STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055408	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bellflower Post Acute	9710 E. Artesia Ave Bellflower, CA 90706

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 44055 Based on interview and record review, the facility failed to involve one of three sampled resident's (Resident 26) in the resident's initial Interdisciplinary Team (IDT-team of health care professionals that work together toward and prioritize the resident 's needs) care conference. This deficient practice violated Resident 26's rights to be informed and the right to participate in resident's plan of care. Findings: During a review of Resident 26's Admission Record, the Admission Record indicated Resident 26 was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (brain problem), type 2 diabetes (disorder characterized by difficulty in blood sugar control and poor wound healing), and muscle weakness. During a review of Resident 26's Minimum Data Set (MDS), a resident assessment tool, dated 2/20/2025, the MDS indicated Resident 26's cognition was severely impaired. The MDS indicated Resident 26 was dependent on staff for all activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During an interview and record review on 2/21/2025 at 8:15 a.m., with Registered Nurse 1 (RN 1), Resident 26's Interdisciplinary Team Conference Record, dated 2/14/2025, was reviewed. RN 1 stated according to the IDT record Nursing, Dietary, and therapist attended the meeting, but the resident was not in attendance during the initial IDT care conference. RN 1 stated Resident 26 should have participated in the IDT care plan meeting, or if Resident 26 refused a notation should have been indicated in the record. During an interview on 2/21/2025 at 8:28 a.m. with the Director of Nursing (DON), the DON stated IDT care conferences were completed on admission and quarterly. The DON stated the resident, or representative should always be part of the IDT. (continued on next page)

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

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	055408	A. Building B. Wing	02/21/2025

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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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Comprehensive Care Planning, revised 1/2017, the P&P indicated to the extent possible the resident, resident's family and/or responsible party should participate in the development of the care plan. The P&P indicated every effort will be made to schedule care plan meetings to accommodate the availability of the resident and family or responsible party.

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NAME OF PROVIDER OR SUPPLIER Bellflower Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 9710 E. Artesia Ave Bellflower, CA 90706	

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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. 28851 Based on interview and record review, the facility failed to ensure nurses would document resident's pain level before removing pain medication from inventory, and document resident's refusal of administration, for one of one residents (Resident 43). This deficient practice had the potential of medication error and/or narcotic diversion. Findings: During an observation at the medication cart 1 on 2/19/25 at 3:45 PM, there was a multiple-dose blister pill pack (bubble pack) for Resident 43. The medications in the bubble pack were labeled as oxycodone with acetaminophen (generic for Percocet, a potent opioid to treat severe pain) 10/325 milligrams (mg, an unit of measuring mass). During an interview and a concurrent review of Resident 43's controlled drug record (an accountability record or count sheet for narcotics) for Percocet, the licensed vocational nurse (LVN 3) stated the count sheet indicated there were two doses marked wasted, one each on 12/4/24 (no time noted) and 2/13/25 (6 AM). LVN 3 reviewed Resident 43's electronic medication administration record (eMAR) and stated the eMAR did not have a documentation of Resident's pain episode and/or the refusal of Percocet on 12/4/24 and 2/13/25. During an interview on 2/20/25 at 11:32 AM, the registered nurse (RN 1) stated the facility process of administering as needed (PRN, not routine) medication for pain starts with the resident requesting their pain medication, then the LVN would ask the resident's pain level and document in the eMAR, before preparing the administration of the pain medication. RN 1 stated the nurse would also perform nonpharmacological interventions. During an interview on 2/20/25 at 11:38 AM, RN 1 confirmed nurses failed to document Resident 43's pain level before removing Resident 43's Percocet from the inventory. A review of Resident 43's physician order, dated 11/30/24 on 8:34 PM, indicated to give 1 tablet of Percocet 10/325 mg by mouth every 4 hours as needed for moderate to severe pain (pain level) 4-10. A concurrent review of Resident 43's weights and vitals summary indicated a pain level of 3 on 2/13/25 at 9 AM and on 12/4/24 at 5:06 AM. During an interview on 2/20/25 at 11:49 AM, the director of nursing (DON) stated nurses should not access or remove the narcotic medication from the bubble pack if the pain level did not meet the criteria (a rating of 4-10) as stated in the order. A review of the Resident 43's eMAR on 12/4/24 and 2/13/25 did not indicate non-pharmacological interventions were performed after the pain assessment. A review of the facility policy and procedures, Medication Administration-General Guidelines (dated 10/2017), indicated . Medications are administered in accordance with written orders of the attending physician .

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46415 Based on observation, interview and record review, the facility failed to appropriately assess and monitor one of one sampled resident (Resident 15) during the use of an abdominal binder (a wide belt that provides light compression around the stomach) placed over Resident 15's a gastrostomy (g-tube: a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). This deficient practice had the potential to place the resident on unnecessary restraints. Findings: During a review of Resident 15's Admission Record, the Admission Record indicated Resident 15 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including gastrostomy, dysphagia (difficulty swallowing), and Huntington's Disease (a progressive inherited neurodegenerative disorder that affects the brain). During a review of Resident 15's History and Physical (H&P), dated 6/22/2024, the H&P indicated Resident 15 did not have the capacity to understand and make decisions. During a review of Resident 15's Minimum Data Set [MDS] a resident assessment tool), dated 1/24/2025, the MDS indicated Resident 15's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills were severely impaired. The MDS indicated Resident 15 was 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 15 did not have any physical restraints, which are any manual method, or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. During a review of the Order Summary (physician notes) dated 2/20/2025, the Order Summary indicated an active order dated 6/21/2024 for an abdominal binder at all times to prevent Resident 15 from pulling out g-tube due to diagnosis of Huntington's disease (may remove abdominal binder during ADL's). During a review of Resident 15's Care Plan, the Care Plan indicated Resident 15 required an abdominal binder at all times, except during ADLs to prevent Resident 15 from pulling out the g-tube due to a diagnosis of Huntington's Disease. The Care Plan approach indicated to ensure the abdominal binder was properly fitted and secured at all times during ADLs, monitor skin integrity daily for any signs of irritation or breakdown. The Care Plan indicated to document and report any signs of discomfort, skin breakdown, or non-compliance. During a review of the Medication Administration Record (MAR: documentation of medications administered to residents) dated 2/1/2025 to 2/28/2025, the MAR indicated the section for monitoring the abdominal binder at all times to prevent pulling out g-tube do to (d/t) diagnosis of Huntington's disease (may remove during ADL's) were all documented as X. (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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation of Resident 15, and interview on 2/20/2025 at 9:52 a.m., with Licensed Vocational Nurse 3 (LVN 3), Resident 15 had an abdominal binder on where his g-tube was located. LVN 3 stated Resident 15 was always wearing an abdominal binder so he did not pull out the g-tube as he could not control his movements. During a concurrent interview and record review of the MAR dated 2/1/2025 to 2/28/2025 on 2/20/2025 at 3:18p.m. with the Director of Staff Development (DSD), the DSD stated the section that indicated the abdominal binder on at all times should have contained documentation of Resident 15's abdominal binder assessments, and the X that staff have been documenting meant nothing. The DSD stated this abdominal binder should have had better monitoring. The DSD stated it should be monitored to ensure the abdominal binder is in place or if the resident is tugging on it. During an interview on 2/20/2025 at 4:26p.m. with the Director of Nursing (DON), the DON stated restraints are particular devices that restrict mobility of residents, and an abdominal binder can be a form of restraint depending on the condition of the resident. The DON stated if a resident has a diagnosis of Huntington's Disease that causes uncontrollable moving and jerking, an abdominal binder will protect his g-tube and does not restrict him from moving. The DON stated an abdominal binder is a physical device and requires a consent, needs to monitor the skin integrity of sight, and release during ADL to monitor for skin breakdown. The DON stated restraints are reassessed quarterly for appropriateness. During a review of the facility's policies and Procedures (P&P), titled Restraint Assessments: Chemical (Psychotropic Meds) and Physical, revised 1/2014, the P&P indicated the facility shall engage in a systematic and gradual process towards reducing restraints for those residents whose care plans indicate the need for restraints. Physical restraints: are any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom or movement or normal access to one's body. Includes but not limited to leg restraints, arm restraints, hand mittens, soft ties or vests .the resident cannot remove easily. Institute a trial period where less restrictive measures are used. Document the types and duration of the less restrictive measures used and the results. The need for the restraint shall be periodically reevaluated and attempts shall be made to engage in a systematic and gradual process to minimize and/or eliminate their use whenever possible. The resident's functional status shall be regularly reassessed regarding the resident's ongoing medical indication for a restraint and the resident's care plan shall be updated accordingly. During a review of the facility's P&P, titled Physical Restraints, revised 9/2017, the P&P indicated upon admission, quarterly and with a change of condition, residents shall be assessed for the need or lack of physical restraints. The need for restraints will be re-evaluated at least quarterly to determine their continued need. Every effort will be made to eliminate their use.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055 Based on interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for one of two sampled residents (Resident 37) addressing Resident 37's anticoagulant (medications that prevent blood from clotting) use. This deficient practice had the potential to result in poor quality of care and a delay of care and services. Findings: During a review of Resident 37's Admission Record, the admission record indicated Resident 37 was admitted to the facility on [DATE] with diagnosis including acute respiratory failure (when the air sacs of the lungs cannot release enough oxygen into the blood), and atrial fibrillation (irregular heartbeat). During a review of Resident 37's Minimum Data Set ([MDS] a resident assessment tool) dated 11/8/2024, the MDS indicated Resident 37's cognition (ability to think and reason) was moderately impaired. The MDS indicated Resident 37 was dependent on staff for all activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 37's Order dated 8/28/2024, the order indicated to Apixaban (medication to treat atrial fibrillation) 2.5 milligrams via gastrostomy tube (a tube inserted through the belly that brings nutrition directly to the stomach) two times a day. During an interview and record review on 2/20/2025 at 8:24 a.m. with Registered Nurse (RN) 1, Resident 37's care plan, RN 1 stated Resident 37 did not have a care plan for anticoagulant use and should have had one. During an interview on 2/20/2025 at 4:26 p.m. with the Director of Nursing (DON), the DON stated the resident needs a care plan for anticoagulant use to guide care rendered. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, revised 12/2016, the P&P indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The care plan describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The care plan builds on the resident's strengths; and reflects currently recognized standards of practice for problem areas and conditions.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055 Based on interview and record review the facility failed to ensure one of two sampled resident's (Resident 37) care plans were reviewed and updated on a quarterly basis. This deficient practice had the potential to result in poor quality of care and a delay in care and services. Findings: During a review of Resident 37's Admission Record, the admission record indicated Resident 37 was admitted to the facility on [DATE] with diagnosis including acute respiratory failure (when the air sacs of the lungs cannot release enough oxygen into the blood), type 2 diabetes (long-term condition in which the body has trouble controlling blood sugar and using it for energy), hypertension (condition in which the force of the blood against the artery walls is too high), and dementia (a progressive state of decline in mental abilities). During a review of Resident 37's Minimum Data Set ([MDS] a resident assessment tool) dated 11/8/2024, the MDS indicated Resident 37's cognition (ability to think and reason) was moderately impaired. The MDS indicated Resident 37 was dependent on staff for all activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 37's Care Plans, the following eight care plans were all created 8/28/2024 and were due for review on 11/2024, but have not been reviewed as of 2/18/2025, Care plans titled, Cognitive Loss, Communication, Oral/Dental, Weight loss/gain/dehydration, Cardiac circulation, Elopement, Aging process, and Breathing pattern. During an interview and record review on 2/18/2025 at 4:26 p.m. with the MDS Coordinator (MDSN) 2, Resident 37's care plans were reviewed. The MDSN 2 stated Resident 37's care plans should have been reviewed and reevaluated since November 2024 but have not been. During an interview on 2/20/2025 at 4:26 p.m. with the Director of Nursing (DON), the DON stated care plans need to be reviewed at least quarterly to make sure if it still applies or if it needs to be revised. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, revised 12/2016, the P&P indicated a comprehensive, person-centered care plan must be reviewed and revised periodically, at least quarterly and on an ongoing basis to reflect changes in the resident and the services provided or arranged must be consistent with each resident's written plan.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28851 Based onobservation, interview and record review, the facility failed to 1.Ensure nurses would document resident's pain level before removing pain medication from inventory, and document resident's refusal of administration, for one of one residents (Resident 43). These deficient practices had the potential of medication error and/or narcotic diversion. 2. Ensure one of one sampled residenst (Resident 48) had a urology (a medical specialty that focuses on the diagnosis, treatment, and prevention of diseases and disorders related to the urinary system) consult and received services to meet professional standards of practice. These failures had the potential for Resident 48's penile (located on the penis) open wound to get infected. Findings: 1. During an observation at the medication cart 1 on 2/19/25 at 3:45 PM, there was a multiple-dose blister pill pack (bubble pack) for Resident 43. The medications in the bubble pack were labeled as oxycodone with acetaminophen (generic for Percocet, a potent opioid to treat severe pain) 10/325 milligrams (mg, an unit of measuring mass). During an interview and a concurrent review of Resident 43's controlled drug record (an accountability record or count sheet for narcotics) for Percocet, the licensed vocational nurse (LVN 3) stated the count sheet indicated there were two doses marked wasted, one each on 12/4/24 (no time noted) and 2/13/25 (6 AM). LVN 3 reviewed Resident 43's electronic medication administration record (eMAR) and stated the eMAR did not have a documentation of Resident's pain episode and/or the refusal of Percocet on 12/4/24 and 2/13/25. During an interview on 2/20/25 at 11:32 AM, the registered nurse (RN 1) stated the facility process of administering as needed (PRN, not routine) medication for pain starts with the resident requesting their pain medication, then the LVN would ask the resident's pain level and document in the eMAR, before preparing the administration of the pain medication. RN 1 stated the nurse would also perform nonpharmacological interventions. During an interview on 2/20/25 at 11:38 AM, RN 1 confirmed nurses failed to document Resident 43's pain level before removing Resident 43's Percocet from the inventory. During a review of Resident 43's physician order, dated 11/30/24 on 8:34 PM, indicated to give 1 tablet of Percocet 10/325 mg by mouth every 4 hours as needed for moderate to severe pain (pain level) 4-10. During a concurrent review of Resident 43's weights and vitals summary indicated a pain level of 3 on 2/13/25 at 9 AM and on 12/4/24 at 5:06 AM. During an interview on 2/20/25 at 11:49 AM, the director of nursing (DON) stated nurses should not access or remove the narcotic medication from the bubble pack if the pain level did not meet the criteria (a rating of 4-10) as stated in the order. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the Resident 43's eMAR on 12/4/24 and 2/13/25 did not indicate non-pharmacological interventions were performed after the pain assessment. A review of the facility policy and procedures, Medication Administration-General Guidelines (dated 10/2017), indicated . Medications are administered in accordance with written orders of the attending physician . 50387 2. During a review of Resident 48's Admission Record, the Admission Record indicated the facility admitted Resident 48 on 4/29/2024 and readmitted on [DATE] with diagnoses including urinary tract infection (UTI-a bacterial infection in they urinary system, which includes the kidneys, ureters, bladder, and urethra) and pressure ulcer (localized damage to the skin or underlying tissue due to unrelieved pressure) of sacral region (tailbone), stage 3 (full-thickness loss of skin, dead and black tissue may be visible). During a review of Resident 48's History and Physical (H&P), dated 12/18/2024, the H&P indicated Resident 48 could make needs known but not make medical decisions. During a review of Resident 48's Minimum Data Set (MDS- a resident assessment tool), dated 12/22/2024, the MDS indicated Resident 48 was cognitively (related to thinking) intact. The MDS indicated Resident 48 had functional limitation in range of motion (the distance and direction a joint can move) on both upper extremities (arm, including your shoulder, elbow, wrist, and hand) and both lower extremities (leg, including your hip, thigh, knee, shin, ankle, and foot). During a review of Resident 48's Initial Nursing History and Assessment, dated 12/17/2024, the Initial Nursing History and Assessment indicated that Resident 48 had penile erosion ([pressure ulcer] a gradual wearing away or eating away of a surface layer of tissue) upon admission, measuring of 4 centimeter (cm a unit of measure of length)x2cmx0.5cm with red appearance. During a review of Resident 48's Order Summary Report, orders as of 2/19/2025, the Order Summary Report indicated a physician order dated 12/17/2024 to place a wound consult for evaluation and a physician order dated 2/6/2025 for an appointment with a urologist. During a review of Resident 48's Wound Physicians Progress Note, dated 12/24/2024, the Wound Physicians Progress Note indicated Resident 48 had an indwelling Foley catheter (a thin, flexible tube inserted into the bladder through the urethra, which stays in place to continuously drain urine into a collection bag). The Wound Physicians Progress Note indicated Resident 48 had penile erosion and a urology appointment was scheduled on 2/6/2025. The Wound Physicians Progress Note indicated the wound's measurement were 4 cmx2 cmx0.5 cm, exudate (a fluid that leaks out of blood vessels into nearby tissues, usually as a result of an injury or inflammation): serous (watery), minimal amount of exudate. During a review of Resident 48's Wound Physicians Progress Note, dated 12/31/2024, the Wound Physicians Progress Note indicated Resident 48's penile wound was due to the foley catheter, and Resident 48 had an appointment with a urologist on 2/6/2025. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 48's care plan for alteration (a change or modification made to something) in skin integrity, created on 12/17/2024, the care plan indicated, Resident 48 had skin erosion on the penile area, and the measurement upon admission was 4 cmx2 cmx0.5 cm, with moderate serous drainage. The care plan goal indicated Resident 48 would be free from infection. The care plan's approaches and plan included calling physician if treatment is ineffective and provide a wound consult. During a review of Resident 48's care plan for skin break down, initiated on 12/19/2024, the care plan indicated Resident 48 was high risk for further skin break down. The care plan approaches and interventions included notifying the physician if no noted progress towards healing. During a concurrent observation and interview on 2/19/2025 at 9:29 a.m., with Licensed Vocational Nurse (LVN) 4, in Resident 48's room, LVN 4 was changing the Resident 48's penile wound dressing. LVN 4 stated that the penile wound had drainage like and the wound had a split at the tip. During an interview on 2/19/2025 at 1:30 p.m., with LVN 4, LVN 4 stated that wound physician evaluated Resident 48 on 12/24/2024 and a week later 12/31/24 which the wound physician signed off from the consult and referred Resident 48 to a urologist. LVN 4 stated, she was present at Resident 48's bedside when the wound physician explained that Resident 48 might need a procedure to close the wound, based on the urologist's evaluation. LVN 4 stated that Resident 48 had a scheduled appointment on 2/6/2025 but missed the appointment with the urologist due to transportation issues. LVN 4 stated the next appointment was rescheduled for 3/27/2025, but LVN 4 stated she did not notify a physician that Resident 48 had missed his appointment with the urologist on 2/6/2025, assuming it was not urgent since the wound remained unchanged. During an interview on 2/19/2025 at 12:51 p.m., with the Director or Nursing (DON), the DON stated that Resident 48 was at high risk for infection, due to age, bowel incontinence (no voluntary control of bowel movements), poor skin turgor (the elasticity of skin, or its ability to change shape and return to normal), decreased mobility, and existing wounds. The DON stated that Resident 48's care plan identified high infection risk, making it unacceptable to delay the urologists consult appointment without notifying the physician that Resident 48 missed the appointment scheduled for 2/6/2025 . The DON stated that LVN 4 should have sought alternatives and notified the physician, as failing to do so did not meet the standard of practice. The DON stated that this failure could lead to infections. During the facility's policy and procedure (P&P) titled, Treatment nurse job description, not dated, the P&P indicated treatment nurse must initiate communication to physician and other disciplines regarding negative response to treatment administration or changes in resident's condition as per policy and nursing practices. During the facility's P&P titled, Quality of Care, Routine Resident Monitoring and Scope of Services, revised 1/2017, indicated the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being consistent with the resident's comprehensive assessment and plan of care. The P&P indicated the facility will provide care consistent with professional standards for residents to prevent pressure injuries.

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	055408	A. Building B. Wing	02/21/2025

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Bellflower Post Acute	9710 E. Artesia Ave Bellflower, CA 90706

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 44055 Based on interview, and record review the facility failed to ensure one of two sampled residents' (Resident 5) foley catheter (a device that drains urine from your urinary bladder into a collection bag outside of your) drainage bag was changed as ordered. This deficient practice had the potential to result in complications that can negatively affect the resident's wellbeing. Findings: During a review of Resident 5's Admission Record, the Admission Record indicated Resident 5 was readmitted to the facility on [DATE] with diagnoses including acute kidney failure (A condition in which the kidneys suddenly can't filter waste from the blood), and acute cystitis (infection of the bladder - organ that holds the urine). During a review of Resident 5's Minimum Data set (MDS), A resident assessment tool, dated 1/15/2025, the MDS indicated Resident 5's cognitive skills (functions your brain uses to think, pay attention, process information, and remember things) for daily decision-making was intact. The MDS indicated Resident 5 required moderate assistance (helper does less than half the effort to complete the task) with eating, maximal assistance (helper does more than half the effort to complete task) with showering, oral hygiene, toileting hygiene, and personal hygiene. During a review of Resident 5's Order Summary Report as of 2/19/2025, the report indicated, starting on 1/9/2025, to keep foley catheter for urinary retention (difficulty urinating and completely emptying the bladder). The order also indicated, stating 1/9/2025, to change foley catheter bag every 7 days, change strap/stat lock (a device that stabilizes a catheter in place and reduces the risk of it being pulled out) if applicable, every day shift every 7 day(s). During an interview and record review on 2/19/2025 at 11:40 a.m. with Registered Nurse (RN) 1 of Resident 5's Treatment Administration Record (TAR) for 1/2025, RN 1 stated the TAR indicated, starting on 1/9/2025, to change foley catheter bag every 7 days, change strap/stat lock if applicable, every day shift every 7 day(s). RN 1 stated the TAR indicated the task was not completed on 1/9/2025, 1/16/2025, and 1/23/2025 as ordered. RN 1 stated orders should have been followed or if the order was inappropriate then it should have been clarified. During an interview on 2/20/2025 at 4:26 p.m., with the Director of Nursing (DON) the DON stated physician orders always need to be followed. During a review of the facility's policy and procedure (P&P) titled, Indwelling Catheter Care, revised 3/2021, the P&P indicated it was the facility policy to provide catheter care as ordered.

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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** 44055 Based on observation, interview, and record review the facility did not provide care and services consistent with professional standards of practice to three of three residents (Resident 5, 30, 49) receiving supplemental oxygen (element essential for life) when the facility failed to: a. Ensure Resident 5 had visible signage warning others oxygen was in use to prevent hazardous practices. b. Ensure Resident 30 and 49's nasal canula (device that delivers oxygen through the nostrils) was labeled with a date to ensure it was changed timely. c. Ensure Resident 30's oxygen use was being documented in the Medication administration record. These deficient practices had the potential to result in unsafe and unsanitary administration of oxygen in the facility. Findings: a) During a review of Resident 5's Admission Record, the Admission Record indicated Resident 5 was readmitted to the facility on [DATE] with diagnoses including acute respiratory failure (life-threatening condition that occurs when the lungs and blood are unable to exchange gases properly), and asthma (chronic lung disease). During a review of Resident 5's Minimum Data set (MDS), A resident assessment tool, dated 1/15/2025, the MDS indicated Resident 5's cognitive skills (functions your brain uses to think, pay attention, process information, and remember things) for daily decision-making was intact. The MDS indicated Resident 5 required moderate assistance (helper does less than half the effort to complete the task) with eating, maximal assistance (helper does more than half the effort to complete task) with showering, oral hygiene, toileting hygiene, and personal hygiene. During a review of Resident 5's Order Summary Report as of 2/19/2025, the report indicated may use oxygen 2 to 3 liters per minute via nasal canula as needed to maintain oxygen saturation (a measurement of how much oxygen the blood is carrying as a percentage) above 92 percent as needed for shortness of breath or wheezing (a high pitch whistling sound made while breathing showing the person may be having breathing problems). During an observation and interview on 2/18/2025 at 11:02 a.m., in Resident 5's room, with Licensed Vocational Nurse (LVN) 3, Resident 5 was noted using oxygen via nasal canula at 3 liters per minute. There was no signage on the door indicating resident was using oxygen. LVN 3 stated there should be a sign on the door indicating resident 5 was using oxygen for safety reasons. During an interview on 2/20/2025 at 4:26 p.m., with the Director of Nursing (DON) the DON stated need signage on door if resident was on oxygen because of risk of fire. (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, Oxygen Administration, revised 3/2017, the P&P indicated to use the sign No smoking/ Oxygen in Use. 50387 b. During a review of Resident 30's Admission Record, the Admission Record indicated Resident 30 was readmitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (a long-term lung disease that makes breathing difficult) with exacerbation (a sudden worsening) and chronic (something that continues or happens again and again over a long period of time) cough. During a review of Resident 30's MDS, dated [DATE], the MDS inicated Resident 30 was cognitively (related to thinking) intact. The MDS indicated Resident 30 had no limitation in range of motion (the distance and direction a joint or body part can move) on both upper extremities (your shoulders, elbows, wrists, and hands) and lower extremities (your hips, knees, ankles, and feet). During a review of Resident 30's Order Summary Report as of 2/18/2025, the Order Summary Report indicated, may use oxygen at 2 liter per min via nasal cannula as needed to keep oxygen saturation above 92 percent. During an observation on 2/18/2025 at 9:51 a.m., in Resident 30's room, observed Resident 30 receiving oxygen at 2 liters per minute via nasal cannular while in bed. The nasal cannula did not have a date on it. During a concurrent observation and interview on 2/18/2025 at 12:07 p.m., in Resident 30's room, with Registered Nurse (RN) 1, observed, RN 1 checked Resident 30's nasal cannular and confirmed no date was marked. RN 1 also stated that date should be dated each time the nasal cannular is changed to ensure proper infection control. Failure to do so could increase the risk of infection. During an interview on 2/20/2025 at 11:15 a.m. with the DON, the DON stated Resident 30 was high risk for infections due to her age and medical diagnoses. The DON stated the nasal cannula should be changed and dated to ensure proper communication among facility staff. The DON stated failure to do so could increase the risk of infection for the resident. c. During a review of Resident 49's Admission Record, the Admission Record indicated Resident 49 was admitted to the facility on [DATE] with diagnoses including pulmonary hypertension (a chronic condition that causes high blood pressure in the arteries of the lungs) due to lung diseases, hypoxia (a condition where there isn't enough oxygen in your body's tissues, cells or blood) and immunodeficiency (a condition where the body's immune system is weakened, making it harder to fight infections and other diseases). During a review of Resident 49's MDS, dated [DATE], the MDS indicated Resident 49's was cognitively intact. The MDS indicated Resident 49 required moderate assistance (helper does less than half the effort to complete the task) with eating, oral hygiene, and personal hygiene, maximal assistance (helper does more than half the effort to complete task) with showering, toileting hygiene, and personal hygiene. (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 Resident 49's Order Summary Report as of 2/18/2025, the report indicated may use oxygen 2 to 3 liters per minute via nasal cannula as needed to maintain oxygen saturation (a measurement of how much oxygen the blood is carrying as a percentage) above 92 percent as needed for shortness of breath. During an observation on 2/18/2025 at 11:16 a.m. in Resident 49's room, the resident was observed receiving oxygen at 2 liters per minute via nasal cannula in the bed. The nasal cannula did not have a date on it. During a concurrent observation and interview on 2/18/2025 at 12:11 a.m. in Resident 49's room, with Registered Nurse (RN) 1, observed, RN 1 checked Resident 49's nasal cannular and confirmed no date was marked. RN 1 also stated that date should be dated each time the nasal cannular is changed to ensure proper infection control. Failure to do so could increase the risk of infection. During an observation on 2/20/2025 at 10:17 a.m., in Resident 49's room, the resident was observed using oxygen at 2 liters per minute via nasal cannular while in bed. During a concurrent interview and record review on 2/202/205 at 10:50 a.m., with the DON, Resident 49's Medication Administration Record (MAR), for the month of February was reviewed. The MAR indicated that there was no documentation reflecting that the oxygen order was carried out. The MAR showed that Resident 49 did not use oxygen for the month of February until 2/20/2025. The DON stated that Resident 49's oxygen order should be recorded on the MAR, but it was missing. The DON stated that this omission could interfere with providing proper care to the resident. The DON stated the Resident 49 was at risk for infection due to comorbidities (two or more disease or conditions that occur in a person at the same time), immunodeficiency, not dating the nasal cannula was unacceptable as it could lead to infections. During a review of the facility's P&P titled, Oxygen Administration, revised 3/2017, the P&P indicated to document the method of delivery, rate of oxygen flow and the reason for administration if administered PRN (as necessary). During a review of the facility's P&P titled, Oxygen Concentrators, dated 6/2017, the P&P indicated that cannulas should be replaced weekly.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055 Based on interview and record review, the facility failed to ensure three of three Residents on hemodialysis ([HD]a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) , received dialysis care and services based on professional standards (Resident 17, 27, and 113). The facility failed to: a. Ensure staff assessed Resident 113 prior to sending Resident 113 to dialysis. b. Ensure Resident 17 had equipment and supplies necessary to manage emergencies such as bleeding at the bedside. c. Ensure staff assessed Resident 27 and 113 after the residents returned from the dialysis center. These deficient practices had the potential to result in undetected complications from dialysis, or delayed treatment of complications. Findings: a.During a review of Resident 113's Admission Record, the Admission Record indicated Resident 113 was originally admitted to the facility on [DATE] with diagnoses including end stage renal disease (ESRD -irreversible kidney failure) and dependence on renal dialysis. During a review of Resident 113's Minimum Data Set (MDS - a resident assessment tool), dated 2/10/2025, the MDS indicated Resident 113's cognition (ability to think) was severely impaired. The MDS indicated Resident 113 needed set up assistance when eating, supervision with oral and personal hygiene, and substantial assistance (helper does more than half the effort) with toileting hygiene and showering. During a review of Resident 113's Physician Order Report: active orders as of 2/19/2025, the Physician Order Report indicated, starting 2/3/2025, hemodialysis procedure to an outpatient dialysis center Monday, Wednesday, and Friday. During an interview and record review on 2/19/2025 at 3:10 p.m. with Licensed Vocational Nurse (LVN) 7, Resident 113's Dialysis form, dated 2/10/2025, was missing from the medical records and LVN 7 stated the pre and post assessment section to be completed by the facility was blank indicating it was not completed. LVN 7 stated it should have been filled out for continuity of care. LVN 7 stated it was important to monitor residents for changes and complications of dialysis therapy. b. During a review of Resident 17's Admission Record, the Admission Record indicated Resident 17 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including end stage renal disease (kidney failure), type 2 diabetes mellitus (a condition in which the body has trouble controlling blood sugars and using it for energy without complications and hyperlipidemia (an excess of fats) in the blood). (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During review of Resident 17's history and physical (H&P), the H&P indicated Resident 27 has the capacity to understand and make decisions. During a review of Resident 17's MDS, a resident dated 12/27/2024, the MDS indicated Resident 27 required substantial/maximal assistance (helper lifts or holds trunk or limbs and provides more than half the effort with toileting, upper body dressing , personal hygiene , sit to stand, and roll left to right. During a review of Resident 17's Order Summary Report, the Order Summary Report indicated dialysis was scheduled to an outpatient center Tuesday, Thursday and Saturday at 09:00 a.m., may apply pressure dressing to LUA left upper arm) arteriovenous shunt (direct connections between arteries [blood vessels that take blood from the heart] and veins [blood vessels that take blood to the heart]). During an observation and interview on 2/18/2025 at 11:45 a.m., with Licensed Vocational Nurse 4 (LVN 4) assisted Resident 17 after he arrived in his room from the dialysis center. (LVN 4) assessed the dressing site that covered Resident 17's left upper arm shunt. LVN 4 stated Resident 17 did not have an emergency kit (e-kit equipment used to stop sudden and heavy bleeding from an AV shunt) at the bedside and did not know where to find one. LVN 4 stated by not having an e-kit at the bedside there could have been a bad outcome, the resident could loose blood from his LUA AV shunt and pass out because blood could not be controlled. LVN 4 stated there should always be an e kit readily available in case of an emergency. During an interview on 2/20/2025 at 4:29 p.m., with the DON, the DON stated when a resident arrives to our facility after dialysis it is important for the nurse to make sure the resident is stable, monitor the shunt for bleeding and make sure the e kit is available because bleeding may happen at any time. c. During a review of Resident 27's Admission Record, the Admission Record indicated Resident 27 was admitted to the facility on [DATE] with diagnosis including end stage renal disease, essential (primary) hypertension (high blood pressure) and cardiomegaly (enlarged heart) . During a review of Resident 27's MDS, a resident assessment tool, dated 1/18/2025, the MDS indicated Resident 27's cognition was intact. The MDS indicated Resident 27 needed substantial/maximal assistance (Helper lifts or holds trunk or limbs but provides less than half the effort) with toileting , upper body dressing and substantial/maximal assistance - (Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with lying to sitting on side of bed, lower body dressing ,putting on/taking off footwear. During a record review of Resident 27's Order Summary Report, the Order Summary Report indicated a start date 1/13/2025 for dialysis on Tuesday Thursday and Saturday at an outpatient dialysis center. During an interview and record review on 2/20/2025 at 12:58 p.m., with LVN 2, Resident 27's Dialysis form, dated 1/23/2025, 1/28/2025, 2/4/2025, and 2/11/2025 were missing from the medical records and LVN 2 stated the post assessment section to be completed by facility staff was blank indicating it was not completed. LVN 2 stated we do post monitoring when a resident arrives from dialysis to make sure there is no bleeding, vitals are stable and no changes in condition. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/20/20205 at 4:06 p.m., with LVN 8 , LVN 8 stated it is important to chart on the Post Dialysis form to show you assessed the resident making sure there is no physical injury . During an interview on 2/20/2025 at 4:26 p.m. with the Director of Nursing (DON), the DON stated staff need to assess the dialysis residents before sending residents to dialysis and the staff need to fill out the form with the pre-dialysis assessment to send to the dialysis center for report, so the dialysis center knows what's going on with the resident. The DON stated the dialysis resident should be assessed post dialysis to make sure there are no complications or problems. The DON stated dialysis residents need an emergency kit at the bedside in case of bleeding it can be fatal. During a review of the facility's policy and procedure (P&P) titled, Dialysis Care revised 9/2020, the P&P indicated the following: 1. In case of emergency, at the bedside of a dialysis resident, there should be a clamp (tool used to control bleeding), tape, gauze pads (thin, loosely woven fabric used for wound care), and Kerlix (brand of sterile, absorbent gauze that's used for wound dressing). 2. A Pre-Dialysis Checklist will be completed by the facility each time the resident is scheduled for dialysis. This checklist includes the following information: a. Vital Signs (measurements that indicate a person's basic physiological functions) b. Information regarding the type of access site (site used for dialysis treatment) and the condition of the access site and the dressing. c. The resident's skin condition and the presence of any skin tears, discolorations, or pressure ulcers (localized damage to the skin and/or underlying tissue usually over a bony prominence) d. any medications sent with the resident to the dialysis unit, e. any additional information or comments, signature of licensed nurse, date and time. This form will accompany the resident to dialysis. 3. The post dialysis checklist part of this form is to be completed by the facility upon return of the resident. Information to be documented includes: a. vital signs b. Information regarding the type of access site and the condition of the access site and the dressing c. The resident's skin condition and the presence of any skin tears, discolorations, or pressure ulcers noted d. any additional instructions from the dialysis unit (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	e. any additional information or comments, signature of licensed nurse, date and time. 45777

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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. 45777 Based on observation, interview, and record review, the facility failed to ensure that one of three Licensed Vocational Nurse (LVN 9) had the specific competencies and skills sets necessary to care for residents by failing to ensure LVN 9's SNF (Skilled Nursing Facility) Licensed Nurse Orientation Annual Competency checklist (a systematic evaluation of nursing staff's competency levels in various areas of practice) was up to date. This deficient practice had the potential for residents not to receive appropriate nursing services and care which had the potential for injury to residents. Findings: During a record review LVN 9 was hired on 8/22/2023, on 9/18/2023 the form titled SNF Licensed Nurse Orientation Annual Competency Checklist was completed by LVN 9 . During a record review and interview on 2/20/2025 at 11:27 a.m., with the Director of staff Development (DSD), the DSD stated LVN 9's last annual competency check list was completed on 9/18/2023 with an expiration date of 3/31/2024 . The DSD stated LVN 9 was 11 months past due. The DSD stated it was important to make sure competencies are up to date it let us know nurses are doing their skills right and following the policies of the facility. The outcome of not having the skills that are required is the nurses can be missing steps during a resident care related task. During an interview on 2/21/2025 at 9:42 a.m., with the Director of Nursing (DON), the DON stated competencies are done yearly and when necessary for all staff. The DON stated competencies are important to make sure nurses are doing the proper care for the residents , it let us know if staff need more education, tells their overall performance and tells the overall picture of the nurse. During a review of the facility's policy and procedure (P&P) titled, Policy for Staff Competencies, dated 1/2017 the P&P indicated, it is the policy of facility that each employee will receive periodic performance reviews to ensure staff competencies. Performance evaluations are to ensure that staff has the appropriate competencies and skills to ensure resident safety and to provide care which includes assessing, evaluating planning, implementing resident care plan and responding to resident's needs.

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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 observations, interviews, and record review, the facility failed to develop a facility policy that matched the facility's current method of documentation, specifically in the relations to medication administration record. This deficient practice had the potentials of inaccurate records, drug loss and/or diversion. Findings: A review of the facility policy and procedures, Medication Administration-General Guidelines (dated 10/2017), indicated .An explanatory note is entered on the reverse side of the record provided for PRN documentation . During a concurrent interview on 2/20/25 at 12:28 PM, the director of nursing (DON) stated the facility did not have a more updated version of the aforementioned policy. DON stated the facility had been using electronic medication administration records (MAR) and not the paper MAR. DON stated the policy was referred to the paper MAR that was no longer in use. DON stated the current practice is for the nurse to initiate a text box that will populate in the eMAR for documentation. DON agreed the aforementioned policy needs to be updated.

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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** 44055 Based on interview and record review, the facility failed to hold (not administer) the hypertensive medications (drugs used to treat high blood pressure - condition where the force of blood against the artery walls is too high) for two of three residents (Resident 27 and 112) when the residents blood pressures were below given parameters (sets the condition of providing the medication). This deficient practice had the potential to result in hypotension (condition where the blood pressure falls below normal levels) which can cause fainting or dizziness because the brain does not receive enough blood. Findings: During a review of Resident 112's Admission Record, the record indicated Resident 112 was admitted to the facility on [DATE] with a diagnosis including essential hypertension (a condition characterized by persistently high blood pressure without an identifiable underlying cause). During a review of Resident 112's Minimum Data Set (MDS), a resident assessment tool, dated 2/11/2025, the MDS indicated Resident 112's cognition (ability to think) was intact. The MDS indicated Resident 112 needed supervision (helper provides verbal cues) with oral and personal hygiene, and moderate assistance (helper does less than half the effort) with toileting hygiene, showering, and dressing. During a review of Resident 112's Order Summary Report, as of 2/19/2025, the report indicated, Metoprolol tartrate (medication for hypertension) oral tablet 25 milligrams (mg) one tablet by via gastrostomy tube (G-tube - a tube inserted through the belly that brings nutrition directly to the stomach) every 12 hours hold if systolic blood pressure (first number - measures the pressure your blood is pushing against your artery walls when the heart beats) is below 110 millimeters of mercury (mmHg - unit used to measure pressure) or pulse rate less than 60 beats per minute (bpm). During an interview and record review on 2/19/2025 at 3:48 p.m., with Registered Nurse (RN)1, Resident 112's Medication administration record (MAR), 2/2025, was reviewed. RN1 stated the MAR indicated on 2/15/2025 and 2/16/2025 at 9 p.m. Metoprolol was administered to Resident 112 despite having a blood pressure reading of 100/74 mmHg on 2/15/2025 and 106/68 mmHg on 2/16/2025. RN 1 stated the medication should not have been administered on those times because it was the order to hold if below 110 mm Hg. 45777 During a review of Resident 27's Admission Record, the Admission Record indicated Resident 27 was admitted to the facility on [DATE] with diagnoses including end stage renal disease (Kidney failure), essential hypertension and cardiomegaly (enlarged heart). (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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 27's MDS, dated [DATE], the MDS indicated Resident 27's cognition was intact. The MDS indicated Resident 27 needed substantial/maximal assistance (helper lifts or holds trunk or limbs and provides more than half the effort) with toilet hygiene, upper body dressing and lying to sitting on side of bed, lower body dressing, and putting on/taking off footwear. During a record review of Resident 27's Order Summary Report, the Order Summary Report indicated, start date 2/4/2025, to give hydralazine hydrochloride (medication that lowers blood pressure) oral tablet 50 mg by mouth every 8 hours every Monday Wednesday, Friday and Saturday, hold for Systolic Blood Pressure (SBP the pressure exerted by blood against the blood vessel walls when the heart contracts and pumps blood out) below 110 millimeters of mercury (mmHg a unit of pressure). During a review of Resident 27's care plan titled Cardiac/ Circulatory, dated 11/11/2022, the care plan intervention indicated to give medications as ordered. During record review and interview on 2/20/2025 at 3:15 p.m., with the Director of staff Development (DSD), the DSD viewed the Medication Administration Record (MAR) and stated the hydralazine hydrochloride 50 mg was given on 1/26/2025 at 10 p.m. Resident 27's blood pressure was 106/64, and hydralazine hydrochloride 50 mg was given and on 2/7/2025 at 2 p.m. Resident's blood pressure was 105/63. The DSD stated the order was not followed, the medication should have been held, and not administered, the resident received the blood pressure medication even though his blood pressure as below the levels set by the physican's order which can make the blood pressure drop lower. During an interview on 2/20/2025 at 4:26 p.m., with the Director of Nursing (DON) the DON stated medications should be administered as ordered. The DON stated not following the blood pressure parameters can cause hypotension to the residents. During a review of the facility's P&P titled, Medication Administration - General Guidelines, effective 10/2017, the P&P indicated, medications are administered as prescribed in accordance with good nursing principles and practices.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 28851 Based on observation, interview, and record review, the facility failed to: 1. Ensure active medications for current residents would not be stored in a cabinet labeled for discontinued medicines. 2. Ensure multiple dosed medication container had an open date and outdated medications would not be stored in the medication cart. These deficient practices had the potentials of medication errors, delay in receiving medications, and/or receiving outdated medications. Findings: 1. During an observation on 2/19/25 at 2:59 PM in the medication room located in the nursing station 1 with a licensed vocational nurse (LVN 3), there was a cabinet above the sink and labeled discontinued medicines. Inside the aforementioned cabinet, LVN 3 confirmed there were 17 multiple-dose blister pill packs (bubble packs) in the middle shelf. LVN stated these bubble packs were refill medications appeared to have been delivered within the last week. LVN stated newly delivered medications would be stored in the medication carts. LVN 3 stated this cabinet is for the storage of discontinued or discharged medications. There was no cabinet or space labeled for the storage of active medications. During an interview on 2/19/25 at 3:15 PM, LVN 3 stated the aforementioned 17 bubble packs were active medications for 8 residents currently residing in the Station 2 of the facility. During an interview on 2/19/25 at 3:23 PM LVN 2 at the nursing station 2 confirmed the aforementioned 17 bubble packs were refills for current residents and proceeded to store them in the medication cart. During an interview on 2/19/25 at 3:57 PM, the director of nursing (DON) stated the pharmacy usually delivered medications to the corresponding stations, and nurses would put the medications in the corresponding medication carts. During a review of the facility's policy and procedures, Pharmacy Delivery (dated 4/2008), indicated . the courier delivers the medication directly to a licensed nurse . A licensed nurse receives medications delivered to the facility . immediately delivers the medications to the appropriate secure storage area . assures medication are incorporated into the resident's specific allocation prior to the next medication pass . (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During an observation at the medication cart 1 on 2/19/25 at 3:32 PM a licensed vocational nurse (LVN 3) opened the bottom drawer, and there were two boxes of ipratropium bromide/albuterol sulfate inhalation solutions (medications to treat certain lung conditions) with foil pouches opened and there were 3 vials inside the box and outside of the opened pouch. LVN 3 examined the boxes and stated 1 of 2 boxes (for Resident 57) did not have an open date written and the pharmacy label indicated it was dispensed on 1/15/25 as needed for shortness of breath or wheezing; LVN 3 stated the other box (labeled for Resident 5) had an open date of 1/23/25 and the label indicated the dispense date was 1/17/25). LVN 3 reviewed the instruction on the box and stated the medications should be used within 2 weeks of opening. LVN 3 could not confirm box A was opened within the past 2 weeks due to the lack of the open date. LVN 3 confirmed box B was opened more than 2 weeks ago. During a review of the facility's policy and procedures, Storage of Medications (dated 4/2008), indicated Medications . are stored safely, securely, and properly, following manufacturer's recommendations . Outdated, . medications, . are immediately removed from stock, disposed of .

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055 Based on interview and record review the facility failed to ensure one of two sampled resident's (Resident 37) lab test was completed timely. This deficient practice resulted in a delay of care that had the potential to result in a continued undiagnosed problem that may be harmful for Resident 37. Findings: During a review of Resident 37's Admission Record, the admission record indicated Resident 37 was admitted to the facility on [DATE] with diagnosis including acute respiratory failure (when the air sacs of the lungs cannot release enough oxygen into the blood), type 2 diabetes (long-term condition in which the body has trouble controlling blood sugar and using it for energy), hypertension (condition in which the force of the blood against the artery walls is too high), and dementia (a progressive state of decline in mental abilities). During a review of Resident 37's Minimum Data Set ([MDS] a resident assessment tool) dated 11/8/2024, the MDS indicated Resident 37's cognition (ability to think and reason) was moderately impaired. The MDS indicated Resident 37 was dependent on staff for all activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 37's Order, dated 2/1/2025, the order indicated to complete the following laboratory tests: basic metabolic profile (measures eight different substances in your blood), prealbumin (protein made in the liver), Glycohemoglobin (Hb A1C - blood test that measures the average blood glucose [sugar] level over the past 2-3 months), complete blood count (blood test that measures the number and types of various cells in the blood), and thyroid stimulating hormone (blood test that measures this hormone produced in the brain). During a review of Resident 37's Lab Results Report, the report indicated the lab draw was completed on 2/18/2025 with results reported the same day. The lab report, page 4, signature line for the reviewer's name, signature, and date was blank indicating not completed. During an interview and record review on 2/18/2025 at 4:26 p.m. with the MDS Coordinator (MDSN) 2, Resident 37's medical records was reviewed. The MDSN 2 stated the order for lab tests were given on 2/1/2025 but it was drawn 2/18/2025, seventeen days later. The MDSN 2 stated the tests should have been drawn sooner. During an interview on 2/20/2025 at 4:26 p.m. with the Director of Nursing (DON), the DON stated lab orders need to be completed as ordered and results relayed to the ordering physician as soon as possible. (continued on next page)

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F 0770 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 Laboratory and Radiology Documentation, Revised 8/2016, the P&P indicated it was the policy of the facility that laboratory and radiology reports shall be performed as prescribed by the physician and shall be filed in the resident' s medical record. The abnormal laboratory results are to be called into the physician promptly by the licensed nurse.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. 50387 Based on observation, interview, and record review, the facility failed to ensure Jello items were stored and maintained at the required temperature of 41-degree Fahrenheit (a temperature scale, range for cold food is below 41 degrees). This failure had the potential to result in food spoilage, compromised taste for residents as proper temperature control is essential to ensure food safety and quality. Findings: During an observation on 2/18/2025 at 11:35 a.m., in the kitchen, observed that the Dietary Supervisor (DS) pulled out one cup of Jello from the refrigerator and checked its temperature, which measured 54 degrees. During an observation on 2/18/2025 at 11:48 a.m., in the kitchen, observed that the DS checked temperature of another Jello, which measured 48 degrees. During an observation on 2/18/2025 at 12:22 p.m. in the kitchen, observed that Dining cart #1, #2 were being transported from the kitchen with the Jello items. Before cart #3 left the kitchen, the DS checked temperature of Jello again, and the thermometer indicated at 48 degrees. During an interview on 2/19/2025, the DS stated that the Jello item on the lunch menu should be kept at 41 degrees or lower. The DS also stated that if not stored properly, the Jello could spoil which would also impact its taste. During a review of the facility's policy and procedure titled, Meal Service, dated 2023, the P&P indicated, cold food items will be placed on the trays as close to serving time as possible to assure the temperature is below 41degrees.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50387 Based on observation, interview, and record review, the facility failed to: a. Label food items properly. -One opened bottle of 'Thick and Easy' (thickener-a substance which can increase the viscosity of a liquid without substantially changing its other properties) -Two cups of chicken noodle soup -One bag of Seven Zucchinis -Two bunches of Celery -Four lettuces and the Five tomatoes in one container -One bag of cookie dough b. Remove expired items. -Diabetisource AC (a tube feeding formula) -Two bags of bread c. Test and document the concentration of the sanitizing solution and dish machine prior to use. These failures had the potential to result in contamination, or improper sanitation, compromising resident safety, infection control and food borne illness. Findings: a. During a concurrent observation and interview on [DATE] at 8:12 a.m., with the Dietary Supervisor (DS), in the kitchen, the following items were found without proper labeling or date marking in the refrigerator and freezer: -One opened bottle of 'Thick and Easy' (thickener-a substance which can increase the viscosity of a liquid without substantially changing its other properties) labeled [NAME] [DATE] but missing an open date. The DS stated that [NAME] means Delivered date, the Thick and Easy is safe for use up to 7 days after opening, but he could not tell when it was opened. -Two cups of chicken noodle soup, without labels or dates. The DS stated that there was no date marked, and he could not confirm when it was prepared. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-One bag of Seven Zucchinis, without a label or date. The DS stated that he could not confirm the delivery date. --Two bunches of Celery, without a label or date. The DS sated that he could not confirm the delivery date. -Four lettuces and the Five tomatoes in one container, labeled as onions with a date [DATE]. The DS stated that staff did not update the old label when they put lettuce and tomato in the container. -One bag of brown pieces without a label or date, The DS stated that these were cookie doughs, and confirmed there was no label or date marked. b. During a concurrent observation and interview on [DATE] at 8:12 a.m., with the DS, in the kitchen, observed following expired items. -Diabetisource AC (a tube feeding formula) with expiration date of [DATE] in refrigerator 2, the DS stated that it was not supposed to be there. -Two bags of bread on a shelf were labeled [DATE] without any indication of what the date represented. The DS stated that the date may indicate a delivery date, but there was no label confirming this. The DS also stated the bread should be used in one week or stored in the freezer if it kept longer. c. During an observation on [DATE] at 9:20 a.m., in the kitchen, there was a red sanitary backet used during morning tasks remined in a sink. Dietary Aid (DA)1 tested the sanitizing solution using a Hydron test strip (a type of test strip used to measure the concentration of hydrogen peroxide in a solution), which was expired on [DATE]. During a review of Dish machine temperature and sanitizing agent log, dated [DATE], the log indicated, kitchen staff did not test and document the temperatures prior to use of the dish machine. During a review of Quat Sanitizer Spray Bottles/ buckets log, dated [DATE], the log indicated, staff did not test the sanitizing solution prior to use. During an interview on [DATE] at 3:15 p.m. with the Director of Nursing (DON), the DON stated that stated these practices could lead to a foodborne illness, adverse effect for residents like infection control issues, nausea, vomiting, abdominal pain, or GI problem (a problem with your digestive system). During an interview on [DATE] at 4:00 p.m. with the DS, the DS stated that the staff should test the dishwasher and sanitizing solution bucket prior to use them and temperature should be recorded. The DS stated that failure to do so could lead to contamination. (continued on next page)

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F 0812 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, Labeling and dating of foods, dated 2023, the P&P indicated, Food delivered to facility needs to be marked with a received date, note that the delivery sticker is dated, and it can serve as the delivery date for the product. The P&P indicated, newly opened food items will be to be labeled with an open date and used by the date, all prepared foods need to be covered, labeled, and dated. The P&P also indicated, produce is to be dated with received date, leftovers will be covered, labeled, and dated. During a review of the facility's P&P titled, Dietary-Labeling and Dating Foods, dated ,d+[DATE], The P&P indicated, refrigerated foods will be covered, clearly labeled without using abbreviations, and dated. During a review of the facility's P&P titled, Storage of Food and Supplies, dated 2023, the P&P indicated, Bread products not used within 5 days can be frozen, some breads do last ,d+[DATE]days. During a review of the facility's P&P titled, Dishwashing, dated 2023, the P&P indicated, a temperature log (and chlorine log for low-temperature machines) will be kept and maintained by the dishwashers to assure that the dish machine is working correctly. This log will be completed each meal prior to any dishwashing. During a review of the facility's P&P titled, Quaternary ammonium log policy dated 2023, the P&P indicated, the replacement solution will be tested prior to usage.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 45777 Based on interview, and record review, the licensed nursing staff failed to maintain and complete accurate medical records in accordance with accepted professional standards for one of three sampled residents (Resident 27) by failing to: 1.Ensure Resident 27's Dialysis (mechanical removal of waste from the body due to kidney failure) Communication Record DCR (a medical document about a patient's dialysis treatment) was completed. 2. Ensure Licensed Vocational Nurse (LVN) 8, did not falsify Resident 27's Dialysis Communication Record for dates 1/23/2025, 1/28/2025, 2/4/2025 and 2/11/2025 when he (LVN 8) documented about Resident 8 even though he (LVN 8) was not working on those days. This deficient practice of falsifying Resident 27's Dialysis Communication Record indicated an inaccurate state of the resident's condition, and placed Resident 27 at risk of not receiving appropriate care due to inaccurate and incomplete resident medical care information. Findings: During a review of Resident 27's Admission Record, the Admission Record indicated Resident 27 was admitted to the facility on [DATE] with diagnoses including end stage renal disease (kidney's inability to filter waste from the body), hypertension (high blood pressure) and cardiomegaly (enlarged heart). During a review of Resident 27's Minimum Data Set (MDS), a resident assessment tool, dated 1/18/2025, the MDS indicated Resident 27's cognition (ability to make decisions of daily living) was intact. The MDS indicated Resident 27 required substantial/maximal assistance (Helper lifts or holds trunk or limbs but provides less than half the effort) with toilet, upper body dressing and substantial/maximal assistance - Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort with lying to sitting on side of bed, lower body dressing, putting on/taking off footwear. During a concurrent interview and record review on 2/20/2025 at 3:15 p.m. with the Director of Staff Development (DSD), Resident 27's Dialysis Communication Records dated 1/23/2025, 1/28/2025, 2/4/2025, and 2/11/2025 were reviewed. The DSD stated the post dialysis (documentation of the assessment of the resident's basic health information after finishing dialysis) documentation on 1/23/2025, 1/28/2025, 2/4/2025, and 2/11/2025 were blank and not done. The DSD stated if the documentation is blank then the assessment was not done. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 2/20/2025 at 4:06 p.m. with LVN 8, the DCR documents dated 1/23/2025, 1/28/2025, 2/4/2025, and 2/19/2025, were reviewed. The DCR documents dated 1/23/2025, 1/28/2025, 2/4/2025 and 2/19/2025 contained documentation of Resident 27's post dialysis assessments. LVN 8, stated on 2/20/2025 he completed the documentation and signed the DCR documents for the past dates of dates of1/28/2025 and 1/23/2025, 2/4/2025 and 2/19/2025. LVN 8 stated the DCR form was empty, and he charted on it. LVN 8 stated he did not work on 2/4/2025 and 1/23/2025, he stated he wanted to make sure the documents were all filled in and signed. LVN 8 stated he knew it looked wrong, and it as falsifying records. LVN 8 stated the post dialysis assessments of Resident 27 should be documented on the date the assessment was completed. During an interview on 2/20/2025 at 4:29 p.m.,with the Director of Nursing (DON) , the DON stated when licensed staff completed post dialysis documentation, but staff documented late, staff must indicate they are charting late and that is a 'late entry'. The DON stated charting must be accurate and done on the day of assessment. The DON stated this is the standard of practice. During a review of the facility's policy and procedure (P&P) titled Dialysis Care, dated 9/2020 the P&P indicated, the post dialysis check list part of this form is to be completed by the facility upon return of the resident. Information to be documented includes: a. Vital signs (assessment of the boy's basic functions) b. Information regarding the type of access site (device implanted in the patient's body to allow for dialysis) and condition of the dressing and access site. c. Skin condition d. Any additional instructions from the dialysis unit. e. Any additional comments or signatures of the Licensed nurse, date and time. During a review of the facility's P&P titled Documentation Principles, dated 1 /2014 the P&P indicated, The following principles shall be used for documenting: Never sign an entry for someone else. Entries must be: Accurate Timely- recorded within the required time period Late entry- include the date/time of the correct entry, the date / shift or time the entry should have been made and proceed with the data entry.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 44055 Based on interview and record review the facility's Quality Assessment and Assurance (QAA) Committee, thereby affecting 47 out of 47 residents, failed to identify and implement corrective action to the systemic problems identified: a. Ensure medication parameters are followed when administering medication to residents b. Ensure dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) residents are assessed before departing for dialysis and after residents return from outpatient dialysis. c. Ensure the kitchen store, prepare and distribute food in accordance with professional standards for food service safety. These deficient practices placed the residents at risk for not receiving the quality treatment necessary to adequately meet their highest practicable well-being. Findings: During an interview on 2/21/2025 at 9:26 a.m., with the Administrator (ADM), the ADM stated the following systemic issues identified were not identified by the QAA committee: a) ensure medication parameters are followed wen medicating residents b) ensure dialysis residents are assessed before departing for dialysis and after residents return from outpatient dialysis. c) ensure the kitchen store, prepare and distribute food in accordance with professional standards for food service safety. During a record review of the facility's policy and procedure (P&P) titled, Quality assurance performance Improvement Plan and Committee, revised 12/2024, the P&P indicated the QAA committee will identify and address specific care and quality issues and implement actions plan to resolve these issues. Cross Reference F760, F698, F812

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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** 45777 Based on observation, interview, and record review, the facility failed to: a. Ensure Resident 7's, foley catheter (a thin, flexible tube inserted into the bladder [an organ that stores urine] to drain urine) was not touching the floor. b.Ensure facility staff used the correct Personal Protective Equipment (PPE: equipment worn (gown, gloves, goggles) to help create a barrier between a healthcare worker and germs) when caring for one of two sampled residents (Resident 15) that was on Enhanced Barrier Precautions (EBP: infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs)) and not performing hand hygiene prior to entering room. c. Ensure the facility staff had access to PPE d. Conduct annual Legionella (a severe form of lung infection that causes lung inflammation caused by bacteria) facility risk assessment. These deficient practices had the potential to transmit infectious microorganisms and increase the risk of infections for the residents. During a review of Resident 7's Admission Record, the Admission Record indicated Resident 7 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including primary hypertension (high blood pressure) retention of urine, unspecified (when person is unable to completely empty the bladder) and difficulty in walking, not elsewhere classified. During a review of Resident 7's History and Physical (H&P), dated 12/11/2025, the H&P indicated, Resident 7 had the capacity to make decisions. During a review of Resident 7's Minimum Data Set (MDS- a resident screening tool) dated 1/29/2025, the MDS indicated, Resident 7 required partial/moderate assistance - helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort with lower body dressing, putting on/taking off footwear, shower/bathe self and Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity upper body dressing and sit to stand. During a review of Resident 7's Order Summary Report (OSR) dated 1/1/2025 , the OSR indicated foley catheter French 20 (size of the catheter / 10 cc (balloon that can be inflated with 10 milliliters of water to secure it within the bladder). During a record review of Resident 7's undated Care Plan titled Foley Catheter, the Care Plan indicated to place all tubing without touching the floor. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Bellflower Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 9710 E. Artesia Ave Bellflower, CA 90706	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an initial observation and interview on 2/18/2025 at 11:55 a.m., in the activity room. Resident 7 was observed sitting in his wheelchair alert and oriented the foley catheter tubing was hanging from Resident 7's right pant leg the catheter bag was attached to the back of his wheelchair and the tubing was lying on the floor. Licensed Vocational Nurse 4 (LVN 4) observed the catheter was on the floor and stated it is nurses' responsibility to make sure the foley catheter is off the floor before taking the resident from his room, LVN 4 stated that dragging the foley catheter tubing on the floor can cause the tubing to break and spill urine on the floor this can cause the spread of infection to the residents. During an interview on 2/18/2025 at 11:55 a.m., with LVN 2, LVN 2 indicated Certified Nurse Assistants (CNA), Licensed Vocational Nurses (LVN) and Treatment Nurses (TN) are responsible for making sure the foley catheter bag is below the bladder and make sure the tubing is not resting on the floor. LVN 2 stated this is an infection control issue, and one can spread germs causing the resident to get an infection. During an interview on 2/20/2025 at 4:29 p.m., with the Director of Nursing (DON) , the DON stated when working with foley catheter tubing's staff need to make sure they are hanging the drainage bag below the bladder, ensure there are no kinks in the tubing and do not place it on floor because there is a risk for infection . b/cDuring a review of Resident 15's Admission Record, the Admission Record indicated Resident 15 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including gastrostomy (g-tube: a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), dysphagia (difficulty swallowing), and Huntington's Disease (a progressive inherited neurodegenerative disorder that affects the brain). During a review of Resident 15's H&P dated 6/22/2024, the H&P indicated Resident 15 did not have the capacity to understand and make decisions. During a review of Resident 15's MDS dated [DATE], the MDS indicated Resident 15's cognitive skills were severely impaired. The MDS indicated Resident 15 was dependent on all aspects of activities of daily living (ADL: bathing, chair/bed-to-chair transfer, personal hygiene, toileting hygiene, oral hygiene). During a concurrent observation and interview on 2/20/2025 at 9:52 a.m. with LVN 3, LVN 3 did not perform hand hygiene prior to entering Resident 15's room,LVN 3 put on gloves, and went to Resident 15's bed. Resident 15's g-tube feeding was running. Resident 15 had an abdominal binder (devide that wraps around the abdomen). LVN 3 stated Resident 15 was on EBP due to having a g-tube. LVN 3 stated she wore a gown when she passed medications, provided ADL's, and for residents that have a g-tube, a foley catheter, or open wounds. LVN 3 stated she should have been wearing a gown when observing Resident 15's g-tube. LVN 3 stated not wearing PPE exposes staff to more bacteria. LVN 3 stated the PPE was not easily accessable because they were not placed outside rooms that have reesidents on EBP. LVN 3 stated the gowns are at the front of Nursing Station 1 in the linen cart. LVN 3 stated she should perform hand hygiene when she gives eye drops, medications, when changing gloves, and before and after patient care. LVN 3 stated the purpose of hand hygiene is for infection control. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/20/2025 at 3:19p.m., with the Director of Staff Development (DSD), the DSD stated gowns are kept in the front of Nursing Station 1, in the middle of the hallway, and at the back where Nursing Station 2 is located. The DSD stated gowns are worn when they provide direct patient care, but when answering the call light or talking to the resident, gowns are not necessary. The DSD stated if one is observing a g-tube or a resident has a foley, a gown should be worn to protect the resident and staff. as it is an additional. The DSD stated hand hygiene is performed before entering and after exiting the residents' room and prior to wearing gloves to prevent spread of infection. During an interview on 2/20/2025 at 4:46 p.m., with the Director of Nursing (DON), the DON stated hand hygiene is important and not performing hand hygiene will give residents an infection as hands touch many things and can cause cross contamination. The DON stated if a resident has a g-tube, Staff are supposed to wear a gown as part of the infection control precautions. The DON stated PPE should be easily accessible as it promotes compliance with infection control when the PPE is stored close to the rooms, if that resident is on infection control precaustions such as EBP. d. During a concurrent interview and record review of the water management program on 2/19/2025 at 3:39 p.m., with the Administrator (ADM), the ADM stated they do not have the facility's Legionella Risk Assessment for 2024. During an interview on 2/20/2025 at 4:45 p.m. with the DON, the DON stated Legionella prevention is important since the facility population are elderly and have lowered resistance to infections and can increase their risk for infection. The DON stated if the policy indicated to do a Legionella Risk Assessment, the policy should be followed. During a review of the facility's policies and Procedures (P&P), titled Indwelling Catheter Care revised 3/2021, the P&P indicated the catheter tubing must remain patent, with the drainage bag kept below the level of the bladder to maintain unobstructed urine flow and prevent pooling and back flow of the urine into the bladder. The drainage bag should be kept off the floor. The drainage bag should be placed in a privacy dignity bag. During a review of the facility's P&P, titled Enhanced Standard Precautions, revised 5/2024, the P&P indicated standard precautions will be used in care of all residents regardless of their diagnoses or suspected or confirmed infection status. Standard precautions presume that all blood, body fluids, secretions, and excretions (except sweat), non-intact skin and mucous membranes may contain transmissible infectious agents. Wear a gown (clean, non-sterile) to protect skin and prevent soiling of clothing during procedures and resident care activities that are likely to generate splashes or sprays of blood, body fluids, secretions, or excretions or cause soiling of clothing. Wera a gown that is appropriate to the task you are performing. During a review of the facility's policies and Procedures (P&P), titled Hand Hygiene, revised 7/2019, the P&P indicated it is the policy of the facility that all staff members perform hand hygiene before and after direct resident care and after contact with potentially contaminated substances to prevent, to the extent possible, the spread of infection. Hand hygiene will be performed by staff as follows: before touching a resident; if gloves will be worn, before gloving. (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 P&P, titled Policy for Legionnaire's Disease (Legionella Pneumophila), revised 6/2017, the P&P indicated the facility will complete a Legionella Risk Assessment to determining their risk for Legionella outbreaks. This assessment will be completed annually. 46415

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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** 44055 Based on observation, interview, and record review, the facility failed to offer and monitor the immunization (a process whereby a person is made resistant to a disease through medication administration) status for the Influenza (flu: a contagious respiratory illness) and Pneumococcal (bacterial infection that causes serious lung infections) vaccinations (medication to prevent a particular disease) for one of five sampled residents (Resident 9). This deficient practice resulted in Resident 9's medical records being incomplete. Findings: During a review of Resident 9's Admission Record, the Admission Record indicated Resident 9 was admitted to the facility on [DATE] with diagnoses including gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), cerebral palsy (group of disorders that affect muscle tone and movement), and asthma (chronic lung disease that causes inflammation in the airway). During a review of Resident 9's History and Physical (H&P), dated 6/22/2024, the H&P indicated Resident 9 does not have the capacity to understand and make decisions. During a review of Resident 9's Minimum Data Set [MDS] a resident assessment tool), dated 12/23/2024, the MDS indicated Resident 9 's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills were moderately impaired. The MDS indicated Resident 9 was 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 9 had impairments on both of the upper (arms/shoulders) extremities. During a review of the Immunization History Report dated 2/19/2025, the immunization history report indicated Resident 9 had no record of having received the flu or the pneumococcal vaccines (PCV). During an interview on 2/19/2025 at 4:11p.m., with the Infection Preventionist Nurse (IPN), the IPN stated the PCV are offered within seven (7) days of admission and verifying records by speaking to the family, or by looking at the California Immunization Registry (CAIR: web-based database that stores immunization records of children and adults) to check the immunization status for the resident. The IPN stated her PCV spreadsheet for the residents was not up to date and has residents that have already been discharged . The IPN stated if the PCV is offered they would document it, and if the resident declined the PCV, they would offer it again within 90 days. During a concurrent interview and record review on 2/19/2025 at 4:33 p.m. with the IPN, the spreadsheet (influenza vaccination tracker) undated was reviewed. The IPN stated Resident 9 is not listed on her spreadsheet (vaccine) that lists the PCV statuses of the residents. The IPN stated she would have offered the vaccines at admission and indicated vaccinations are important as the residents are vulnerable, and it is to protect the residents. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/20/2025 at 4:48p.m. with Director of Nursing (DON), the DON stated residents have to have updated immunizations and records as they are at higher risk for infection. The DON stated the PCV vaccine is offered upon admission, and if the resident has not received the PCV vaccine, they have to try and offer the vaccine. During a review of the facility's policies and Procedures (P&P), titled Pneumonia Vaccine for Residents, revised 1/2024, the P&P indicated it is the policy of the facility to offer residents pneumonia vaccine in accordance with the latest U.S. Department of Health and Human Services, Centers for Disease Control and Prevention recommendations (CDC). On admission, all residents will be evaluated for pneumococcal vaccination status. Before offering the pneumococcal immunization, each resident of their responsible party will receive education regarding the benefits and potential side effects of immunization. Each resident will be offered a pneumococcal immunization, unless the immunization is medically contraindicated, or the resident has already been immunized. The resident's clinical record should include documentation that the resident or their responsible party was provided education regarding the benefits and potential side effects of pneumococcal immunization; and that the resident either received the immunization or did not receive the immunization due to medical contraindications or refusal. The pneumonia vaccination status of the resident will be determined, and vaccines will be offered as recommended by the U.S. Department of Health and Human Services, Centers for Disease Control and Prevention recommendations (CDC). During a review of the facility's P&P, titled Flu (Influenza) Vaccination for Residents, revised 1/2024, the P&P indicated it is the policy of the facility to offer residents flu (influenza) vaccine yearly, in accordance with the newest recommendations. On admission, all residents will be evaluated for flu (influenza) vaccination needs. The flu (influenza) vaccination status of the resident will be determined, and vaccines will be offered as follows: the resident's clinical record should include documentation that indicates that the resident or their representative was provided education regarding the benefits and potential side effects of the immunization and that the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications, refusal or had received it prior to admission. 46415

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 all employees screening, education, offering, and current Corona virus disease, COVID-19 (contagious infectious disease), vaccination (medications used to prevent diseases usually given by injection or by mouth) status. This failure had the potential to place staff and residents at risk for negative health outcomes such as being hospitalized due to COVID-19. Findings: During a concurrent interview and record review of the Covid-19 Staff Vaccination Status (document that reflects staff employee vaccination status) on 2/19/2025 at 4:36 p.m., with the Infection Prevention Nurse (IPN), the IPN stated she does not know the facility physicians and consultants Covid-19 immunization status. During an interview on 2/20/2025 at 4:42 p.m., with the Director of Nursing (DON), the DON stated the Covid-19 vaccination status for all employees including doctors, rehabilitation departments, and consultants that come in contact with residents must be known as they put the residents they are incontact with at risk for contracting infections. During a review of the facility's policy and procedure (P&P) titled, Coronavirus Vaccine Policy (COVID-19 Vaccine Policy), dated 2/2025, the P&P indicated staff: for the purposes of this policy, staff refers to any individual that works or volunteers in the facility at least once a week. This includes individuals under contract or arrangement (e.g., medical directors, hospice and dialysis staff, therapists, mental health professionals, or volunteers). The facility will maintain documentation for all residents and staffs on Covid-19 vaccination status.

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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** 44055 Based on observation, interview, and record review, the facility failed to ensure 20 of 29 resident rooms (Rooms 1 to 7, 11 to 14, 19, 23-29) met the requirements of 80 square feet for each resident in multiple resident bedrooms. The 20 rooms consisted of two beds in each bedroom. This deficient practice had the potential to limit space to provide nursing care, and limit privacy for residents. Findings: During a review of the facility's Client Accommodations Analysis form, submitted 2/18/2025, the form indicated the following resident rooms measured: room [ROOM NUMBER] (2 beds) 155.76 total, 77.88 square footage per resident room [ROOM NUMBER] (2 beds) 153.4 total, 76.8 square footage per resident room [ROOM NUMBER] (2 beds) 146.72 total, 73.36 square footage per resident room [ROOM NUMBER] (2 beds) 148.7 total, 74.4 square footage per resident room [ROOM NUMBER] (2 beds) 158.12 total, 79.0 square footage per resident room [ROOM NUMBER] (2 beds) 138.32 total, 69.16 square footage per resident room [ROOM NUMBER] (2 beds) 150.3 total, 75.2 square footage per resident room [ROOM NUMBER] (2 beds) 150.3 total, 75.2 square footage per resident room [ROOM NUMBER] (2 beds) 143.2 total, 71.6 square footage per resident room [ROOM NUMBER] (2 beds) 158.12 total, 79.0 square footage per resident room [ROOM NUMBER] (2 beds) 158.12 total, 79.0 square footage per resident room [ROOM NUMBER] (2 beds) 149.16 total, 74.8 square footage per resident room [ROOM NUMBER] (2 beds) 158.6 total, 79.3 square footage per resident room [ROOM NUMBER] (2 beds) 151.42 total, 75.71 square footage per resident room [ROOM NUMBER] (2 beds) 152.92 total, 76.46 square footage per resident (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	room [ROOM NUMBER] (2 beds) 148.74 total, 74.37 square footage per resident room [ROOM NUMBER] (2 beds) 159.1 total, 79.6 square footage per resident room [ROOM NUMBER] (2 beds) 141.9 total, 70.8 square footage per resident room [ROOM NUMBER] (2 beds) 150.29 total, 75.15 square footage per resident room [ROOM NUMBER] (2 beds) 146.52 total, 73.26 square footage per resident The request indicated the rooms fall short of the minimum requirements, but the needs of the residents were fully accommodated. The request indicated the residents were able to move about freely, the toilets and closet space are easily accessible, and the facility was adequately equipped environmentally for comfort and privacy of residents. The request indicated there was adequate space for nursing care and residents can be quickly and safely evacuated in the event of an emergency. During observation from 2/18/2025 to 2/20/2025 of the facility and the residents' rooms, the residents in the facility did not have difficulty going in and out of their rooms. Each resident in the affected room had beds and side drawers and were satisfied with the room size. There was adequate room for the operation and use of wheelchairs and walkers. The nursing staff had full access to provide treatment, administer medications, and assist residents. During the Resident Council meeting on 2/19/2025 at 2 p.m., there were no concerns brought up regarding room size. During an interview with the administrator (ADM) on 2/19/2024 at 3:15 p.m., the ADM stated some of the rooms are smaller than required but no residents have complained about the room size and the staff were able to provide adequate care to the residents.