAROM to both arms and legs had a start date of 12/16/2023 and a discontinue date of 10/4/2024 (three months in the future). RNA Record A indicated Resident 40's RNA for sit to stand transfers using the FWW had a start date of 4/11/2024 and a discontinue date of 10/4/2024 (three months in the future). During a review of Resident 40's Restorative Nursing records for 7/2024 located in Resident 40's clinical record on 4/17/2025 (RNA Record B), RNA Record B indicated Resident 40 received RNA for AAROM to both arms and legs and sit to stand transfers using the FWW, four times per week. RNA Record B indicated RNA 1, RNA 2, and RNA 3 provided Resident 40 with RNA services. RNA Record B indicated Resident 40's RNA for AAROM to both arms and legs had a start date of 12/16/2023. RNA Record B indicated Resident 40's RNA for sit to stand transfers using the FWW had a start date of 4/11/2024. RNA Record B did not include a discontinue date. During a concurrent interview and record review on 4/17/2025 at 3:24 p.m. with the Administrator (ADM) and the Director of Medical Records (DMR), Resident 40's RNA Record A was reviewed. The DMR stated it did not make sense for Resident 40's RNA Record A, dated 7/2024, to have a future discontinue date of 10/4/2024. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 4/17/2025 at 3:49 p.m. with the ADM, Resident 40's RNA Record A and the facility's sign-in sheets from 7/1/2024 to 7/31/2024 were reviewed. RNA Record A indicated the initials of the RNA on Resident 40's Restorative Nursing record for the following dates: - 7/2/2024: RNA 1 - 7/3/2024: RNA 2 - 7/4/2024: RNA 2 - 7/15/2024: RNA 2 - 7/16/2024: RNA 1 - 7/17/2024: RNA 2 - 7/18/2024: RNA 2 - 7/22/2024: RNA 2 - 7/25/2025: RNA 1 The ADM reviewed the facility's sign-in sheets from 7/1/20204 to 7/31/2024 and stated the following: - 7/2/2024: RNA 1 did not sign in. - 7/3/2024: RNA 2 did not sign in. - 7/4/2024: RNA 2 did not sign in. - 7/15/2024: RNA 2 did not sign in. - 7/16/2024: RNA 1 called off. - 7/17/2024: RNA 2 did not sign in. - 7/18/2024: RNA 2 did not sign in. - 7/22/2024: RNA 2 did not sign in. - 7/25/2024: RNA 1 did not sign in. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 4/17/2025 at 4:29 p.m. with the ADM, Resident 40's RNA Record B was reviewed. The ADM stated the RNA staff providing RNA services to Resident 40 was more consistent with the facility's sign-in sheets. The ADM stated it was wrong for RNA 1 and RNA 2 to sign Resident 40's RNA services if they were not physically present at the facility. The ADM stated RNA 1 and RNA 2 may not have signed into work on the identified dates because the facility could have called them into work to assist with RNA services. During a concurrent interview and record review on 4/17/2025 at 4:44 p.m. with Payroll, RNA 1, RNA 2, and RNA 3's timecards were reviewed for 7/2024. Payroll reviewed the timecards and stated the following: - 7/2/2024: RNA 1 did not work. - 7/3/2024: RNA 2 did not work. - 7/4/2024: RNA 2 did not work. - 7/15/2024: RNA 2 did not work. - 7/16/2024: RNA 1 did not work. - 7/17/2024: RNA 2 did not work. - 7/18/2024: RNA 2 did not work. - 7/22/2024: RNA 2 did not work. - 7/25/2025: RNA 1 did not work. During a concurrent interview and record review on 4/18/2025 at 11:32 a.m. with RNA 1 and RNA 2, Resident 40's RNA Record A for 7/2024 and the Restorative Nursing record for 4/2025 were reviewed. RNA 2 stated the RNA providing the resident's RNA treatment (in general) should initial the Restorative Nursing record. RNA 1 stated either RNA could initial on the Restorative Nursing record if the resident required two-person assistance since both RNAs were involved in the treatment. RNA 1 and RNA 2 reviewed RNA Record A which included the dates RNA 1 and RNA 2 did not work in 7/2024. RNA 1 and RNA 2 stated they did not know the reason why they initialed Resident 40's RNA Record A on dates they did not work in 7/2024. RNA 1 and RNA 2 reviewed Resident 40's Restorative Nursing record for 4/15/2025. RNA 1 stated she initialed Resident 40's Restorative Nursing record for 4/15/2025 because RNA 2 had to weigh the residents. RNA 2 stated she communicated with RNA 1 regarding Resident 40's RNA session for 4/15/2025. RNA 2 stated the RNAs constantly communicated with each other and would initial RNA treatments for each other. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 4/18/2025 at 11:50 AM with the Director of Nursing (DON), Resident 40's RNA Record A for 7/2024, RNA Record B for 7/2024, and Restorative Nursing record for 4/15/2025 were reviewed. The DON stated the resident's medical record (in general) was a record of a resident's health information, including but not limited to any medications and treatment the resident received. The DON stated the resident's medical records were legal documents. The DON stated the RNA providing the treatment should be signing the provision of treatment in the medical record. The DON reviewed Resident 40's RNA Record A for 7/2024. The DON stated Resident 40's RNA Record A for 7/2024 should not have a future discontinued date of 10/2024. The DON stated RNA Record A was inaccurate if the RNAs initialed the provision of services on dates they did not work at the facility. The DON stated the RNA providing Resident 40's treatment should be signing the medical record. The DON reviewed Resident 40's Restorative Nursing documentation for 4/15/2025 and stated RNA 1 should not have initiated Resident 40's RNA Nursing documentation if RNA 2 provided the treatment. The DON stated Resident 40's Restorative Nursing documentation for 4/15/2025 was inaccurate. The DON stated the RNA 1 and RNA 2 should not be initialing any resident's RNA documentation for each other since that would be inaccurate medical records. During an interview on 4/18/2025 at 3:02 p.m. with the ADM, the ADM stated the facility did not have a policy and procedure for accurate medical record documentation.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. 46415 Based on interview and record review, the facility's Quality Assessment and Assurance Committee (QAA: committee that focuses on identifying and addressing quality deficiencies in resident care) failed to ensure effective oversight of the facility and implementation of their Quality Assurance and Performance Improvement (QAPI: systemic approach to improve the quality of care and services provided to residents) plan. This deficient practice had the potential to have reoccurring deficient practices that can impact the quality of care for the residents. Findings: During an interview on 4/18/2025 at 4:39p.m. with Administrator (ADM), ADM stated QAPIs are projects for areas of concern that require improvement, identify negative trends, and initiate a plan to improve the facility. During an interview on 4/18/2025 at 4:59p.m. with ADM, ADM stated they had recently initiated a QAPI plan for skin on 4/15/2025. ADM stated weight loss and skin correlate with one another and had a discussion regarding one resident who had a pressure injury (localized damage to the skin and underlying soft tissue) sometime in February or March. ADM stated skin did not become a main focus as they have never had any skin issues. ADM stated if the issue was identified, they would QAPI it if it is wide spread, however since it was one resident that was affected, they did not think skin was wide spread. ADM stated if there were issues with wounds, they would initiate a QAPI for in house pressure ulcers (PU) (damage to the skin and underlying tissue caused by prolonged pressure on a bony prominence). During a concurrent interview and record review on 4/18/2025 at 5:19p.m. with ADM, ADM stated on the QA & A minutes summaries/discussion section dated 3/13/2025, it indicated to work on weights and PU. ADM stated it was skin issues were triggered in March, discussed in March, and it should have been implemented in March. ADM stated if there was no QAA, there would no discussions about what is happening or the negative trend in the facility. During a review of the facility's policy and procedure (P&P) titled, Quality Assessment and Performance Improvement, revised on 9/2017, the P&P indicated the facility will establish and implement a Quality Assessment and Assurance Committee .and implement Performance Improvement Projects (PIP) through a data driven and proactive approach. The purpose of the QAPI Plan and processes is to continually assess the facility's performance in all service areas, so that systems and processes achieve the delivery of person-centered care, and which maximizes the individual's highest practicable physical, mental, and social well-being. Committee functions include: QAPI plan, identifying and prioritizing PIPs, implementing actions to correct quality issues, and monitoring to ensure the corrective action implemented is being sustained.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50144 Based on observation, interview and record review, the facility failed to: a. follow transmission-based precautions (TBP) for one of three sampled residents (Resident 64) in contact isolation for clostridium difficile (C. diff- a highly contagious bacteria that causes severe diarrhea), b. follow enhanced barrier precautions (EBP) and indwelling catheter (type of flexible tube which a clinician passes through the urethra and into the bladder to drain urine) was not touching the floor for one of three sampled residents (Resident 70), and c. report an outbreak of C.diff to the local and state health departments. This failure had the potential to prevent an outbreak from spreading and transmit infectious diseases placing all residents at an increased risk of infection. Findings: a. During a review of Resident 64's Admission record , the Admission record indicated Resident 64 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including pancytopenia (a condition in which there is a low level of all three types of blood cells: red blood cells (cells that transport oxygen from the lungs to the body's tissues), white blood cells (a blood cell that helps attack infection or injury in the body), and platelets (cell fragments that play a crucial role in blood clotting), multiple myeloma (type of blood cancer that affects plasma cells, which are white blood cells that produce antibodies to fight infections) in remission, and hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) affecting left nondominant side. During a review of Resident 64's Minimum Data Set (MDS - a resident assessment tool), dated 4/2/2025, the MDS indicated Resident 64 had moderate cognition (ability to learn, reason, remember, understand, and make decisions) impairment, required setup for eating and oral hygiene, required moderate assistance (helper does less than half the effort) for toileting and dressing, and required maximal assistance (helper does more than half the effort) for bathing. During a review of Resident 64's Physician Order Summary, the Order Summary indicated Resident 64 had an order for Transmission Based Precautions: Contact. Apply PPE per protocol. Organism: C.Diff in stool every shift, ordered on 3/30/2025 and discontinued on 4/15/2025. During a concurrent observation and interview on 4/14/2025 at 12:32 p.m., Certified Nurse Assistant (CNA) 3 observed delivering a lunch tray to Resident 64 without wearing a gown or gloves. Resident 64's family member (FM 8) was sitting next to Resident 64 without a gown or gloves. CNA 3 stated there is a sign outside Resident 64's room, but she only needs to wear a gown and gloves if she touches the resident, not when delivering a lunch tray. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 4/14/2025 at 12:25 p.m., FM 8 was observed sitting at Resident 64's bedside without a gown or gloves. FM 8 stated she visits Resident 64 about 3 times a week and had never been told to wear a gown or gloves. During a concurrent observation and interview on 4/14/2025 at 12:49 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 64 was observed to have signage and PPE cart outside the room indicting Resident 64 was on contact isolation. LVN 1 stated all staff and visitors are to wear gown and gloves when entering a TBP room, including when delivering a meal tray. LVN 1 stated nursing explains and educates the visitors to wear PPE in TBP rooms. LVN 1 stated the visitors in Resident 64's room were not wearing gowns or gloves. During an interview on 4/17/2025 at 11:36 a.m. with the Infection Preventionist Nurse (IPN), the IPN stated TBP such as contact isolation for C.diff requires the use of soap and water for hand hygiene and proper donning and doffing of gloves and a gown (Personal protective equipment - PPE) as soon as anyone enters the room. The IPN stated the use of PPE in TBP rooms applies to all staff and visitors to decrease the spread of infection to other residents. The IPN stated nursing staff educates the Resident's visitors on proper hand hygiene and PPE and should remind visitors if they are not wearing PPE in the room. b. During a review of Resident 70's Admission record, the Admission record indicated Resident 70 was admitted to the facility on [DATE] with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness or paralysis on one side of the body) following cerebral infarction (stroke - loss of blood flow to a part of the brain) affecting left dominant side and neuromuscular dysfunction of bladder (condition where the nerves controlling bladder function are damaged, leading to impaired bladder muscle coordination resulting in difficulty urinating or incontinence). During a review of Resident MDS, dated [DATE], the MDS indicated Resident 70 had moderate cognition impairment impairment, uses a walker and wheelchair, required maximal assistance for bathing, and is dependent for hygiene, toileting, and dressing. During a review of Resident 70's Physician Order Summary the Order Summary indicated Resident 70 had an order for indwelling catheter (cath) 16 French (Fr- a unit of measurement for the outer diameter of medical instruments) 10 cubic centimeters (CC- a unit of measurement) closed drainage system may change catheter as needed for dislodgement check for placement/functionality of stat lock every day shift, ordered 3/28/2025 and Enhanced Barrier Precautions related to (R/T) indwelling catheter and Gastrostomy (surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) tube (GTUBE), at risk for Multi drug resistant organisms (MDROs), ordered 3/31/2025. During a review of Resident 70's care plan titled Has indwelling catheter 16 FR/10CC in closed drainage system for diagnosis (DX) of neurogenic bladder, the care plan indicated a goal to show no signs and/or symptoms (S/SX) of urinary infection, and an intervention to secure catheter to facilitate flow of urine, prevent kinking of tubing, and accidental removal. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 70's care plan titled, Enhanced barrier precautions R/T indwelling catheter, at risk for Multi drug resistant organisms (MDROs), the care plan indicated the interventions at risk for for contracting infections due to impaired immune status monitor/document/report the physician (MD) as needed (PRN) any S/SX of infection. During a concurrent observation and interview on 4/14/2025 at 10:57 a.m. with Certified Nurse Assistant (CNA) 1, Resident 70's foley catheter bag was observed on the floor. CNA 1 stated the urinary bag is missing the hook. CNA 1 stated the urinary bag should be hanging off the side of the bed and not on the floor. CNA 1 was observed inspecting and lifting Resident 70's foley catheter bag without wearing a gown or gloves During an interview on 4/17/2025 at 11:36 a.m. with the IPN, the IPN stated the staff should implement EBP when touching a foley catheter bag to decrease the risk of infecting the resident. c. During a concurrent interview on 4/17/2025 at 11:36 a.m. with the IPN, and record review of the Infection Surveillance 2025-2025. The Infection Surveillance Data indicated the following C.diff monthly totals: January 2025 - one positive case, February 2025 - two positive cases, March 2025 - four positive cases. The IPN stated an outbreak is conserved two or more positive cases of an infectious disease. The IPN stated the outbreak was not reported to the local or state public health departments, but it should have been reported. The IPN stated it is important to report outbreaks to ensure proper guidance and resources to contain and prevent the spread of infection. During an interview on 4/18/2025 at 12:18 p.m. with the Director of Nursing (DON), the DON stated it is important for staff and visitors to wear proper PPE for TBP residents to prevent the spread of an active infection to staff, visitors, and other residents. The DON stated it is important to wear proper PPE during high contact care for EBP residents, such as handling a foley catheter bag, to prevent the spread of infection to the resident. The DON stated it is important to report outbreaks to local and state health departments to receive proper guidance and prevent the spread of infection. During a review of the facility's policy and procedure (P&P), titled IPCP Standard and Transmission-Based Precautions, revised 3/2024, the P&P indicated: 1. Contact Precautions (Transmission-Based Precautions or TBP) are used with a known infection that is spread by direct or indirect contact with the resident or resident's environment. Personal Protective equipment (PPE): wear a gown and gloves for all interactions that may involve contact with the patient or patient's environment. [NAME] PPE upon room entry, then doff and properly discard PPE and perform hand hygiene before exiting he patient room to contain pathogens. 2. Enhanced Barrier Protection (EBP) is used in conjunction with standard precautions and expand the use of PPE through the use of gown and gloves during high-contact resident care activities that provide opportunities for indirect transfer of MDRO's to staff hands and clothing then indirectly transferred to residents or from resident-to-resident. PPE: the use of gown and gloves for high-contact resident care activities is indicated, when Contact precautions do not otherwise apply, for nursing home residents with wounds and /or indwelling medical devices regardless of known MDRO infection or colonization. Examples of high-contact resident care activities requiring gown and glove use for Enhanced barrier precautions include device care or use: central vascular line (including hemodialysis catheters), indwelling urinary catheter, feeding tube, tracheostomy/ventilator. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P), titled Indwelling Urinary Catheter Care, revised 12/2023, the P&P indicated it is the policy of this facility that each resident with an indwelling catheter will receive catheter care daily and as needed (PRN) to promote hygiene, comfort, and decrease the risk of infection. During a review of the facility's policy and procedure (P&P), titled Infection Surveillance (outcome) and Reporting, revised 10/2022, the P&P indicated the IP/DNS/Designee will review the log during the morning routine to ensure all potential/actual infections/outbreaks are being identified. The P&P indicated should any resident(s) or staff be suspected or diagnosed as having a reportable communicable/infectious disease according to state-specific criteria, such information shall be promptly reported to appropriate local and/or state health department officials.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46415 Based on observation, interview, and record review, the facility failed to monitor the immunization status for the Influenza (flu: a contagious respiratory illness) and Pneumococcal (PC: bacterial infection that causes serious lung infections) vaccinations (medication to prevent a particular disease) for two of five sampled residents (Resident 12 and 49). This deficient practice resulted in Resident 12 and 49's incomplete medical records. Findings: a. During a review of Resident 12's Admission record (Face Sheet), the Face Sheet indicated Resident 12 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD: a chronic lung disease causing difficulty in breathing), atrial fibrillation (irregular and rapid heart rhythm), and hypertension (HTN: high blood pressure). During a review of Resident 12's History and Physical (H&P), dated 3/23/2025, the H&P indicated Resident 12 has the capacity to understand and make decisions. During a review of Resident 12's Minimum Data Set [MDS] a resident assessment tool), dated 3/24/2025, the MDS indicated Resident 12 's cognitive skills (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) were mildly impaired. The MDS indicated Resident 12 is dependent on putting and removing shoes, required maximal assistance in bathing, dressing lower body (waist below), toilet transfer, chair/bed-to-chair transfer, required moderate assistance in toilet hygiene, and required supervision for eating and oral hygiene. The MDS indicated Resident 12 utilizes a wheelchair and has an impairment on one side of the lower (hips/legs) extremities. During a review of the spreadsheet undated, the spreadsheet indicated Resident 12 had refused the flu vaccine and indicated not applicable (N/A) for the pneumococcal vaccines (PCV). During a review of Resident 12's consent for influenza and pneumococcal dated 3/26/2025, the consent indicated Resident 12 had already received the flu and PC vaccines. During a concurrent interview and record review on 4/17/2025 at 11:42a.m. with Infection Preventionist Nurse (IPN), IPN stated there were no records of Resident 12's flu vaccination and PCV status on the California Immunization Registry (CAIR: web-based databases that stores immunization records of children and adults). IPN stated when the flu or PC vaccination status is unknown, she will request the resident or family member to provide their vaccination records and offer the flu and PCV vaccinations upon admission. b. During a review of Resident 49's Face Sheet, the Face Sheet indicated Resident 49 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including Type II Diabetes Mellitus (DM: a disorder characterized by difficulty in blood sugar control and poor wound healing), heart failure (heart unable to pump enough blood to meet the body's needs), and HTN. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 49's MDS, dated [DATE], the MDS indicated Resident 49's cognitive skills were severely impaired. The MDS indicated Resident 49 is dependent on all aspects of activities of daily living (ADL: bathing, chair/bed-to-chair transfer, personal hygiene, toileting hygiene, oral hygiene). The MDS indicated Resident 49 does not have any impairments on both the upper (arms/shoulders) and lower extremities. During a review of the spreadsheet undated, the spreadsheet indicated Resident 49 had refused the flu vaccine and N/A for the PCV. During a review of Resident 49's consent for influenza and pneumococcal dated 1/28/2025, the consent indicated Resident 49 verbally declined the flu and PC vaccines. During a concurrent interview and record review on 4/17/2025 at 11:47a.m. with IPN, IPN stated on CAIRs, there are no history of the flu or PC vaccination statuses. IPN stated she asked Resident 49 if she wanted the flu vaccine in August 2024 and again in January 2025 unless the residents request to receive the vaccination. During an interview on 4/17/2025 at 11:54a.m. with IPN, IPN stated vaccination statuses are required to identify if a resident is due for their vaccine and prevent them from getting exposed and acquiring the infections. IPN indicated she gets her vaccination status of residents from CAIRs. IPN stated the N/A on the undated spreadsheet indicated she does not know what kind of PCV the resident has received IPN stated if the vaccination status is not available on CAIRs, she will ask the residents family member, but until there is proof of vaccination, she would not know the status of the resident's vaccination status. During an interview on 4/18/2025 at 12:09p.m. with Director of Nursing (DON), DON stated resident vaccination status is important as the residents are at risk for infections and want to ensure interventions are placed to prevent and minimize the risk of spreading or acquiring the infection. During a review of the facility's policies and Procedures (P&P), titled Immunizations - Residents, revised 7/2023, the P&P indicated receipt of vaccinations is essential to the health and well-being of long-term care residents. Establishing immunization program against influenza, pneumococcal disease, and Corona Virus Disease, ([COVID-19] a contagious infectious disease) facilitates achievement of this objective. Influenza or COVID-19 outbreaks place both the residents and staff at risk of infection. Residents will be screened at the time of admission to determine vaccine status and eligibility. Individual resident information ill be documented in the electronic health record, and decisions will be made on a case-by-case basis.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 46415 Based on interview and record review, the facility failed to provide documented evidence of facility employees' screening, education, offering (vaccination), and current Corona virus disease, ([COVID-19] a highly contagious infectious disease), vaccination (medications used to prevent diseases usually given by injection or by mouth) status. This deficient practice had the potential to place the facility staff and residents at risk for outcomes such as severe pneumonia (inflammation of lungs that cause difficulty breathing) which could lead to hospitalization due to COVID-19. Findings: During a concurrent interview and record review on 4/17/2025 at 11:34 a.m. with the Infection Prevention Nurse (IPN), the IPN stated she does not have the Covid-19 vaccination status for on-call (employees not actively performing job duties but remain under the employer) and part time employees and indicated she should have the Covid-19 vaccination statuses for the on-call and part time employees. The IPN stated she does not have the Medical Doctor (MD) or other licensed professional's Covid-19 vaccination statuses that enter the facility. The IPN stated the Covid-19 vaccination status are important to prevent the staff from getting exposed and acquiring the infection. During an interview on 4/18/2025 at 12:06 p.m., with the Director of Nursing (DON), the DON stated employees of the facility included Director of Staff Development (DSD), nurses, Certified Nursing Assistants (CNA's), MD, and Nurse Practitioners (NP's). The DON stated vaccination statuses are important for employees to prevent any breakouts. During a review of the facility's policy and procedure (P&P) titled, Immunizations - Staff, revised on 7/2023, the P&P indicated staff for purposes of this policy, staff includes individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement. This includes facility employees, students, trainees, volunteers, licensed practitioners, and onsite contractors (even those who do not provide care to residents). Documentation of previous vaccination or vaccination outside of the facility should be provided to the facility. Infection Preventionist will maintain surveillance data on influenza and COVID-19 vaccine coverage and reported rates of influenza and COVID-19 among residents and staff.

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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** 46415 Based on observation, interview, and record review the facility failed to ensure two (2) of 75 resident rooms met the requirements of 80 square feet ([sq. ft.] a unit of area measurement) per residents in multi-bed resident rooms and 100 sq. ft for each single bed resident room. This deficient practice had the potential to result in inadequate space to provide privacy, space during daily care, and access during an emergency. Findings: During a review of the facility's Client Accommodations Analysis form, provided by the facility on 4/18/2025, the facility had 2 rooms that measured less than 80 sq. ft. per resident in multi-bedrooms and two rooms that measured less than 100 sq. ft for a single bedroom. The resident rooms were as follow: -room [ROOM NUMBER] (six [6] beds) 459.55 sq. ft. -room [ROOM NUMBER] (6 beds) 469.00 sq. ft. During a concurrent observation and interview on 4/17/2025 at 2:51p.m. with Maintenance Supervisor (MS), the room size measured for 26 was 464.90 sq. ft. and room [ROOM NUMBER] was 465.90 sq. ft. MS stated he does not know how many sq. ft. each resident should be provided and indicated there are no certain sq. ft for each room. MS stated the rooms measured for 26 and 29 are adequate and indicated if there is not enough space, the residents may complain and would request to be moved to have more room space. During an interview on 4/18/2025 at 1:50p.m. with Director of Nursing (DON), DON stated the residents should have enough space to have their belongings and person items in the room and have space to provide care for the resident and indicated without enough room, care cannot be provided to the residents.