STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055372	A. Building B. Wing	05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Post Acute	3111 Santa Anita Ave El Monte, CA 91733

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42781 Based on observation, interview, and record review, the facility failed to ensure the call light was within reach for two of two sampled residents (Resident 241 and Resident 28) in accordance with the facility's policy titled Answering the Call Light. This failure had the potential to result in Resident 241 and Resident 28 not receiving care or receiving delayed services to meet the residents' needs and could result in a fall or injury. Findings: During a review of Resident 241's Admission Record (AR), the AR indicated Resident 241 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included muscle wasting (weakening, shrinking, and loss of muscle) and atrophy (decrease in size or wasting away of a body part or tissue) and abnormalities of gait (a person's manner of walking) and mobility (the ability to move). During a review of Resident 241's Care Plan dated 3/27/2025, the Care Plan indicated Resident 241 was at risk for falls related to impaired cognition and unsteady gait. The Care Plan intervention indicated for the nursing staff have Resident 241's call light within reach and to educate and remind the resident to call for assistance with all transfers. During a review of Resident 241's Fall Risk Evaluation (FRE- method of assessing a patient's likelihood of falling) dated 4/17/2025, the FRE indicated Resident 241 was assessed as high risk for falls due to moderately impaired vision, dependent on staff and incontinent (involuntary loss of bladder or bowel control), ambulatory with problems and with devices (gait unsteady), During a review of Resident 241's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 4/23/2025, the MDS indicated, Resident 241 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 241 was dependent (helper does all of the effort) on staff for eating, oral hygiene, toileting hygiene, shower, upper/lower body dressing, putting on/off footwear and personal hygiene. (continued on next page)

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

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 4/29/2025 at 9:24 a.m., with the Infection Prevention Nurse (IPN), Resident 241 was asleep, lying in bed with the call light hanging on the top of the bed board. The IPN stated Resident 241 was unable to reach the call light. The IPN stated the call light needed to be within easy reach at all times for Resident 241 to use to call for assistance from the staff. During an interview on 4/30/2025 at 3:50 a.m. with the facility's Director of Nursing (DON), the facility's DON stated, a residents' call light needed to be within reach at all times for residents to be able to use it to call for assistance from the staff to maintain residents' safety. During a review of the facility's Policy and Procedure (P&P) titled, Answering the Call Light. dated 10/2010, the P&P indicated when the resident is in bed or in a chair be sure the call light is within easy reach of the resident. 49252 b. During a review of Resident 28's Admission Record (AR), the AR indicated Resident 28 was admitted to the facility on [DATE] with diagnoses that included anemia (a condition where the body does not have enough healthy red blood cells) and muscle weakness. During a review of Resident 28's History & Physical (H&P), dated 11/11/2024, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 28's Minimum Data Set (MDS, a resident assessment tool), dated 2/25/2025, the MDS indicated Resident 28 had severely impaired cognition (ability to understand), used a wheelchair, and needed substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunks or limbs and provides more than half the effort) for toilet transferring (ability to get on and off a toilet or commode). During a review of Resident 28's Fall Risk Observation/Assessment (FRO), dated 3/21/2025, the FRO indicated Resident 28 was at a high risk for falls. During an observation on 4/29/2025 at 10:22 a.m. while in Resident 28's room, Resident 28 was in her wheelchair on the right side of her bed (when facing the wall) pointing to the bathroom, verbally requesting assistance. There was no call light visible and within Resident 28's reach. During a concurrent observation and interview on 4/29/2025 at 10:23 a.m. with Infection Preventionist Nurse (IPN) while in Resident 28's room the IPN pulled at Resident 28's call light wire and placed the call light near Resident 28, clipping it onto the pillow. The IPN stated Resident 28 knew how to use the call light, but it was not within reach. The IPN further stated, the call light needed to be within reach of residents to allow them to call for assistance, if needed. During an interview on 5/2/2025 at 10:24 a.m. with the Director of Nursing (DON), the DON stated Resident 28 was at high risk for falls. The DON further stated, call lights should always be within the resident's reach for safety, to allow the resident to request help or assistance. The DON stated, if the resident was unable to ask for assistance they could fall if they attempted to get up alone. (continued on next page)

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F 0558 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, Answering the Call Light, revised 3/2024, the P&P indicated, the purpose of the procedure is to respond to the resident's requests and needs. The P&P indicated, when the resident is in bed or in a chair be sure the call light is within easy reach of the resident.

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 40438 Based on interview and record review, the facility failed to ensure the Physician Orders for Life-Sustaining Treatment (POLST, a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end-of-life) and Advance Directive (AD, a legal document indicating resident preference on end-of-life treatment decisions) Acknowledgement Form were completed upon admission for one of one sampled resident (Resident 35) in accordance with the facility's Policy and Procedure (P&P) on AD. This failure had the potential for the facility staff to provide medical treatment and services against the will of Resident 35. Findings: During a review of Resident 35's Admission Record (AR), the AR indicated Resident 35 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control), end stage renal disease (ESRD, irreversible kidney failure) and hypertension (HTN, high blood pressure). During a review of Resident 35's Minimum Data Set (MDS, a resident assessment tool) dated 4/15/2025, the MDS indicated Resident 35 had moderately impaired cognition (ability to understand and process information). The MDS indicated Resident 35 required substantial/maximal assistance (helper did more than half the effort) with eating and oral hygiene, and dependent (helper did all the effort, resident did none of the effort to complete the activity) with toileting, showering and upper and lower body dressing. During a concurrent interview and record review on 4/29/2025 at 10:41 am with the Assistant Director of Nursing (ADON), Resident 35's medical record (chart) was reviewed. The ADON stated Resident 35's POLST and AD Acknowledgement Form were not completed on re admission. The ADON stated the POLST and AD Acknowledgement Form should be completed and updated for all residents with every admission and re admission to ensure staff provide care and services according to the wishes of Resident 35. During a concurrent interview and record review on 4/30/2025 at 4:38 pm with the Director of Nursing (DON), Resident 35's PointClickCare (PCC, a cloud-based software) was reviewed. The DON stated Resident 35 needed a new and updated POLST and AD Acknowledgment Form with every admission to ensure Resident 35 wanted the same care, had the same wishes and care preferences from the previous admission. During a review of the facility's P&P titled, Advance Directives, revised February 2024, the P&P indicated, Prior to or upon admission of a resident, the social services director or designee inquires of the resident, his or her family members and/or his or her legal representative, about the existence of any written advance directives. The interdisciplinary team will review annually with the resident his or her advance directives to ensure that such directives are still the wishes of the resident. Such reviews will be made during the annual assessment process and recorded in the medical record.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36924 Based on interview and record review, the facility failed to accurately encode the hearing capability and the discharge status on the Minimum Data Set (MDS- a resident assessment and care screening tool), for two of two sampled residents (Residents 51 and 88). a. Resident 51's hearing need was not addressed resulting in a delay in evaluation for hearing aids. b. Resident 88 discharge status was incorrectly coded as discharged to a General Acute Care Hospital on 2/15/25. Resident 88 was discharged to Skilled Nursing Facility (SNF). These failures resulted in inaccurate assessment and had the potential to negatively affect the residents' quality of life. Findings: a. During a review of Resident 51's Admission Record (AR), the AR indicated the facility readmitted the resident on 3/21/25 with diagnoses that included encephalopathy (neurologic disorder), acute pulmonary edema (too much fluid in the lungs), and chronic kidney disease (kidney failure). During a review of Resident 51's MDS dated [DATE], the MDS indicated Resident 51 had severely impaired cognition (ability to understand) and required substantial/maximal assistance with sitting to stand and upper & lower body dressing, personal and toileting hygiene. During an interview on 4/29/25 at 9:49 a.m., Resident 51 was observed putting his hand up and Resident 51 stated he could not hear when interview was attempted. During an interview on 4/29/25 at 9:55 a.m., with Certified Nurse Assistant 3 (CNA 3), CNA 3 stated CNA 3 had to talk loud to Resident 51. CNA 3 stated Resident 51 cannot hear and had no hearing aid. During an interview on 5/2/25 at 9:48 a.m., with CNA 7, CNA 7 stated Resident 51 had difficulty hearing CNA 7 when CNA 7 speaks because of Resident 51's facial expression. CNA 7 stated Resident 51 would lean over to hear. CNA 7 stated CNA 7 had to be in front of Resident 51 and CNA 7 had to speak slowly. CNA 7 stated CNA 7 did not see a hearing aid for Resident 51. CNA 7 stated Resident 51 had a hard time hearing and Resident 51 could benefit from a hearing aide. During a subsequent interview on 5/2/25 at 12:58 p.m. with Resident 51, Resident 51 stated Resident 51 was hard of hearing and Resident 51 would read lips. Resident 51 stated Resident 51 had no hearing aid and Resident 51 would like to have a hearing aid. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and concurrent record review on 5/2/25 at 1:04 p.m., with Minimum Data Set Coordinator 1 (MDSC 1), MDSC 1 stated, when completing a resident's MDS, MDSC 1 would see the resident and ask questions. MDSC 1 stated MDSC 1 would ask the resident if the resident could hear well and if the resident would say yes then there was no difficulty in the resident's hearing. MDSC 1 stated MDSC 1 asked Resident 51 if Resident 51 was able to hear MDSC 1 adequately using a normal tone of voice. MDSC 1 stated Resident 51 did not complain of being hard of hearing at that time of the assessment. During an interview on 5/2/25 at 3:35 p.m., with the Assistant Director of Nursing (ADON), the ADON stated the MDS should match Resident 51's current condition. The ADON stated it was important for the MDS to match the resident's condition as a basis for care and services the resident needed. During a review of the facility's Policy & Procedure (P&P), titled, Certifying Accuracy of the Resident Assessment, dated May 2024, the P&P indicated all residents of the facility receive appropriate, high-quality care and services in accordance with state regulations, federal laws, and evidence-based best practices, promoting dignity, safety, and quality of life. 42781 b. During a review of Resident 88's Admission Record (AR), the admission record indicated Resident 88 was admitted to the facility on [DATE] with diagnoses that included dysphagia (difficulty swallowing) and essential hypertension (high blood pressure). During a review of Resident 88's Progress Notes, dated 2/14/2025, at 1:02 p.m. the notes indicated that Resident 88 was accepted for facility transfer to a SNF for continued long term care. During a review of Resident 88's Order Summary Report, dated 2/15/2025, the report indicated Discharge Resident 88 to SNF for continued long term care per family request on Saturday, 2/15/2025. During a review of Resident 88's Discharge Summary, dated 2/15/2025, at 9 a.m., the notes indicated that Resident 88 was transferred to a SNF for continued long term care. During a review of Resident 88's Progress Notes, dated 2/15/2025, at 9:28 a.m., the notes indicated that Resident 88 was taken by the driver to a SNF. During a review of Resident 88's MDS, dated [DATE], the MDS indicated Resident 88 was discharged to a short-term general hospital. During a concurrent interview and record review of Resident 88's MDS Nurse 1 (MDS N 1) on 5/1/2025 at 10:56 am, MDSN 1 stated Resident 88 was coded as discharged to a short-term general hospital. MDSN 1 stated Resident 88 was discharged to a SNF on 2/15/2025 and not to a general hospital. MDSN 1 stated, Resident 88's MDS assessment needed to be coded discharged to SNF. MDSN 1 stated Resident 88's MDS assessment needed to be coded accurately to provide accurate information to the Centers for Medicare and Medicaid services. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled, Resident Assessments, dated 10/2024, the P&P indicated, a comprehensive assessment of each resident is completed at intervals designated by Omnibus Budget Reconciliation Act (OBRA) regulations and Prospective Payment System (PPS) requirements. The P&P indicated, OBRA required assessments are federally mandated and must be performed for all residents of Medicare and/or Medicaid certified nursing homes including discharge assessment (return anticipated and return not anticipated). The P&P indicate the resident assessment coordinator is responsible for ensuring the interdisciplinary team conducts timely and appropriate resident assessments.

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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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40438 Based on observation, interview, and record review, the facility failed to provide the resident with a communication device with the language that the resident understood for one of one sampled resident (Resident 70). This failure had the potential to affect Resident 70's communication with staff and delay the provision of care, treatment, and services the resident needed. Findings: During a review of Resident 70's Admission Record (AR), the AR indicated Resident 70 was admitted to the facility on [DATE] with diagnoses that included hypertension (HTN, high blood pressure), atrial fibrillation (an irregular, often rapid heart rate that causes poor blood flow) and malignant neoplasm (cancerous tumor) of the lung. During a review of Resident 70's Minimum Data Set (MDS, a resident assessment tool) dated 3/14/2025, the MDS indicated Resident 70 speaks Cantonese and needed or wanted an interpreter to communicate with a doctor or health care staff. During a concurrent observation inside Resident 70's room and interview on 4/29/2025 at 9:28 am with Certified Nurse Assistant 4 (CNA 4), Resident 70 was in bed. CNA 4 stated, Resident 70 spoke only Chinese language. CNA 4 stated Resident 70 did not have a communication board or any communication device at bedside. CNA 4 stated Resident 70 was alert and should have a communication board at bedside for Resident 70 to use to communicate Resident 70's needs to the staff. During an interview on 4/30/2025 at 3:50 pm with the Director of Nursing (DON), the DON stated, all alert, non-English speaking residents should be provided with communication board at bedside with the language the resident understood so that the resident could communicate their needs, and staff could provide the care and services the resident needs. During a review of the facility's Policy and Procedure (P&P) titled, Communication Language Barrier, revised 3/2024, the P&P indicated, To assist and provide appropriate communication for residents who have barriers to communicate. Residents with visual, hearing, or language barriers will be provided an equal opportunity to participate in and to benefit from these services. Utilize visual aide (i.e. communication board, white board, tablets) and/or gestures for basic care needs.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 36924 Based on observation, interview, and record review the facility failed to assess the resident's skin condition and report the skin condition to the physician for one of one sampled resident (Resident 49). This failure resulted in the resident experiencing unrelieved itchiness in her vaginal and buttock areas. Findings: During a review of Resident 49's Admission Record (AR), the AR indicated the facility admitted the resident on 6/7/23 with diagnoses that included Type 2 diabetes mellitus (elevated blood sugar level), neuralgia and neuritis (damaged, irritated and inflamed nerves), and obesity (disorder involving too much body fat). During a review of Resident 49's Minimum Data Set (MDS, a resident assessment tool) dated 3/4/25, the MDS indicated Resident 49 had moderately impaired cognition (ability to understand and process thoughts) and required substantial/maximal assistance with rolling left and right, sit to stand, and dependent for toileting hygiene. During a record review of Resident 49's recapitulated Physician's Orders (PO) for 4/1/25 - 5/2/25, the PO indicated gynecological (GYN-medicine dealing with function and diseases specific to women) consult for chronic vaginal yeast infection (fungal infection causing irritation to the vaginal area). During a review of Resident 49's untitled Care Plan (CP) initiated on 2/16/25, the CP indicated to monitor and record any complaints of pain/itching/discomfort (location, duration, quantity, quality, alleviating factors, aggravating factors) and observe for new redness or increase itching and report to physician if noted. During a review of Resident 49's untitled CP initiated on 3/5/25, the CP indicated to evaluate effectiveness of medication, monitor for side effects of antibiotic therapy (i.e., symptoms of secondary infection), and notify physician if observed. During a review of Resident 49's untitled CP initiated on 3/6/25, the CP indicated Resident 49 may have a gynecological consultation. During a review of Resident 49's Change of Condition (COC) forms, the COC indicated on 2/16/25, Resident 49 had redness and complained of itchiness around the vaginal area. The COC dated 3/5/25 indicated Resident 49 had redness with complaints of itchiness around the vaginal area. The COC dated 12/9/24 indicated Resident 49 verbalized vaginal discomfort. The COC dated 12/5/24 indicated Resident 49 complained of vaginal itchiness. Resident 49 was not scheduled for a GYN consultation as indicated in the PO. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 5/1/25 at 9:47 a.m., with Resident 49, Resident 49 stated Resident 49 had itching on the outside vaginal area. Resident 49 was observed putting Resident 49's hands into the inside of Resident 49's adult brief. During an interview on 5/1/25 at 10:15 a.m. with Resident 49, Resident 49 stated Resident 49 had vaginal itching on the outside of her vagina and towards her buttocks. During a concurrent observation and interview on 5/2/25 at 8:45 a.m., Resident 49 stated Resident 49 experienced itching on both sides of her buttocks, vaginal creases, and down the middle of the vagina area. Resident 49 stated Resident 49 told the licensed nurses about her itching. Resident 49 stated the medication cream works for about 20 minutes and then the itching returns. Resident 49 stated that sometimes Resident 49 would change Resident 49's own adult brief and clean Resident 49's perineal area with water or the itching got worse. Resident 49 was observed with facial grimacing. Resident 49 stated the itching made her feel anxious and sometimes the itching would affect her sleep at night. Resident 49's buttocks were observed with redness and the skin was flaky (tendency to break into small, thin pieces). During an interview on 5/2/25 at 9:55 a.m. with Certified Nurse Assistant 7 (CNA 7), CNA 7 stated CNA 7 cared for Resident 49 in the past. CNA 7 stated Resident 49 complained of itching and told CNA 7 that Resident 49 had itching in Resident 49's vaginal area and buttocks. CNA 7 stated, yesterday (5/1/25), Resident 49 complained of itching in Resident 49's vaginal creases. CNA 7 stated CNA 7 reported to the Charge Nurse and the Charge Nurse stated Resident 49 was already being treated. During an interview on 5/2/25 at 10:58 a.m., with the Treatment Nurse (TN), the TN stated nothing was reported to TN this week. TN stated satellite pustules were observed on Resident 49's buttocks and the inside of Resident 49's vaginal area was red and inflamed. The TN stated if a new skin condition was reported to the TN, the TN would do a skin assessment on the resident. During a concurrent interview and record review on 5/2/25, at 11:22 a.m., with the Director of Nursing (DON), the DON stated Resident 49 was treated for yeast infection in November 2024 and Resident 49 complained of (c/o) vaginal itchiness with no new orders (NNO). On 12/23/24, Resident 49 had redness with complaints of itchiness around vaginal area and was given Flucanozole 200 milligrams (mg). Resident 49 c/o redness with complaints of itchiness around vaginal area on 2/16/25 with NNO. The DON stated on 3/5/25 Resident 49 had redness with complaints of vaginal itching and was given Flagyl 500 mg, by mouth (PO), every day (QD) for seven days. During an interview on 5/2/25 at 3:08 p.m., with Licensed Vocational Nurse 6 (LVN 6), LVN 6 stated if a CNA would see something different on the resident's skin, the CNA would report to the Charge Nurse or a Supervisor. LVN 6 stated LVN 6 relied on the CNAs to report any abnormalities on the residents. LVN 6 stated, LVN 6 would assess an issue if the issue was endorsed to LVN 6 during shift change. LVN 6 stated there was no report of buttock irritation on Resident 49 before 5/2/25. LVN 6 stated it was important for the CNAs to report resident changes to the Charge Nurse immediately to resolve the problem. During a review of the facility's undated Policy and Procedure (P&P) titled, Care and Services Policy the P&P indicated all residents of the facility receive appropriate, high-quality care and services in accordance with state regulations, federal laws, and evidence-based best practices, promoting dignity, safety, and quality of life.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36924 Based on interview and record review, the facility failed to provide care and services to meet the resident's need for one of one sampled resident (Resident 51) by failing to ensure Resident 51 who had difficulty hearing was scheduled for an audiology consult and/or hearing aids. This failure resulted in the resident's inability to hear adequately, requiring the resident to be spoken to loudly, and for the resident to lip read during conversation. Findings: During a review of Resident 51's Admission Record (AR), the AR indicated the facility readmitted the resident on 3/21/25 with diagnoses that included encephalopathy (neurologic disorder), acute pulmonary edema (too much fluid in the lungs), and chronic kidney disease (kidney failure). During a review of Resident 51's MDS dated [DATE], the MDS indicated Resident 51 had severely impaired cognition (ability to understand) and required substantial/maximal assistance with sitting to stand and upper & lower body dressing, personal and toileting hygiene. During an interview on 4/29/25 at 9:49 a.m., Resident 51 was observed putting his hand up and Resident 51 stated he could not hear when interview was attempted. During an interview on 4/29/25 at 9:55 a.m., with Certified Nurse Assistant 3 (CNA 3), CNA 3 stated CNA 3 had to talk loud to Resident 51. CNA 3 stated Resident 51 cannot hear and had no hearing aid. During a review of Resident 51's Belongings Inventory dated 3/14/25, the Belongings Inventory did not indicate Resident 51 had a hearing aid. During an interview on 5/2/25 at 9:48 a.m., with CNA 7, CNA 7 stated Resident 51 had difficulty hearing CNA 7 when CNA 7 speaks because of Resident 51's facial expression. CNA 7 stated Resident 51 would lean over to hear. CNA 7 stated CNA 7 had to be in front of Resident 51 and CNA 7 had to speak slowly. CNA 7 stated CNA 7 did not see a hearing aid for Resident 51. CNA 7 stated Resident 51 had a hard time hearing and Resident 51 could benefit from a hearing aide. During a subsequent interview on 5/2/25 at 12:58 p.m. with Resident 51, Resident 51 stated Resident 51 was hard of hearing and Resident 51 would read lips. Resident 51 stated Resident 51 had no hearing aid and Resident 51 would like to have a hearing aid. During a review of the facility's Policy & Procedure (P&P) titled, Assistive Devices and Equipment, revised January 2020, the P&P indicated: The facility provides the resident with assistance in locating available resources to obtain assistive devices that are not provided by the facility, including (but not limited to): a. Glasses, contact lenses, or magnifying devices; and (continued on next page)

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	055372	A. Building B. Wing	05/02/2025

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Hearing aids, amplifiers, etc. Recommendations for the use of devices and equipment are based on comprehensive assessment and documented in the resident care plan. During a review of the facility's P&P titled, Social Services, dated 2001, the P&P indicated the facility provides medically-related social services to assure that each resident can attain or maintain his/her highest practicable physical, mental, or psychosocial well-being.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 36924 Based on observation, interview, and record review the facility failed to ensure the resident was repositioned every two hours to prevent further skin breakdown (prolonged pressure on the skin causing tissue damage and potentially open sores) for one of one sampled resident (Resident 44). This failure placed the resident at risk of further deterioration of a sacro-coccyx (lowest sections of the spine) Stage 4 pressure ulcer (ulcers that extend deep into the tissue reaching the bones). Findings: During a review of Resident 44's Admission Record (AR), the AR indicated the facility readmitted the resident on 12/6/23 with diagnoses that included encephalopathy (neurologic disorder), hepatomegaly (enlarged liver), and chronic obstructive pulmonary disease (COPD- lung diseases that block the airflow). During a review of Resident 44's Minimum Data Set (MDS, a resident assessment tool) dated 3/28/25, the MDS indicated Resident 44 had severely impaired cognition (ability to understand and process thoughts) and required substantial/maximal assistance with rolling left and right. During a record review of Resident 44's Physician Order Recapulation Order (PO) for 4/1/25 - 5/2/25, the PO indicated for licensed staff to clean Resident 44's Sacro coccyx Stage 4 pressure ulcer with normal saline, pat dry, apply collagen then cover with Hydrofera blue (a foam wound antibacterial dressing), cover with foam dressing as needed for 30 days, soiled or dislodged and every day shift for 30 days until finished. During a review of Resident 44's Impaired Skin Integrity Care Plan (CP) dated 3/3/25, the CP indicated to encourage and assist to re-position the resident. During a review of Resident 44's Impaired Physical Mobility CP dated 3/29/22, the CP indicated if resident was unable to reposition self, staff needed to assist in repositioning every two hours and as needed. During a concurrent observation and interview on 5/1/25, at 9:49 a.m., Resident 44 was observed positioned lying in supine (lying flat on back) position and Resident 44 stated Resident 44 needed assistance turning in bed. Resident 44 should have been positioned on the left side at this time, according to the facility's turning schedule. During an interview on 5/1/25 at 10:02 a.m. with the Treatment Nurse (TN), the TN stated Resident 44 had a Stage 4 pressure ulcer. The TN stated interventions for a Stage 4 pressure ulcer included low air loss mattress (LAL- tiny laser made air holes in the mattress top surface continually blow out air causing the patient to float) and turning and repositioning the resident every 2 hrs. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/1/25 at 2:37 p.m. with Certified Nurse Assistant 11 (CNA 11), CNA 11 stated every two hours Resident 44's position needed to be changed and CNA 11's badge displayed the position the resident should be in, based on turning schedule. CNA 11 stated changing position was important to avoid pressure injuries or injuries to the skin. During a concurrent observation and interview on 5/1/25 at 2:51 p.m. with Licensed Vocational Nurse 1 (LVN 1) and CNA 11, CNA 11 stated Resident 44 was lying in a supine position. According to the turning schedule on CNA 11's badge, Resident 44 should have been positioned on Resident 44's right side at 2:00 p.m. During an interview on 5/1/25 at 4:00 p.m., with the Assistant Director of Nursing (ADON), the ADON stated repositioning every two hours was important because repositioning would promote wound healing by alleviating pressure on the pressure ulcer by redistributing the resident's weight from just one area. During an interview on 5/2/25 at 11:09 a.m. with the Director of Nursing (DON), the DON stated Stage 4 pressure ulcer interventions included wound treatment, weekly wound consultation, LAL mattress and turning and repositioning the residents at least every two hours. The DON stated the practice and protocol of the facility was to turn the resident every two hours and it was discussed with the staff to turn the resident every two hours. During a review of the facility's undated Policy and Procedure (P&P), titled, Care and Services Policy, the P&P indicated all residents of the facility receive appropriate, high-quality care and services in accordance with state regulations, federal laws, and evidence-based best practices, promoting dignity, safety, and quality of life.

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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** 40438 Based on interview and record review, the facility failed to ensure the resident had an environment free from accident hazards (risks) for one of four sampled residents (Resident 7) by failing to: 1. Ensure Resident 7 was provided with adequate supervision during the performance of activity of daily living (ADL, activities such as bathing, dressing, and toileting a person performs daily). 2. Ensure licensed staff developed an individualized person-centered care plan for Resident 7 who was assessed as high-risk for falls. These failures placed Resident 7 at risk of recurrent falls and injury. Findings: During a review of Resident 7's Admission Record (AR), the AR indicated Resident 7 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), hemiparesis (weakness on one side of the body, often affecting the arm, leg, and the face), and Alzheimer's disease (a disease characterized by a progressive decline in mental abilities). During a review of Resident 7's Minimum Data Set (MDS, a resident assessment tool) dated 3/1/2025, the MDS indicated Resident 7 had severely impaired cognition (ability to understand and process information). The MDS indicated Resident 7 was dependent (helper did all the effort, resident did none of the effort to complete the activity, the assistance of 2 or more helpers are required for the resident to complete the activity) with eating, oral hygiene, toileting, showering, upper/lower body dressing and personal hygiene. The MDS indicated Resident 7 was dependent on rolling left and right. During a review of Resident 7's Fall Risk Observation/Assessment (FROA) dated 3/1/2025, the FROA indicated Resident 7 was assessed as high risk for fall. During a review of Resident 7's Change in Condition Evaluation (CCE) dated 3/19/2025, timed at 5:20 am, the CCE indicated Resident 7 had an incident of fall. During a review of Resident 7's Progress Notes (PN) dated 3/19/2025, timed at 5:20 am, the PN indicated Resident 7 rolled into the floor when an unidentified Certified Nurse Assistant (CNA) moved Resident 7 to her side during changing. The PN indicated Resident 7 did not sustain an injury. During an interview on 5/1/2025 at 3:21 pm with Certified Nursing Assistant 12 (CNA 12), CNA 12 stated Resident 7 needed 2-person assistance for all ADLs and bed mobility such as turning, repositioning, changing, and cleaning. During an interview on 5/1/2025 at 3:32 pm with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated Resident 7 should be cleaned and changed with 2-person assistance for the safety of the resident and to prevent fall. (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 interview and record review on 5/1/2025 at 3:38 pm with the Assistant Director of Nursing (ADON), Resident 7's CCE dated 3/19/2025, PNs dated 3/19/2025 and care plans were reviewed. The ADON stated Resident 7 had a fall on 3/19/2025 at 5:20 am. The ADON stated an unidentified CNA changed Resident 7, turned the resident to her side and the resident rolled to the floor. The ADON stated based on the documentation, Resident 7 was turned by only one CNA. The ADON stated Resident 7 was assessed as dependent on toileting and personal hygiene. The ADON stated changing Resident 7 should be performed by two CNAs to hold the weight of Resident 7 on the other side of the bed to prevent a fall. The ADON stated Resident 7 was assessed as high risk for fall. The ADON stated Resident 7 did not have a care plan for fall developed and initiated before the incident of the fall on 3/19/2025. The ADON stated a care plan should have been developed to address the resident's risk for fall and for the resident to receive necessary care and services to prevent fall and injury. During a review of the facility's Policy and Procedure (P&P) titled, Activities of Daily Living (ADL,), Supporting, revised 3/2024, the P&P indicated Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. During a review of the facility's P&P titled, Care Plans, Comprehensive Person-Centered, revised2/2024, the P&P, The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual, Significant Change in Status), and no more than 21 days after admission. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40438 Based on observation, interview, and record review, the facility failed to provide necessary care and services for a resident with Foley Catheter (FC, a medical device that helps drain urine from the bladder) in accordance with the facility's Policy and Procedure (P&P) on catheter care for one of two sampled residents (Resident 69). This failure had the potential to result in catheter-related complications for Resident 69. Findings: During a review of Resident 69's Admission Record (AR), the AR indicated Resident 69 was admitted to the facility on [DATE] with diagnoses that included diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), hypertension (HTN, high blood pressure), and anxiety (intense, excessive , and persistent worry and fear about everyday situations). During a review of Resident 69's Minimum Data Set (MDS, a resident assessment tool) dated 3/28/2025, the MDS indicated Resident 69 had severely impaired cognition (ability to understand and process information). The MDS indicated Resident 69 required partial/moderate assistance (helper did less than half the effort) with oral hygiene, upper and lower body dressing, and substantial/maximal assistance (helper did more than half the effort) with toileting, shower and personal hygiene. The MDS indicated Resident 69 had an indwelling catheter (a flexible tube inserted into the bladder to drain urine). During a review of Resident 69's untitled Care Plan (CP) dated 3/19/2025, the CP indicated Resident 69 had an indwelling FC for obstructive uropathy (a urinary tract disorder that occurs when urine flow was obstructed). The CP goal indicated for Resident 69 to remain free from catheter-related trauma. During a concurrent observation inside Resident 69's room and interview on 4/29/2025 at 10:37 am with Licensed Vocational Nurse 4 (LVN 4), Resident 69 was sitting in the wheelchair with FC tubing inside Resident 69's night pants and the FC bag was hanging at the back of the wheelchair. LVN 4 stated Resident 69's FC tubing was not secured on the thigh, and the securement device was broken. LVN 4 stated the FC tubing should be secured to prevent pinching and pulling during movement and cause trauma to Resident 69. During an interview on 4/30/2025 at 3:50 pm with the Director of Nursing (DON), the DON stated Resident 69's FC tubing should be anchored and secured on the thigh to hold the catheter in place and to prevent pulling and getting dislodged during movements. During a review of the facility's P&P titled, Catheter Care, Urinary, revised 10/2024, the P&P indicated, Ensure that the catheter remains secured with a securement device to reduce friction and movement at the insertion site.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42781 Based on observation, interview and record review, the facility failed to implement its policy and procedure on Nutritional Management and Care Plans, Comprehensive Person - Centered for two of two sampled residents (Resident 84 and Resident 15) by failing to: a. Ensure Resident 84's fluid intake was accurately monitored as ordered by the primary doctor and an individualized/person-centered care plan was developed and implemented. b. Ensure Resident 15 had weekly weights recorded after a 15-pound (lb.) weight gain. These failures had the potential to result in complications related to electrolyte imbalance for Residents 84 and 15. Findings: a. During a review of Resident 84's Admission Record (AR), the AR indicated Resident 84 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included muscle wasting (weakening, shrinking, and loss of muscle) and atrophy (decrease in size or wasting away of a body part or tissue) and abnormalities of gait (a person's manner of walking) and mobility (the ability to move) and hypo-osmolality and hyponatremia (a condition where the sodium [an electrolyte that helps regulate the amount of water] level in the blood is abnormally low). During a review of Resident 84's Sodium (Na) Level result, dated 4/9/2025, Resident 84's Na level was 122 milliequivalents per liter (mEq/L, unit of measurement). Normal Na range was 136-145 mEq/L. During a review of Resident 84's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 4/19/2025, the MDS indicated, Resident 84 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 84 was dependent (helper does all of the effort) on staff for toileting hygiene, shower, upper/lower body dressing and putting on/off footwear. During a review of Resident 84's Order Summary Report (OSR), dated 4/21/2025, the OSR indicated Resident 84 had an order for fluid restriction (FR, limits the amount of fluids a person consumes each day) of 1,200 cubic centimeters/24 hours (cc/24 hr., measure of volume per day) allotted for dietary of 240 cc for breakfast, 120 cc for lunch, 120 cc for dinner, 120 cc for bedtime, and for nursing of 300 cc for 7 a.m. to 3 p. m. shift, 200 cc for 3 p.m. to 11 p.m. shift and 100 cc for 11 p.m. to 7 a.m. shift. During an observation on 4/29/2025 at 9:18 a.m. while inside Resident 84's room, Resident 84 was awake lying in bed, with a water pitcher at the bedside. During an observation on 4/29/2025 at 12:14 p.m. while inside Resident 84's room, Resident 84 was sitting in bed, with a water pitcher at the bedside. Resident 84 requested cranberry juice from Licensed Vocational Nurse 1 (LVN 1). (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 4/29/2025 at 12:27 p.m. while inside Resident 84's room, Resident 84 consumed a cup of cranberry juice. During an observation on 4/29/2025 at 12:35 p.m. while inside Resident 84's room, Resident 84 requested a cup of juice from Certified Nurse Assistant 9 (CNA 9). CNA 9 stated, she will get back to Resident 84 and get him a cup of juice. During an interview on 5/2/2025 at 10:25 am with CNA 2, the CNA 2 stated Resident 84 was on fluid restriction. CNA 2 stated, she did not document the fluid intake of the resident. The CNA 2 stated there was no clinical documentation that Resident 884's fluid intake was documented or monitored. During an interview on 5/2/2025 at 10:31 a.m. with LVN 9, LVN 9 stated, Resident 84 was placed on fluid restriction of 1,200 cc/day as ordered by the primary doctor. LVN 9 stated there was no documentation or monitoring of Resident 84's fluid intake. LVN 9 stated, Resident 84 needed to be placed on monitoring for fluid intake every meal and when taking medications every shift. LVN 9 stated that Resident 84's Na (Sodium) level was low, and fluid intake needed not to be more than 1,200 cc in a day. During a concurrent interview and record review of Resident 84's medical record (PointClickCare - PCC, a cloud-based software used in long-term and post-acute care facilities) on 5/2/2025 at 11:57 a.m. with the facility's Director of Nursing (DON), the DON stated, Resident 84 was placed on a fluid restriction of 1,200 cc/day. The facility DON stated Resident 84's fluid intake needed to be documented in the Medication Administration Record (MAR) at the end of the shift from medication fluid intake and from the meal tray. The DON stated there was no other clinical documentation that Resident 84's fluid intake was monitored. The DON stated, if fluid intake was not monitored it could cause an electrolyte imbalance. The facility DON stated there was no care plan initiated for Resident 84 who has fluid restriction. The DON stated the care plan needed to be developed and implemented to provide proper treatment and intervention which was specific and individualized to meet the resident's goal. During a review of the facility's undated policy and procedure (P&P) titled, Fluid Restriction, the P&P indicated, the fluid restrictions will be followed per physician's order and monitored by nursing staff for resident compliance. The P&P indicated Fluid Restriction should be documented on the Electronic Medication Administration Record and integrated in the resident's care plan. The P&P indicated, if a resident's fluid was restricted, water pitchers should not be available at the bedside unless evaluated as appropriate. During a review of the facility's undated policy and procedure (P&P) titled, Nutritional Management, the P&P indicated, to ensure timely response to residents' nutritional needs, it was recommended that the nutritional recommendations be implemented and documented within no more than 72 -hours from the time they are issued. During a review of the facility's undated policy and procedure (P&P) titled, Care Plans, Comprehensive Person - Centered, the P&P indicated, the comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (admission, Annual or Significant Change in Status), and no more than 21 days after admission. 49252 (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. During a review of Resident 15's Admission Record (AR), the AR indicated Resident 15 was readmitted to the facility on [DATE] with diagnoses that included ESRD (End Stage Renal Disease-irreversible kidney failure) and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 15's History & Physical (H&P), dated 3/30/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 15's Minimum Data Set (MDS, a resident assessment tool), dated 4/5/2025, the MDS indicated Resident 15 had intact cognition (ability to understand). During an interview on 4/29/2025 at 11:10 am, while in Resident 15's room, Resident 15 stated she had gained 15 lbs. During a review of Resident 15's Nutritional Risk Review (NRR), dated 4/11/2025, the NRR indicated Resident 15 had a 15.46 lb. weight gain and the Registered Dietitian recommendations included to add weekly weights for four weeks. During a review of Resident 15's April 2025 Weights Summary, dated 4/1/2025 to 4/30/2025, the summary indicated no weight measurements were recorded for Resident 15 between 4/12/2025 to 4/23/2025. During a review of Resident 15's Progress notes, dated 4/14/2025 at 5:54 pm, the Progress note indicated Resident 15's physician was made aware of the RD recommendations which were approved to be carried out by the facility. During an interview on 5/1/2025 at 12:10 pm with the Registered Dietitian (RD), the RD stated the facility needs to carry out the RD recommendations within 72 hours if the physician approved. The RD further stated, if there was a significant change in weight, weekly weights would allow them to see if the resident's issues continued or were resolved and were used to ensure patient safety. During a review of Resident 15's Order Summary Report, dated 5/2/2025, the report indicated there was no order present for weekly weights. During a concurrent interview and record review on 5/2/2025 at 10:31 am with the Director of Nursing (DON), the NRR dated 4/11/2025 was reviewed. The NRR included a recommendation for weekly weights for four weeks. The DON stated there should have been an order for weekly weights because Resident 15's physician approved all the RD recommendations, but it was forgotten and not ordered. The DON stated Resident 15 needed monitoring for significant changes in weight because she was a dialysis resident and might have fluid retention. During a review of the facility's policy and procedure (P&P) titled, Nutritional Management, dated 2001, the P&P indicated, to ensure timely response to residents' nutritional needs, it is recommended that the nutritional recommendations be implemented and documented within no more than 72-hours from the time they are issued.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40438 Based on observation, interview, and record review, the facility failed to provide necessary care and services for gastrostomy tube (GT, a tube inserted through the abdomen that delivers nutrition directly to the stomach) site as ordered by the physician and as indicated in the plan of care for two of two sampled residents (Residents 42 and 7). These failures had the potential for complications related to tube feedings for Residents 42 and 7. Findings: a. During a review of Resident 42's Admission Record (AR), the AR indicated Resident 42 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), hemiparesis (weakness on one side of the body, often affecting the arm, leg, and the face) and gastrostomy (a surgical opening fitted with a device to allow to be administered directly to the stomach common for people with swallowing problems). During a review of Resident 42's Minimum Data Set (MDS, a resident assessment tool), dated 3/28/2025, the MDS indicated Resident 42 had severely impaired cognition (ability to understand and process information). The MDS indicated Resident 42 required partial/moderate assistance (helper did less than half the effort) with oral hygiene and upper body dressing and substantial/maximal assistance (helper did more than half the effort) with toileting, shower, lower body dressing and personal hygiene. The MDS indicated Resident 42 had feeding tube for nutrition. During a review of Resident 42's Order Summary Report (OSR) dated 11/21/2023, the OSR indicated Resident 42 had an order for licensed staff to clean the GT site with normal saline solution (NSS), pat dry, cover with draining sponge and secure with retention tape daily and as needed. During a review of Resident 42's untitled Care Plan (CP) dated 4/11/2025, the CP indicated Resident 42 had GT dislodgement and GT replacement. The CP interventions included GT site care per protocol every shift and as needed. During a concurrent observation inside Resident 42's room and interview on 4/29/2025 at 10:14 am with Certified Nurse Assistant 5 (CNA 5), Resident 42 was in bed and lying in bed on her back. Resident 42's GT site did not have a drain sponge dressing and was not secured. b. During a review of Resident 7's AR, the AR indicated Resident 7 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included hemiplegia, hemiparesis and dysphagia (difficulty swallowing). During a review of Resident 7's MDS dated [DATE], the MDS indicated Resident 7 had severely impaired cognition and dependent (helper did all the effort, resident did none of the effort to complete the activity) with eating, oral hygiene, toileting, shower, upper/lower body dressing and personal hygiene. The MDS indicated Resident 7 had a feeding tube for nutrition. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 7's OSR dated 11/23/2024, the OSR indicated Resident 7 had an order for licensed staff to clean the GT site with NSS, pat dry, cover with draining sponge and secure with retention tape daily and as needed. During a review of Resident 7's untitled CP dated 7/16/2024, the CP indicated Resident 7 had a GT and was at risk for enteral nutrition complications related to clogged tubing, infection and tubing displacement. The CP goals included for the GT insertion site be free of signs and symptoms of infection and complications. During a concurrent observation inside Resident 7's room and interview on 4/29/2025 at 9:39 am with the Restorative Nurse Assistant (RNA), the RNA stated Resident 7's GT site did not have a drain sponge dressing and was not secured. During an interview on 4/30/2025 at 3:50 pm with the Director of Nursing (DON), the DON stated the GT site should be kept clean, covered and secured as ordered by the physician for infection prevention, to prevent dislodgement and to prevent skin irritation on the surrounding area around the GT site. During a review of the facility's Policy and Procedure (P&P) titled, Gastrostomy/Jejunostomy Site Care, revised 10/2024, the P&P indicated, The procedure is to promote cleanliness and to protect the gastrostomy or jejunostomy site from irritation, breakdown and infection. Verify that there is a physician's order for this procedure. Apply the T-drain sponge to the area, hold in place with retention tape.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49252 Based on observation, interview, and record review, the facility failed to ensure two of two sampled residents (Residents 58 and 241) who were receiving oxygen therapy was provided respiratory care and resident safety in accordance with the facility's policy and procedure titled Respiratory Therapy-Prevention of Infection, Oxygen Administration, and professional standard of practice. This deficient practice had the potential to increase the risk of the spread of infection and a risk for shortness of breath and/or hypoxia (low levels of oxygen in the body tissues) which could lead to serious respiratory complications. Findings: a. During a review of Resident 58's Admission Record (AR), the AR indicated Resident 58 was readmitted to the facility on [DATE] with diagnoses that included pneumonia (an infection/inflammation in the lungs) and dysphagia (difficulty swallowing). During a review of Resident 58's History & Physical (H&P), dated 4/18/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 58's Minimum Data Set (MDS, a resident assessment tool), dated 4/25/2025, the MDS indicated Resident 58 had intact cognition (ability to understand). During a review of Resident 58's Order Summary Report, dated 4/29/2025, the order summary indicated an active order for continuous oxygen at three (3) liters per minute via NC, [oxygen] concentrator (a medical device that delivers oxygen) every shift for pneumonia (an infection/inflammation in the lungs) /respiratory disorders. During an observation on 4/29/2025 at 11:29 a.m. while in Resident 58's room, Resident 58 was receiving oxygen infusing through a NC at three liters (L) of oxygen connected to an oxygen concentrator with the NC touching the floor. During a concurrent observation and interview on 4/29/2025 at 11:33 am with Licensed Vocational Nurse 7 (LVN 7) while in Resident 58's room, Resident 58 was lying in bed receiving oxygen through a NC with the NC tubing touching the floor. LVN 7 moved the NC tubing on top of the oxygen concentrator and stated, Resident 58's NC tubing should not be touching the floor because the resident could get an infection. During an interview on 5/2/2025 at 10:28 am with the Director of Nursing (DON), the DON stated the NC should not touch the floor when in use because it contaminated the tubing, placing the residents at risk of respiratory infections. The DON stated that the excess NC tubing should be in a bag and if it touches the ground, it should be replaced. (continued on next page)

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F 0695 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, Infection Prevention and Control Program, last revised December 2023, the P&P indicated, the infection prevention and control program is established and maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The P&P stated, important facets of infection prevention included instituting measures to avoid complications or dissemination and ensure staff adhere to proper techniques and procedures. During a review of the facility's policy and procedure (P&P) titled, Oxygen Administration, last revised October 2024, the P&P indicated, all nasal cannulas and oxygen tubing must be replaced at least every seven days, or sooner if visibly soiled or clinically indicated. 42781 b. During a review of Resident 241's Admission Record (AR), the AR indicated Resident 241 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included muscle wasting (weakening, shrinking, and loss of muscle) and atrophy (decrease in size or wasting away of a body part or tissue) and abnormalities of gait (a person's manner of walking) and mobility (the ability to move). During a review of Resident 241's Order Summary Report (OSR), dated 4/21/2025, indicated to apply oxygen at two (2) liters per minute (L/min) via nasal cannula continuously every shift for shortness of breath (SOB) with a goal to maintain oxygen saturation (is a measure of how much oxygen the blood is carrying as a percentage of the maximum it could carry) greater than 90 percent (%) every shift for SOB. During a review of Resident 241's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 4/29/2025, the MDS indicated, Resident 241 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 241 was dependent (helper does all of the effort) on staff for eating, oral hygiene, toileting hygiene, shower, upper/lower body dressing, putting on/off footwear and personal hygiene. During a concurrent observation and interview on 4/29/2025 at 9:26 a.m., with the Infection Prevention Nurse (IPN), Resident 241 was asleep, lying in bed with nasal cannula tubing placed on top of the suction bottle. The nasal prongs were touching the suction bottle with white secretions. The IPN stated that the nasal cannula needed to be inside the plastic bag if not in use for infection control. During an interview on 4/29/2025 at 10:59 am with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated, Resident 241 was on continuous oxygen therapy as ordered by the physician. LVN 2 stated, if oxygen was not administered continuously to Resident 241 it could result in an increase in respiration and could lower the oxygen saturation. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/30/2025 at 3:47 p.m., with the facility's Director of Nursing (DON), the facility's DON stated oxygen therapy should be continuously used for Resident 241 to receive the desired oxygen as ordered by the physician (medical doctor). The facility DON stated, if oxygen was not administered continuously to Resident 241, Resident 241 would not get enough oxygen, and this could cause respiratory distress. The DON stated, if oxygen is not in use it should be inside the plastic bag to prevent cross contamination (the process by which bacteria or other microorganisms are unintentionally transferred from one substance or object to another, with harmful effect). During a review of the facility's P&P titled, Respiratory Therapy-Prevention of Infection revised 3/2024, the P&P indicated, keep the oxygen cannula and tubing used as needed in a plastic bag when not in use. During a review of the facility's P&P titled, Oxygen Administration revised 4/2024, the P&P indicated, for the facility to verify that there is a physician's order for this procedure and review the physician orders or facility protocol for oxygen administration.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40438 Based on observation, interview and record review, the facility failed to attempt to use appropriate alternative interventions before installation of bilateral (both sides) siderails (also known as bedrails, vertical bars or structures attached to the sides of a bed) for one of one sampled resident (Resident 43). This failure placed Resident 43 at risk for entrapment (when a resident can get caught by the head, neck, chest, or other body parts in the tight spaces around the bedrail) and physical injuries. Findings: During a review of Resident 43's Admission Record (AR), the AR indicated Resident 43 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), hemiparesis (weakness on one side of the body, often affecting the arm, leg, and the face) and osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage). During a review of Resident 43 Minimum Data Set (MDS, a resident assessment tool) dated 3/30/2025, the MDS indicated Resident 43 had severely impaired cognition (ability to understand and process information). The MDS indicated Resident 43 was dependent (helper did all the effort, resident did none of the effort to complete the activity) with oral hygiene, toileting, shower, upper and lower body dressing and personal hygiene. During a concurrent observation inside Resident 43's room and interview on 4/29/2025 at 9:37 am with Certified Nurse Assistant 4 (CNA 4), Resident 43 was in bed, lying on her back with upper side rails up on both sides of the bed. CNA 4 stated Resident 43 was confused and could not move the left side of her body. During a concurrent interview and record review on 4/30/2025 at 4:41 pm with the Director of Nursing (DON), the DON stated there was no documented evidence that appropriate alternative interventions were attempted and did not meet the needs of Resident 43 before the installation of bilateral one-fourth side rails. The DON stated appropriate alternative interventions should be attempted, evaluated and documented why it did not meet the needs of the resident, for the resident's safety. During a review of the facility's Policy and Procedure (P&P) titled, Bed Safety and Bed Rails, revised 10/2024, the P&P indicated, The use of bed rails or side rails (including temporarily raising the side rails for episodic use during care) is prohibited of unless the criteria for use of bed rails have been met, including attempts to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent. If attempted alternatives do not adequately meet the resident's needs the resident may be evaluated for the use of bed rails. The interdisciplinary evaluation includes: an evaluation of the alternatives to bed rails that were attempted and how these alternatives failed to meet the resident's needs.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49252 Based on observation, interview, and record review, the facility failed to follow proper food storage and sanitation standards by failing to: a. Ensure food was stored in a sanitary manner when one bag of tortillas was left open in the dry storage area. b. Ensure the kitchen ice machine was without pink and black substances in the interior component of the ice machine. These failures had the potential to result in foodborne illness (illness caused by consuming contaminated food or beverages). Findings: a. During a concurrent observation of the initial kitchen tour and interview on 4/29/2025 at 8:35 a.m. with the Dietary [NAME] (DC), while in the dry storage area, one bag of tortillas was observed open at the top of the bag. The DC stated that maybe it was delivered open but should not have been left open. The DC further stated, she would inform the Dietary Director and put the tie back on, closing the bag. During an interview on 4/29/2025 at 9:05 am with the Dietary Director (DD), the DD stated the open bag of tortillas should not have been kept, but if it was a [kitchen] staff member that opened it, they should have closed it. The DD stated, the bag should have been kept closed to prevent contaminants from getting inside and should be sealed for freshness. During an interview on 5/2/2025 at 10:49 am with the Director of Nursing (DON), the DON stated food should be sealed and closed when stored to ensure food safety for the residents. The DON stated, if it was unsealed it could be contaminated which could cause digestive problems for the residents who were served those items. During a review of the facility's policy and procedure (P&P) titled, Food Receiving and Storage, last revised October 2024, the P&P indicated, foods shall be received and stored in a manner that complies with safe food handling practices. The P&P indicated, when food is delivered to the facility it is inspected for safe transport and quality before being accepted. The P&P indicated, dry foods and goods are handled and stored in a manner that maintains the integrity of the packaging until they are ready to use. b. During a concurrent observation of the initial kitchen tour and interview on 4/29/2025 at 9:28 a.m. with the Maintenance Supervisor (MS), an observation of the ice machine located in the kitchen revealed a pink tinged and dark substance that smeared and was easily removed with a paper towel inside the ice bin. The MS stated, the substances should not be there and could contaminate the residents' ice. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/2/2025 at 10:49 am with the Director of Nursing (DON), the DON stated the ice machine needed to be checked and the proper cleaning technique should be used to disinfect it. The DON stated, if the ice machine was unsanitary, it was a food and safety hazard for the residents because they could consume the ice and become sick. During a review of Scotsman Ice Systems - Installation and User's Manual for Modular Cuber-Models C0322, C0522, C0722, C0330, C0530, C0630, C0830 and C1030, the manual indicated it was the user's responsibility to keep the ice machine and ice storage bin in a sanitary condition and without human intervention, sanitation will not be maintained. During a review of the facility's policy and procedure (P&P) titled, Ice Machines and Ice Storage Chests, last revised March 2024, the P&P indicated, ice machines will be used and maintained to assure a safe and sanitary supply of ice. The P&P indicated ice-making machines and ice can all become contaminated by waterborne microorganisms naturally occurring in the water source, as well as colonization by microorganisms. The P&P indicated, the facility has established procedures for cleaning and disinfecting ice machines which adhere to the manufacturer's instructions.

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F 0848 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide a neutral and fair arbitration process and agree to arbitrator and venue. 42781 Based on observation, interview and record review, the facility failed to ensure its binding arbitration agreements included selection of a venue convenient to both the facility and resident/resident responsible party for one of three sampled residents (Residents 60). This deficient practice placed Resident 60 at risk for an unjust arbitration and delayed arbitration hearing in an event of an arbitration dispute. Findings: During a review of Resident 60's Admission Record (AR), the AR indicated the facility admitted Resident 60 on 5/25/2024 with diagnoses that included diabetes mellitus type 2 (a disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in elevated levels of glucose/sugar in the blood and urine) and hyperlipidemia (high level of fats in the blood). During a review of Resident 60's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 2/10/2025, the MDS indicated, Resident 60 had intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 60 was dependent with showering/bathing self, lower body dressing and taking off footwear. During an observation on 4/29/2025 at 9:02 am, Resident 60 was outside his room sitting in his wheelchair. During a concurrent interview and record review with the Admission Director (AD) on 4/30/2025 at 1:13 p.m. the Arbitration Agreement was reviewed. The form titled, Arbitration Agreement, indicated the agreement was signed by Resident 60 on 5/15/2024. The signed Arbitration Agreement of Resident 60 did not include information regarding the selection of a venue convenient to both facility and resident/resident responsible party. The AD stated it was an old Agreement form that was used by the previous Admission Director. The AD stated it was important for both facility and resident/resident's representatives to have a convenient location for both parties to be able to attend the hearing. During a review of the facility's P&P titled, Binding Arbitration Agreement, revised in 5/20214, the P&P indicated, arbitration agreements provide for the selection of a venue that is convenient to and suitably meets the needs of both parties. The P&P indicated the venue will be agreed upon by both parties. The P&P indicated when selecting a venue for consideration, convenience for the resident (or representative) may be determined by his or her ability to get to the venue.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42781 Based on observation, interview, and record review, the facility failed to ensure signage was posted and a personal protective equipment (PPE equipment worn to minimize exposure to hazards that cause serious workplace injuries and illnesses) cart was provided to one of six sampled residents (Resident 240) with MRSA of the wound placed on Enhanced Standard Precaution (ESP, an approach for the use of PPE to reduce transmission of multidrug-resistant organisms [MDRO] between residents in skilled nursing facilities) in accordance with the facility's policy and procedure title Enhanced Barrier Precautions. This deficient practice had the potential to transmit infectious microorganisms and increase the risk of infection for the residents and staff which could result in a widespread infection in the facility. Findings: During a review of Resident 240's Admission Record (AR), the AR indicated Resident 240 was admitted to the facility on [DATE] with diagnoses that included pneumonia (an infection/inflammation in the lungs) and diabetes mellitus type 2 (a disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in elevated levels of glucose/sugar in the blood and urine). During a review of Resident 240's History and Physical (H&P) from the General Acute Care Hospital 1 (GACH 1) dated 4/23/2025, the H&P indicated Resident 240 was alert and oriented. During a review of Resident 240's Laboratory Comparative Report result from GACH 1 dated 4/27/2025, the report indicated Resident 84's left knee wound culture was MRSA positive. During a review of Resident 240's Laboratory Comparative Report result date 4/28/2025, the report indicated Resident 84's left medial calf wound culture was MRSA positive. During a review of Resident 240's Order Summary Report (OSR), dated 4/29/2025, the OSR indicated to apply Mupirocin External Ointment (antibiotic medication used to treat or prevent infections) two percent (%) on the left knee topically every day and evening shift for methicillin-resistant staphylococcus aureus (MRSA - a bacteria that does not respond to antibiotics) wound for 14 days. During a review of Resident 240's OSR, dated 4/29/2025, the OSR indicated to apply Mupirocin External Ointment 2% on the left medial calf topically every day and evening shift for MRSA for 14 days. During an observation on 4/29/2025 at 9:20 am while inside Resident 240's room, Resident 240 was awake lying in bed with a wound dressing on his left knee and calf. Resident 240's room did not have ESP signage posted outside the room and there was no cart for PPE provided upon entering the residents' room. During an observation on 4/29/2025 at 3:20 p.m. with the Treatment Nurse (TN), the TN was not wearing a gown while inside Resident 240's room while changing Resident 240's wound dressing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/29/2025 at 3:22 pm with the TN, the TN stated, Resident 240 had MRSA of the wound in the left knee and calf. The TN stated, Resident 240 needed to be placed on contact isolation for MRSA of the wound. The TN stated there was no signage posted, and no PPE cart was outside Resident 240's room to notify staff or visitors to wear proper PPE before entering Resident 240's room. The TN stated, she did not wear the gown while changing Resident 240's wound dressing. The TN stated, gowns and gloves needed to be worn while changing a wound dressing for staff not to spread infection to other residents. During an interview on 4/29/2025 at 3:46 pm with the Infection Prevention Nurse (IPN, a healthcare professional who specializes in preventing the spread of infections in healthcare settings), the IP stated Resident 240 has MRSA of the wound on the left knee and calf. The IPN stated, Resident 240 needed to be placed on ESP to prevent the spread of infection to residents and staff. The IPN stated signage, PPE cart and staff needed to wear gowns and gloves when on direct contact with the residents especially wound dressing. During a concurrent observation and interview on 4/29/2025 at 3:34 p.m. with the facility Director of Nursing (DON), the facility DON stated, Resident 240 needed to be placed on contact precaution upon admission for there was a suspected MRSA of the wound and to notify the primary doctor to protect other residents and staff to prevent spread of infection. The facility DON stated that gowns and gloves needed to be worn while giving care and treatment or when in direct contact with the resident. During a review of the facility's policy and procedure (P&P) titled, Isolation Categories of Transmission - Based Precautions, revised on 10/2024, indicated, contact precautions are implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. The P&P indicated contact precautions are used for residents infected or colonized with MDRO's in the following situations: when a resident has wounds, secretions or excretions that are unable to be covered or contained. During a review of the facility's policy and procedure (P&P) titled, Enhanced Barrier Precautions, revised on 12/2024, the P&P indicated a resident was not known to be infected or colonized with any MDRO, has a wound, etc. The P&P indicated EBP's employ targeted gown and glove use in addition to standard precautions during high contact resident care activities when contact precaution do not otherwise apply: Gloves and gown are applied prior to performing the high contact care activity.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055372	A. Building B. Wing	05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Post Acute	3111 Santa Anita Ave El Monte, CA 91733

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40438 Based on interview and record review, the facility failed to implement its Policy and Procedure (P&P) on antibiotic stewardship (a coordinated program that aims to improve the appropriate use of antibiotics to enhance patient outcomes, prevent antimicrobial, and decrease the spread of drug-resistant infections) for three of six sampled residents (Residents 78, 190, and 240). These failures had the potential to result in increased antibiotic resistance (ability of bacteria to withstand the effects of antibiotics, making standard treatments ineffective) and providing antibiotics without relevant justification. Findings: a. During a review of Resident 78's Admission Record (AR), the AR indicated Resident 78 was admitted to the facility on [DATE] with diagnoses that included peritonitis (an inflammation of the thin membrane that lines the abdominal cavity and covers the abdominal organs), resistance to multiple antibiotics and long-term use to antibiotics. During a review of Resident 78's Physician's Order (PO) dated 4/28/2025, the PO indicated Resident 78 had an order for licensed staff to administer Cephalexin (antibiotics, medications used to treat bacterial infections) tablet 500 milligrams (mg, unit of measurement) four (4) times a day for abscess (localized collection of pus) to the left knee for seven (7) days. b. During a review of Resident 190's AR, the AR indicated Resident 190 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included methicillin susceptible staphylococcus (MSSA, a type of bacteria that is resistant to many antibiotics) infection, immune mechanism disorder (occur when the immune system malfunctions) and pseudomonas diseases (a type of bacteria that can cause lung infection). During a review of Resident 190's PO dated 4/27/205, the PO indicated Resident 190 had an order for licensed staff to administer Amoxicillin-Clavulanate tablet (antibiotic) 875-125 mg every twelve (12) hours for MSSA and pseudomonas bacteremia for 7 days. c. During a review of Resident 240's AR, the AR indicated Resident 240 was admitted to the facility on [DATE] with diagnoses that included chronic respiratory failure (long-term condition where the lungs cannot effectively exchange oxygen and carbon dioxide), pneumonia (an infection/inflammation in the lung) and immune mechanism disorder. During a review of Resident 240's PO dated 4/28/2025, the PO indicated Resident 240 had an order for licensed staff to administer Amoxicillin-Clavulanate (Antibiotics) tablet 875-125 mg every 12 hours for pneumonia for 7 days and Doxycycline Hyclate 100 mg two (2) times a day for pneumonia. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/2/2025 at 10:00 am with the Infection Preventionist Nurse (IPN, a healthcare professional who specializes in preventing the spread of infections in healthcare settings), the IPN stated the facility used McGeer Criteria (set of definitions used to identify and track healthcare-associated infections in long-term care facilities) for infection surveillance and screening evaluation. The IPN stated the McGeer Criteria form was not completed for Residents 78, 190, and 240. The IPN stated the McGeer Criteria form should be filled out for all residents on antibiotics to ensure residents were screened before initiating the antibiotic therapy, to ensure antibiotic use was appropriate and met the criteria for the provision of antibiotics. During an interview on 5/2/2025 at 3:22 pm with the Director of Nursing (DON), the DON stated the antibiotic stewardship needed to be done to determine if the residents meet the criteria before receiving antibiotic therapy to prevent unnecessary use of antibiotics and to ensure prescribed antibiotics was effective and appropriate for the residents. During a review of the facility's P&P titled, Antibiotic Stewardship, revised 12/2024, the P&P indicated, Antibiotics will be prescribed and administered to residents under the guidance of the facility's antibiotic stewardship program. The purpose of the antibiotic stewardship program is to monitor the use of antibiotics in our residents.

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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. 42781 Based on observation, interview and record review, the facility failed to provide a minimum of 80 square feet (sq. ft., unit of measurement) per resident area for sixteen (16) out of thirty-two (32) resident rooms (Rooms 2, 3, 4, 5, 6, 8, 10, 11, 22 24, 28, 29, 30, 31, 32, and 33) This deficient practice had the potential to impact the ability to provide safe nursing care and privacy to the residents. Findings: During an interview with the facility Administrator (ADM) on 4/29/2025 at 4:21 pm, the ADM stated the facility would like to request a room waiver (a document recording the waiving of a right or claim) this year for Rooms 2, 3, 4, 5, 6, 8, 10, 11, 22 24, 28, 29, 30, 31, 32, and 33. The ADM stated nothing was changed with the number of bed occupancy in the 16 rooms. During a review of the facility's letter to request for room waiver dated 4/29/2025, the letter indicated the facility was requesting a waiver be granted on the condition that the request did not adversely affect any residents or any resident's special needs. The waiver indicated all proposed rooms provided ample space for safe resident mobility, accessibility and storage. The waiver indicated that all rooms would continue to maintain privacy standards and promote a home-like environment while continuing to maintain infection control and safety standards. During a review of the Client Accommodations Analysis dated 4/29/2025, the analysis indicated the following: Room Sq. Ft. Beds 2 214.5 3 3 214.5 3 4 214.5 3 5 214.5 3 6 218.5 3 8 154 2 10 218.4 3 11 218.4 3 22 214.5 3 (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	24 214.5 3 28 288 4 29 288 4 30 288 4 31 288 4 32 288 4 33 288 4 During the Health Recertification Survey, from 4/29/2025 to 5/2/2025, Rooms 2, 3, 4, 5, 6, 8, 10, 11, 22 24, 28, 29, 30, 31, 32, and 33 had adequate space, nursing care, comfort, and privacy was provided to the residents. There was adequate room for the operation and use of the wheelchairs (a chair fitted with wheels for use as a means of transport by a person who is unable to walk as a result of illness, injury, or disability), walkers (is a device that gives additional support to maintain balance or stability while walking,) and Hoyer lift (a mechanical device used to lift and/or transfer a person from place to place). The residents were observed to have enough space to move freely inside the rooms. Each resident inside the affected rooms had beds and bedside tables with drawers. The room size did not affect the care and services provided by the staff to the residents when staff were observed providing care to the residents. During an interview on 4/29/2025 at 4:39 p.m. with Resident 60, Resident 60 walking with his walker inside the room and transferred to wheelchair next to residents' bed. Resident 60 stated he did not have any problem maneuvering his wheelchair or walker inside the room. Resident 60 stated he has enough space and able to wheel himself in and out of the room with no issues. During an interview on 4/29/2025 at 4:42 p.m. with Resident 19, Resident 19 was lying in bed, with his wheelchair next to his bed. Resident 19 stated he had no issues or complaints about his room space. Resident 19 stated he can move freely while inside his room. During an interview on 4/29/2025 at 4:43 pm with Certified Nurse Assistant 1 (CNA 1), CNA 1 stated there was enough space in the rooms and CNA1 was able to provide care to the residents. CNA 1 stated, she was able to move wheelchairs, Hoyer lifts and walkers inside the rooms with no issues. During an interview on 5/1/2025 at 3:53 pm with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated there was enough space to provide care and treatment to the residents with no issues. LVN 2 stated, there was enough space for the beds, and CNA 1 was able to move wheelchairs and Hoyer Lifts while inside the rooms.