STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055518	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Newport Nursing and Rehabilitation Center	1555 Superior Avenue Newport Beach, CA 92663

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882 Based on interview, medical record review, and facility P&P review, the facility failed to ensure LVN 1 informed the physician of a change in condition for one of three sampled residents (Resident 598) reviewed for falls. This failure had the potential for Resident 598 to have a delay in care and treatment. Findings: Review of the facility's P&P titled Neurological Assessment (Routine) revised 10/2023 showed a routine neurological assessment is conducted to evaluate the resident for small changes over time that may be indicative of neurological injury. Routine neurological exams include assessing the mental status and level of consciousness, pupillary response, motor strength, sensation, and gait. Under the section Pupillary Response, showed to test both the pupils to ensure they are equally round and reactive to light and accommodation. Under the section Reporting, showed to notify the physician of any change in a resident's neurological status and report other information in accordance with facility policy and professional standards of practice. Review of the facility's P&P titled Change in a Resident's Condition or Status revised 2/2021 showed the facility promptly notifies the resident, his or her attending physician, and the resident representative of changed in the resident's medical/mental condition and/or status. The nurse would notify the resident's attending physician or physician on call when there has been a (an): accident or incident involving the resident, discovery of injuries of an unknown source, adverse reaction to medication, significant changes in the resident's physical/ emotional/mental condition, need to alter the resident's medical treatment significantly Medical record review for Resident 598 was initiated on 12/2/24. Resident 598 was admitted to the facility on [DATE]. Review of Resident 598's MDS assessment dated [DATE], showed Resident 598 had severely impaired cognition. Review of Resident 598's plan of care showed a care plan problem initiated on 11/30/24, addressing Resident 598's unwitnessed fall on 11/30/24. The interventions showed to initiate the neurological checks via neurological evaluations for 72 hours: every 15 minutes x 4 (four times), every 30 minutes x 4, every one hour x 4, and every eight hours x 8. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 598's Neurological/Vital Sign Check- V 4 on 11/30/24 at 1400 hours, showed the nurse documented Resident 598's right and left pupils were equal. Review of Resident 598's Neurological/Vital Sign Check- V 4 on 11/30/24 at 1600 hours, showed the nurse documented Resident 598's right and left pupils were equal. Review of Resident 598's Neurological/Vital Sign Check- V 4 on 12/1/24 at 0600 hours, showed the nurse documented Resident 598's right and left pupils were equal. Review of Resident 598's Neurological/Vital Sign Check- V 4 on 12/1/24 at 1100 hours, showed the nurse documented Resident 598's right pupil was non-reactive and left pupil was equal and sluggish. Review of Resident 598's Progress Notes failed to show documentation the physician was notified of the change in Resident 598's pupillary responses for the neurological check on 12/1/24 at 1100 hours. Further review of the notes showed a Change in Condition Note dated on 12/1/24 at 1436 hours, documenting Resident 598 had another fall and was found on the floor with a left forehead skin laceration. On 12/4/24 at 1617 hours, a concurrent interview and medical record review for Resident 598 was conducted with LVN 1. LVN 1 stated the neurological checks and assessments were conducted and should be compared with the previous neurological assessment to check for any neurological impairments or changes related to the resident's fall. LVN 1 further stated upon comparison of the neurological assessments, if there were any changes in the pupillary response, motor function, or level of consciousness, the physician would be informed. LVN 1 reviewed Resident 598's neurological checks and verified she completed the neurological check for Resident 598 on 12/1/24 at 1100 hours. LVN 1 verified there was a change in Resident 598's pupillary responses for the neurological check on 12/1/24 at 1100 hours, compared to the neurological check on 12/1/24 at 0600 hours. When asked, LVN 1 stated she did not compare Resident 598's neurological check with the previous neurological assessment and should have compared the assessments and notified the physician of the change in the assessment findings. On 12/5/24 at 1511 hours, a concurrent interview and medical record review for Resident 598 was conducted with the DON. The DON stated when conducting neuro check assessments on the residents, she expected the nurse to compare the results of the neurological check with the previous neurological check assessment to determine if there was a change in the resident's neurological status. If there was a change in the assessments, the DON stated she expected the nurse to notify the physician and document the physician had been informed. The DON was informed and acknowledged the above findings. On 12/15/24 at 1701 hours, the Administrator and the DON were informed and acknowledged the above findings.

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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 0583 Level of Harm - Potential for minimal harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37726 Based on observation, interview, and facility P&P review, the facility failed to ensure the resident's PHI was utilized in a confidential manner during the medication administration for one nonsampled resident (Resident 301). * Resident 301's PHI was displayed on a computer screen located in the hallway and left unattended by the staff member. This failure had the potential to violate the resident's right to personal health information privacy. Findings: Review of the facility's P&P titled Confidentiality of Information and Personal Privacy revised 10/2017 showed the facility will protect and safeguard resident confidentiality and personal privacy. The facility will safeguard the personal privacy and confidentiality of all the residents' personal and medical records. Access to the residents personal and medical records will be limited to authorized staff. Medical record review for Resident 301 was initiated on 12/2/24. Resident 301 was admitted to the facility on [DATE]. On 12/4/24 at 0821 hours, a medication administration observation for Resident 301 was conducted with LVN 4. LVN 4 prepared Resident 301's scheduled medications on top of the Medication Cart. The Medication Cart was observed in the hallway on the opposite side of Resident 301's room. A computer was observed attached to the Medication Cart. The computer screen displayed Resident 301's personal health information which included the resident's name, prescribed medications, and the medications' indication for use. After having prepared Resident 301's medications, LVN 4 then entered Resident 301's room and administered Resident 301's medications. However, LVN 4 failed to safeguard the computer screen which continued to display Resident 301's PHI (resident's name, prescribed medications, and the medications indication for use). The computer screen was observed facing the hallway where other residents were observed passing by the computer screen. LVN 4 verified the findings and stated Resident 301's medications and their indications for use were considered private health information. LVN 4 stated she should have ensured the computer screen did not continue to display Resident 301's private medical information when she was away from the medication cart.

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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** 37726 Based on observation, interview, and medical record review, the facility failed to ensure the comprehensive care plans were implemented for one of thirteen final sampled residents (Resident 298) and one nonsampled resident (Resident 301). * The facility failed to implement the bilateral floor mats in accordance with the Risk for Falls care plan for Resident 298. * The facility failed to administer Resident 301's Lidocaine 4% external patch for pain management in accordance with Resident 301's At Risk for Pain care plan. These failures placed the residents at risk of not being provided appropriate, consistent, and individualized care. Findings: 1. Medical record review for Resident 298 was initiated on 12/2/24. Resident 298 was admitted to the facility on [DATE]. Review of Resident 298's care plan titled At Risk for Falls initiated 11/30/24, showed Resident 298 was at risk for falls related to generalized weakness, and a history of CVA and TIA. The care plan approaches included the placement of floor pads (mats) next to Resident 298's bed, when Resident 298 was in his bed. On 12/2/24 at 0930 hours, during an observation, Resident 298 was observed lying in bed. Resident 298's bed was observed with a floor mat in place on one side of Resident 298's bed. The opposite side of Resident 298's bed was observed without a floor mat in place. On 12/2/24 at 1213 hours, a concurrent observation, interview, and medical record review was conducted with LVN 4. Resident 298 was observed lying in bed. Resident 298's bed was observed with a floor mat in place on one side of Resident 298's bed. The opposite side of Resident 298's bed was observed without a floor mat in place. LVN 4 verified the findings. LVN 4 stated in accordance with Resident 298's Risk for Falls care plan approaches, a fall mat should have been placed on both sides of Resident 298's bed. Cross reference to F689, example #2. 2. Medical record review for Resident 301 was initiated on 12/2/24. Resident 301 was admitted to the facility on [DATE]. Review of Resident 301's care plan titled At Risk for Pain initiated 11/20/24, showed Resident 301 was at risk for pain related to a history of peripheral vascular disease, osteoporosis, and generalized body pain. The care plan approaches included to administer analgesia medications as ordered by the physician. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/4/24 at 0821 hours, a medication administration observation for Resident 301 was conducted with LVN 4. LVN 4 prepared and administered Resident 301's medications. During the medication administration observation for Resident 301, LVN 4 was observed having applied one lidocaine 4% external patch to Resident 301's hip. However, Resident 301's order for the lidocaine 4% external patch showed to apply two patches one time a day at the same time to the right hip and right foot topically for pain management. LVN 4 verified she applied one lidocaine 4% external patch to Resident 301's hip. On 12/4/24 at 1108 hours, a concurrent interview and medical record review was conducted with LVN 4. LVN 4 verified she failed to administer Resident 301's lidocaine pain medication in accordance with Resident 301's At Risk for Pain care plan. Cross reference to F759, example #2.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the necessary care and services were provided to prevent the development of a new pressure ulcers and promote the healing of the existing pressure ulcers for two of two final sampled residents (Residents 598 and 599) reviewed for pressure ulcers. * The facility failed to ensure the LAL mattress setting was consistent with Resident 599's weight and failed to ensure the wound treatment was administered as per the physician's order for Resident 599. * The facility failed to ensure the LAL mattress setting was consistent with Resident 598's weight. These failures had the potential for Residents 598 and 599 to not benefit from the therapy provided by the LAL mattress, and potential for delayed wound healing or worsening of existing pressure ulcers for Resident 599. Findings: Review of the facility's P&P titled Pressure Ulcers/Skin Breakdown- Clinical Protocol revised 3/2014 showed the physician will authorize pertinent orders related to the wound treatments, including the wound cleansing and debridement approaches, dressings, and application of topical agents if indicated for type of skin alteration. Review of the facility's document titled Power Pro Elite Alternating Pressure with Low Air Loss Mattress system User Manual undated, showed the Power Pro Elite Mattress System is an alternating mattress replacement system used in the prevention and relief for (residents) with, or vulnerable to, pressure ulcers. The Power Pro Elite Mattress System offers (residents) a comfortable and relaxing support surface by using the established principles of alternating therapy, which can both prevent skin breakdown and enhance healing. The comfort level controls the air pressure output level. Press the firm button and the output pressure will increase and higher pressure output will support heavier weight (resident) . According to the weight of the (resident) adjust the pressure setting to the most suitable level without bottoming-out . Please consult with your physician for a proper setting. Further review of the user manual showed Table 1 Weight and Comfort Level Reference for the LAL mattress setting. For a 36-inch mattress, Light 1: 90 to 120 pounds, Light 2: 115 to 145 pounds Light 3: 120 to 175 pounds, Light 4: 145 to 200 pounds, (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Light 5: 175 to 230 pounds, Light 6: 200 to 265 pounds, Light 7: 230 to 300 pounds, and Light 8: 265 to 330 pounds. 1a. On 12/2/24 at 0840 hours, during the initial tour of the facility, Resident 599 was observed in bed, with a LAL mattress. Staff member was not observed in the room providing care to Resident 599. The LAL mattress unit was observed with the firmness level set at the 8th light bar (setting levels for firmness, level one: soft, and level 8: firm), and the static light on. A sticker titled Patient Weight Sticker was observed on the LAL mattress unit and showed for the 8th light bar, the weight indicated on the sticker was 300 to 330 pounds. When asked, Resident 599 stated she had a bedsore on her butt that had developed during her stay at the facility. When asked about the LAL mattress, Resident 599 stated the LAL mattress was supposed to help redistribute the air, but she did not felt the air being redistributed. When asked if the facility discussed the settings of the LAL mattress unit with her, Resident 599 stated the facility did not. Medical record review for Resident 599 was initiated on 12/2/24. Resident 599 was admitted to the facility on [DATE]. Review of Resident 599's MDS dated [DATE], showed Resident 599 was cognitively intact, and was totally dependent on the staff members assistance for bed mobility, to roll from left and right, and from sit to lying, and lying to sitting on the side of the bed. Further review of Resident 599's MDS, showed Resident 599 weighed 230 pounds, was at risk for developing the pressure ulcers/injuries, and Resident 599 did not have one or more unhealed pressure ulcers/injuries; however, the MDS showed Resident 599 had moisture-associated skin damage. Review of Resident 599's Order Summary Report dated 12/3/24, showed the following physician's orders: - dated 11/8/24, the resident was incapable of understanding the rights, responsibilities, and informed consent, - dated 11/20/24, to apply the LAL mattress for wound management, and - dated 11/23/24, for the Stage 2 pressure ulcer at the coccyx, to wash with soap and water, pat dry, apply Triad cream (a sterile, zinc oxide-based wound dressing cream that can be applied directly to broken skin or wounds) and cover with foam dressing, every day shift for 14 days. Review of Resident 599's plan of care showed the following care plan problems: - dated 11/8/24, addressing Resident 599's risk for skin impairment and further decline of skin integrity related to decreased mobility with high risk for friction, thin fragile skin, head of bed elevated most of the time. The interventions showed to apply the pressure reduction mattress to the bed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 11/23/24, addressing Resident 599's Stage 2 pressure ulcer on the coccyx. The interventions did not include the use of a LAL mattress. Further review of Resident 598's plan of care failed to show a care plan problem addressing the use of a LAL mattress or the specific LAL mattress setting specific to Resident 599. Review of Resident 599's TAR for November and December 2024 failed to show documentation the LAL mattress was monitored for functionality and appropriate setting for the resident. On 12/2/24 at 1013 hours, an interview was conducted with LVN 2. LVN 2 stated she was scheduled as the treatment nurse for the day. When asked, LVN 2 stated the treatment nurses and the Maintenance Department were responsible for the set up and initial settings on the LAL mattress when first applied. LVN 2 stated the treatment nurses were responsible for adjusting the level/settings on the LAL mattress unit and the CNAs do not adjust the settings on the LAL mattress unit. When asked about the settings on the LAL mattress unit, LVN 2 stated the settings on the LAL mattress unit would be based on the resident's weight and the setting selected after comparing the resident's weight to the Patient Weight Settings sticker located on the LAL mattress unit. LVN 2 stated the licensed nurses should check the LAL mattress unit every shift, to ensure the LAL mattress unit was on and the settings were correct. On 12/2/24 at 1030 hours, a concurrent observation, interview and medical record review for Resident 599 was conducted with LVN 2. LVN 2 reviewed Resident 599's medical record and stated on 11/25/24, Resident 599 weighed 222 pounds. Resident 599 was observed in bed, and staff was not observed in the room providing care to Resident 599. LVN 2 verified Resident 599's LAL mattress unit was set at the 8th light bar and the static setting was on. LVN 2 reviewed the Patient Weight Settings sticker located on Resident 599's LAL mattress unit and stated the current LAL mattress setting was not appropriate for Resident 599's weight. When asked, LVN 2 stated not having the appropriate LAL mattress setting for the resident would put the resident at risk of not receiving the full benefits of alternating pressure to the wound and may affect wound healing. When asked, LVN 2 stated the checking and monitoring of the appropriate settings on the LAL mattress unit should be done every shift and documented in the TAR. LVN 2 reviewed Resident 599's medical record and stated there was no documentation in Resident 599's medical record to indicate the appropriate LAL mattress setting for the resident and no documentation the LAL mattress settings were checked. On 12/3/24 at 0903 hours, Resident 599 was observed in bed with the LAL mattress unit set at the 5th light bar. On 12/3/24 at 1517 hours, an interview was conducted with LVN 3. LVN 3 stated initially the treatment nurses were responsible for setting the firmness level on the LAL mattress unit. LVN 3 further stated the firmness settings for the LAL mattress was based on the resident's weight and the treatment nurses are responsible for checking the LAL mattress unit daily. LVN 3 stated the CNAs and charge nurses did not touch the settings on the LAL mattress unit. LVN 3 was asked about the static setting on the LAL mattress. LVN 3 stated in static mode, the pressure of the mattress would be the same. LVN 3 further stated the pressure would be alternating and the LAL mattress should not be on static mode, and the static mode should only be used when transferring or changing the resident. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/4/24 at 1453 hours, an interview was conducted with CNA 6. CNA 6 stated Resident 599 had a pressure ulcer on her coccyx and was receiving daily wound treatment by the nurse. CNA 6 stated Resident 599 had a LAL mattress, however CNA 6 stated he did not know what the setting should be set at and he did not touch the settings on the LAL mattress unit. On 12/5/24 at 0906 hours, a concurrent interview and observation was conducted of Resident 599. Resident 599 was observed lying in bed, with the LAL mattress unit set at the 5th light. Resident 599 stated since the settings on the LAL mattress was changed a few days ago, she did feel air in the mattress being circulated more. Resident 599 was asked if the facility discussed the settings of the LAL mattress with her and what settings she was comfortable with, since the application of the LAL mattress. Resident 599 stated no. On 12/5/24 at 1511 hours, an interview was conducted with the DON. The DON stated the licensed nurses should monitor the LAL mattress unit every shift, monitoring for functionality of the unit, and for any leaking, or service lights. The DON stated the monitoring of the LAL mattress unit should be documented on the TAR. When asked about the appropriate settings on the LAL mattress, the DON stated the LAL mattress unit had a sticker to show what the firmness level should be set at, and the setting should be based on the residents' weight. When asked about the potential risk of the LAL mattress setting being set at a level not appropriate for the resident's weight, the DON stated there was the potential to affect the wound healing. When asked about the LAL mattress settings specific to each resident, the DON stated the LAL mattress was an intervention for the residents with pressure injuries, or at risk for developing the pressure injuries, however if the resident had a LAL mattress, then there should be an individualized care plan for the use of the LAL mattress for the resident. 1b. Review of Resident 599's TAR for the month of November and December 2024 showed the wound care order dated 11/24/24, for the Stage 2 pressure ulcer on the coccyx, to wash with soap and water, pat dry, apply Triad cream, and cover with foam dressing, every day shift for 14 days. Further review of Resident 599's TAR for November and December 2024 showed the above wound treatment was administered to Resident 599's Stage 2 pressure ulcer on the coccyx from 11/24/24-12/3/24, during the day shift. Review of Resident 599's plan of care showed a care plan problem dated 11/23/24, addressing Resident 599's Stage 2 pressure ulcer on the coccyx. The care plan interventions showed to administer the medications as ordered, monitor and document for side effects/effectiveness, and for the Stage 2 pressure ulcer on the coccyx: to wash with soap and water, pat dry, apply Triad cream, and cover with foam dressing. On 12/3/24 at 1500 hours, a wound treatment observation for Resident 599 was conducted with LVN 3. LVN 3 was observed cleaning the coccyx wound bed with wipes saturated with water and chlorhexidine (antiseptic and disinfectant) solution. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/3/24 at 1517 hours, a concurrent interview and medical record review for Resident 599 was conducted with LVN 3. LVN 3 verified he used chlorhexidine to clean Resident 599's Stage 2 pressure wound on the coccyx. LVN 3 reviewed Resident 599's medical record and verified the physician's order was to clean the wound with soap and water. LVN 3 stated he had always used chlorhexidine to clean the wound instead of soap. LVN 3 was asked if the physician was aware he was using chlorhexidine instead of soap, as ordered. LVN 3 stated yes. However, when LVN 3 was asked to show the documentation the physician had been informed that the chlorhexidine was used instead of the soap to clean the wound, LVN 3 stated there were no documentation in the resident's medical record. LVN 3 stated if the physician was aware, then the order would have been clarified to accurately reflect the resident's current wound treatment. LVN 3 agreed the soap and chlorhexidine were not the same and stated the order would have been changed. On 12/5/24 at 1118 hours, a telephone interview was conducted with Physician 1. When asked if Physician 1 was aware the facility was using chlorhexidine instead of soap, as ordered to clean Resident 599's Stage 2 pressure ulcer on the coccyx, Physician 1 stated the facility may have mentioned to him. Physician 1 further stated chlorhexidine could be used to cleanse the wound, however if that was the case, the order should have been clarified to use the chlorhexidine instead of the soap. On 12/5/24 at 1511 hours, an interview was conducted with the DON. The DON stated when providing wound treatments, the DON expected the nurse to administer treatments as ordered by the physician. The DON further stated if the treatment nurse was not using what was ordered by the physician, then there should be a clarification of the order to ensure the treatment accurately reflected the physician's order. On 12/5/24 at 1701 hour, the Administrator and DON were informed and acknowledged the above findings. 2. During the initial tour of the facility on 12/2/24 at 0830 hours, Resident 598 was observed lying on a LAL mattress. The LAL mattress unit was observed with the firmness set at the 8th setting (level one: soft and level 8: firm). Resident 598's family member was observed at bedside. When asked about the LAL mattress, FM 1 stated the LAL mattress was for the prevention of the pressure ulcers. When asked, FM 1 stated she did not know what the settings should be set at and the facility did not discuss the settings of the LAL mattress with her. Staff member was not observed in the room providing care to Resident 598 at this time. Medical record review for Resident 598 was initiated on 12/2/24. Resident 598 was admitted to the facility on [DATE], with the diagnosis of hemiplegia (paralysis or weakness in one side of the body) and hemiparesis (weakness or the inability to move on one side of the body) following cerebral infarction (a stroke) affecting the right dominant side. Review of Resident 598's Order Summary Report dated 12/3/24, showed the following physician's orders: - dated 11/26/24, the resident was incapable of understanding the rights, responsibilities, and informed consent, and - dated 11/26/24, to apply the LAL mattress for skin maintenance. (continued on next page)

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Newport Nursing and Rehabilitation Center	1555 Superior Avenue Newport Beach, CA 92663

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 598's MDS dated [DATE], showed Resident 598 weighed 121 pounds, had severely impaired cognition, and was at risk for developing pressure ulcers/injuries. Further review of Resident 598's MDS showed Resident 598 was totally dependent on the staff members assistance for bed mobility, for rolling from left to right, for sitting to lying, for lying to sitting on the side of the bed, and for chair/bed-to-chair transfers. Review of Resident 598's plan of care showed the following care plan problems: - dated 11/26/24, addressing Resident 598's ADL self-care performance deficits. The intervention dated on 12/3/24, showed to apply the LAL mattress for skin maintenance. - dated 11/26/24, addressing Resident 598's risk for skin impairment and further decline of skin integrity. The intervention dated on 11/26/24, showed to apply the pressure reduction mattress to the bed, and dated 12/3/24, showed to apply the LAL mattress for skin maintenance. Further review of Resident 598's plan of care failed to show a care plan problem addressing the use of a LAL mattress or the specific LAL mattress setting specific to the resident. Review of Resident 598's TARs for November and December 2024 failed to show the monitoring of the LAL mattress unit. On 12/2/24 at 1013 hours, an interview was conducted with LVN 2. LVN 2 stated she was scheduled as the treatment nurse for the day. When asked, LVN 2 stated the treatment nurses and the Maintenance Department were responsible for the set up and initial settings on the LAL mattress when first applied. LVN 2 stated the treatment nurses were responsible for adjusting the level/settings on the LAL mattress unit and the CNAs did not adjust the settings on the LAL mattress unit. When asked about the settings on the LAL mattress unit, LVN 2 stated the settings on the LAL mattress unit would be based on the resident's weight and the setting selected after comparing the resident's weight to the Patient Weight Settings sticker located on the LAL mattress unit. LVN 2 stated the licensed nurses should check the LAL mattress unit every shift, to ensure the LAL mattress unit was on and the settings were correct. On 12/2/24 at 1020 hours, a concurrent interview, observation, and medical record review for Resident 598 was conducted with LVN 2. LVN 2 reviewed Resident 598's medical record and stated on 11/27/24, Resident 598 weighed 122 pounds. Concurrent observation of Resident 598's LAL mattress unit was conducted with LVN 2, at Resident 598 bedside. Resident 598 was observed lying in bed and the LAL mattress setting was observed set at the 8th light bar. LVN 2 verified the findings. LVN 2 reviewed the Patient Weight Settings sticker located on Resident 598's LAL mattress unit, and stated per Resident 598's weight, the LAL mattress should be set at 2 light bars, for the weight between 120 to 145 pounds. LVN 2 reviewed Resident 598's medical record and stated there were no documentation of the specific LAL mattress setting for Resident 598. LVN 2 reviewed Resident 598's TAR for November and December 2024, and stated there were no documentation the LAL mattress unit was monitored and the settings were checked. On 12/3/24 at 0852 hours, Resident 598 was observed lying in bed with the LAL Mattress unit set at 2 light bars. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/4/24 at 1453 hours, an interview was conducted with CNA 6. CNA 6 stated Resident 598 had a special mattress, and that he did not touch the settings on the LAL mattress unit. On 12/5/24 at 0944 hours, a follow-up interview was conducted with FM 1. FM 1 stated the facility had discussed the use of the LAL mattress; however the facility did not discuss the specific setting for the LAL mattress. FM 1 stated, since the facility changed the setting on the LAL mattress on Monday, FM 1 noticed her mother complained less of discomfort in her bottom and appeared less fidgety in bed. On 12/5/24 at 1511 hours, an interview was conducted with the DON. The DON stated the licensed nurses should monitor the LAL mattress unit every shift, monitoring for functionality of the unit, and for any leaking, or service lights. The DON stated the monitoring of the LAL mattress unit should be documented on the TAR. When asked about the appropriate settings on the LAL mattress, the DON stated the LAL mattress unit had a sticker to show what the firmness level should be set at, and the setting should be based on the residents' weight. When asked about the potential risk of the LAL mattress setting being set at a level not appropriate for the resident's weight, the DON stated there was the potential to affect the wound healing. When asked about the LAL mattress settings specific to each resident, the DON stated the LAL mattress was an intervention for the residents with pressure injuries, or at risk for developing the pressure injuries, however if the resident had a LAL mattress, then there would be an individualized care plan for the use of the LAL mattress for the resident. On 12/5/24 at 1701 hours, the Administrator and DON were informed and acknowledged the above findings.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure two of three final sampled residents (Residents 298 and 600) reviewed for accident hazards remained free from the accident hazards. * The facility failed to ensure CNAs 2 and 3 used a gait belt as per the fall risk evaluation and care plan when transferring Resident 600 to the commode. * The facility failed to implement the bilateral floor mats for safety and fall prevention in accordance with the physician's order for Resident 298. These failures have the potential to place Residents 298 and 600 at risk for serious injury. Findings: Review of the facility's P&P titled Falls and Fall Risk, Managing revised 3/2018 showed based on the previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. According to the MDS, a fall is defined as unintentionally coming to rest on the ground, floor or other lower level, but not as a result of an overwhelming external force. An episode where a resident lost his/her balance and would have fallen, if not for another person of if he or she had not caught him/herself, is considered a fall. Under the section Resident-Centered Approaches to Managing Falls and Fall Risk showed the staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. 1. On 12/2/24 at 0939 hours, an interview was conducted with Resident 600. Resident 600 stated she had a fall on 11/28/24, during the transfer from her bed to the bedside commode. Medical record review for Resident 600 was initiated on 12/2/24. Resident 600 was admitted to the facility on [DATE]. Review of Resident 600's Fall Risk Evaluation dated 11/23/24, showed Resident 600 was at moderate risk for falls. Under the section Gait, showed Resident 600 had weak on walking and short, shuffle steps, lightly touching furniture for support. Under impaired gait, showed Resident 600 was at risk for falls related to generalized weakness. The approach selected showed Resident 600 had impaired gait/balance, to use the gait belt and the PT had recommended devices per the plan of care for the resident's transfers/ambulation. Review of Resident 600's IDT: Post Accident/Fall dated 11/28/24, showed Resident 600 had a fall on 11/28/24 at 0335 hours. The IDT determined the follow-up measures that were needed to reduce the risk of reoccurrence were to apply non-skid or appropriate footwear, room free of clutter and the use of the gait belt when transferring/ambulating. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 600's Fall Risk Evaluation dated 11/28/24, showed Resident 600 was at moderate risk for falls. Under the section Gait, showed Resident 600 had weak in walking and short, shuffle steps, lightly touching furniture for support. Under impaired gait, showed Resident 600 was at risk for falls related to generalized weakness. The approach selected showed Resident 600 had impaired gait/balance, to use the gait belt and PT had recommended devices per the plan of care for the resident's transfers/ambulation. Review of Resident 600's plan of care showed the following care plan problems: - dated 11/26/24, addressing Resident 600's risk for falls related to her status post anterior and posterior lumbar fusion (a surgical procedure that joins two or more vertebrae in the lower back to relieve pain and restore function) on 11/19/24. The interventions showed Resident 600 had impaired gait/balance, to use the gait belt and PT had recommended devices per the plan of care for the resident's transfers/ambulation. - dated 11/28/24, addressing Resident 600's witnessed fall. The intervention initiated 12/2/24, showed to use the gait belt with resident's transfers and ambulation. Review of Resident 600's MDS dated [DATE], showed Resident 600 was cognitively intact and required substantial/maximal assistance to roll on the left and right, to move from sitting to standing, for chair/bed-to chair transfer, and for toilet transfers. On 12/4/24 at 1516 hours, a phone interview was conducted with CNA 2. CNA 2 stated she was Resident 600's CNA on 11/28/24, when Resident 600 had her fall. CNA 2 stated Resident 600 was alert and was able to verbalize her needs. CNA 2 stated she had previously assisted Resident 600 to the bedside commode prior to her fall. CNA 2 was asked about how she assisted Resident 600 to the bedside commode and CNA 2 stated she used Resident 600's walker. When asked about the use of the gait belt, CNA 2 denied using the gait belt. When asked if CNA 2 offered the use of the gait belt to Resident 600, CNA 2 stated she felt Resident 600 was steady for the use of the walker with the assistance from CNA 2. CNA 2 stated she assessed Resident 600 and the resident was stable and it did not occur to her to use the gait belt. CNA 2 was asked if she was informed by the nurse she needed to use the gait belt with Resident 600 during her transfers, CNA 2 stated no. CNA 2 stated the purpose of the use of the gait belt was to prevent falls. On 12/5/24 at 0914 hours, during an observation, Resident 600 was observed sitting in her wheelchair and informed CNA 3 she needed to use the bedside commode. CNA 3 was observed pulling the privacy curtain, donning gloves, and assisting Resident 600 to the bedside commode. CNA 3 was observed grabbing Resident 600's walker to use during the transfer to the bedside commode and assisted Resident 600 on to the bedside commode. The gait belt was observed on Resident 600's bed and was not observed used during the transfer. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/5/24 at 0927 hours, an interview was conducted with CNA 3. CNA 3 was asked if she was aware Resident 600 had a previous fall. CNA 3 stated she was informed Resident 600 had a previous fall during a transfer to the commode. CNA 3 stated Resident 600 was a fall risk and usually transferred with the gait belt. CNA 3 verified she did not use the gait belt when she transferred Resident 600 to the bedside commode. CNA 3 stated she was familiar with the resident and she felt confident in transferring Resident 600 without the use of the gait belt. When asked when the gait belt should be used, CNA 3 stated the gait belt should be used at all times when moving from one position to another, including from the bed to the wheelchair, and from the wheelchair to the commode. CNA 3 stated she was informed by the charge nurse to use the gait belt during transfers for Resident 600. CNA 3 stated she used the gait belt with Resident 600 in the past, however she was more comfortable with Resident 600 so she did not use the gait belt during the transfer. On 12/5/24 at 0935 hours, an interview was conducted with OT 1. OT 1 stated she was familiar with Resident 600 and was working with Resident 600 on transferring on and off of the toilet/commode, getting dressed and the use of adaptive equipment. OT 1 was asked about the protocol for transferring for Resident 600. OT 1 stated for Resident 600, the resident required partial to moderate assistance with one person assist during the transfers. OT 1 stated for the transferring for Resident 600 to the bedside commode, either from the bed or the wheelchair, Resident 600 must wear her back brace, non skid socks, and the staff assisting with the transfer should use a gait belt and the walker. On 12/5/24 at 1511 hours, a concurrent interview and medical record review for Resident 600 was conducted with the DON. The DON stated if the resident had a previous fall and the IDT recommended the use of the gait belt for transfers, she expected staff to transfer the resident using the gait belt. The DON reviewed Resident 600's fall risk evaluations and post fall IDT recommendations and verified the approaches and recommendations. The DON was asked and stated the use of the gait belt was for the safety of the resident and the CNA. On 12/5/24 at 1604 hours, an interview was conducted with Resident 600. Resident 600 stated staff were supposed to use the gait belt when they transfer her. When asked, Resident 600 denied refusing the use of the gait belt during her transfers. On 12/5/24 at 1701 hours, the Administrator and the DON were informed and acknowledged the above findings. 37726 2. Medical record review for Resident 298 was initiated on 12/2/24. Resident 298 was admitted to the facility on [DATE]. Review of Resident 298's Order Summary Report showed a physician's order dated 11/30/24, for the bilateral floor mats for safety and fall prevention. Review of Resident 298's care plan titled At Risk for Falls initiated 11/30/24, showed Resident 298 was at risk for falls related to generalized weakness, and a history of CVA and TIA. The care plan approaches included the placement of floor pads (mats) next to Resident 298's bed when Resident 298 was in his bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/2/24 at 0930 hours, during an observation, Resident 298 was observed lying in bed. Resident 298's bed was observed with a floor mat in place on one side of Resident 298's bed. The opposite side of Resident 298's bed was observed without a floor mat in place. On 12/2/24 at 1213 hours, a concurrent observation, interview, and medical record review was conducted with LVN 4. Resident 298 was observed lying in bed. Resident 298's bed was observed with a floor mat in place on one side of Resident 298's bed. The opposite side of Resident 298's bed was observed without a floor mat in place. LVN 4 verified the findings. LVN 4 stated as per the physician's order, a fall mat should have been placed on both sides of Resident 298's bed to reduce the risk of injury as Resident 298 was at risk for falls. Cross reference to F656, example #1.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43119 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to maintain the IV access for one of 13 final sampled residents (Resident 398). * The facility failed to ensure the PICC line external catheter and arm circumference measurements were completed and documented in the medical record for Resident 398. This failure had the potential to delay the identification of catheter related complications for the resident. Findings: Review of the facility's P&P titled Central Venous Catheter Care and Dressing Changes dated 2001 showed the purpose of this procedure is to prevent complications associated with intravenous therapy, including catheter-related infections that are associated with contaminated, loosened, soiled, or wet dressings. Measure the length of the external central vascular access device with each dressing change or if catheter dislodgement is suspected. Compare with the length documented at insertion. For PICCs, measure arm circumference and compare to baseline when clinically indicated to assess for edema and possible deep-vein thrombosis. Medical record review for Resident 398 was initiated on 12/2/24. Resident 398 was admitted to the facility on [DATE]. Review of Resident 398's H&P examination dated 11/20/24 showed Resident 398 had the capacity to understand and make decisions but failed to show the information of the measurement and assessment of the PICC line was documented when the resident was admitted to the facility. Review of Resident 398's Order Summary Report for December 2024 showed a physician's order dated 11/25/24, for PICC line dressing and cap change every seven days and as needed with CVC dressing kit. Apply Biopatch (a chlorhexidine (CHG)-impregnated sponge that releases CHG continuously for up to seven days. It prevents skin organisms from entering the body at the insertion site and reduces the risk of catheter-related bloodstream infections) around catheter at insertion site. Transparent dressing placed over Biopatch dressing, no gauze over site. Measure the external length of the catheter and upper arm circumference (10 cm above insertion site) every day shift, every Sunday. Review of Resident 398's care plan dated 12/2/24, showed the resident had a PICC line on the right upper arm with two lumens. Under the section approaches/tasks showed to measure the external length of the catheter and upper arm circumference (10 cm above insertion site). Review of Resident 398's IV Administration Record dated 11/26/24, showed the measurements for the arm circumference of 32 cm and catheter was zero. Further review of Resident 398's medical record failed to show a documented evidence of the measurements of the length of the PICC line catheter above the insertion site and arm circumference were obtained upon admission. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/5/24 at 1327 hours, a concurrent interview and medical record review for Resident 398 was conducted with RN 1. RN 1 stated the dressing change for the PICC line was performed every seven days. RN 1 verified Resident 398's medical record did not show the PICC line external catheter and arm circumference measurements upon admission to the facility. RN 1 stated there should have been a measurement of the length of the catheter and arm circumference upon admission of the resident. In addition, RN 1 stated the arm circumference measurement would indicate signs and symptoms of infection such as swelling, and blood clots and the external catheter length would indicate dislodgement. On 12/5/24 at 1700 hours, the DON was informed and verified the above findings.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the safe respiratory care for one of three final sampled residents (Resident 12) reviewed for respiratory care. * The facility failed to ensure Resident 12's CPAP machine was cleaned as per the manufacturer's user cleaning guidelines. This failure had the potential to adversely affect the health and well-being Resident 12 and posed the risk for equipment contamination and respiratory complications. Findings: Review of the facility's P&P titled CPAP/BiPAP Support revised 3/2015 showed the specific cleaning instruction guidelines are obtained from the manufacturer of the PAP device. For the machine cleaning, to wipe the machine with warm, soapy water and rinse at least once a weeks and as needed. For the humidifier (if used), to use clean, distilled water, to clean the humidifier weekly and air dry, to disinfect, place vinegar-water solution (1:3) in the clean humidifier, soak for 30 minutes and rinsed thoroughly. For the components of the machine such as the masks, nasal pillows, and tubing, to clean daily by placing in warm, soapy water and soak/agitating for five minutes. Mild dish detergent is recommended. To rinse with warm water and allow to air dry between uses. For the headgear, to wash with warm water and mild detergent as needed and allow to air dry. On 12/2/24 at 0900 hours, a concurrent observation and interview was conducted with Resident 12. Resident 12's bedside drawer was noted to have a CPAP (ResMed Air Sense 11) machine, which was observed off with the CPAP mask observed on top of the CPAP machine. The mask was not observed stored in a plastic bag. Resident 12 was asked about his CPAP machine and stated he used his CPAP machine every night. Resident 12 was asked if the staff cleaned the CPAP machine, tubing and mask. Resident 12 stated no, he had not seen staff member clean it since he started using the CPAP at the facility. Review of the ResMed Air Sense 11 (CPAP machine) user guide, undated showed under the section Cleaning and Caring For the Device, showed to clean the device and its components according to the schedules shown in this guide, to maintain the quality of the device and to prevent the growth of germs that can adversely affect your health. Medical record review for Resident 12 was initiated on 12/2/24. Resident 12 was admitted to the facility on [DATE]. Review of Resident 12's MDS dated [DATE], showed Resident 12 had moderately impaired cognition and was coded for the use of the CPAP machine. Review of Resident 12's Order Summary Report dated 12/3/24, showed the following physician orders: - dated 10/14/24, the resident was capable of understanding the rights, responsibilities, and informed consent (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 10/14/24, to apply the CPAP at 5.5 cm H2O with the oxygen concentrator every evening and night shift. The Order Summary Report failed to show a physicians order for the cleaning of the CPAP machine and its components. Review of Resident 12's plan of care showed a care plan problem dated 10/27/24, addressing Resident 12's CPAP Therapy. The interventions showed to educate the resident on the importance of the CPAP therapy and to encourage the resident's use of the CPAP. The care plan problem failed to show the specific CPAP setting for Resident 12 and failed to show interventions for the maintenance and care of the CPAP machine and the components. On 12/3/24 at 0841 hours, a concurrent observation and interview was conducted with Resident 12. Resident 12's CPAP mask was observed on top of a pillow on the bedside drawer. The CPAP mask was not observed inside a storage bag. Resident 12 was asked if a staff member had cleaned his CPAP mask this morning, Resident 12 stated no. On 12/4/24 at 0826 hours, a concurrent observation and interview was conducted with CNA 4. Resident 12's CPAP mask was observed on Resident 12's bedside drawer. The CPAP mask was not observed inside a storage bag. The CPAP tubing was observed on top of the CPAP mask, and an ice bag inside of the sling was observed on top of the CPAP mask. Resident 12 stated at home, he cleaned his CPAP machine and mask once a week or as needed. CNA 4 stated he assisted Resident 12 to remove his CPAP mask in the mornings. CNA 4 stated he did not clean the CPAP mask and was not sure who was responsible for the cleaning of the CPAP mask, and how often it should be cleaned. On 12/4/24 at 0842 hours, a concurrent interview and medical record review for Resident 12 was conducted with the DSD. The DSD stated for the use of a CPAP machine, there should be a physician's order for how to clean and the frequency of the cleaning of the CPAP machine and its components. The DSD stated the cleaning of the CPAP masks are done by the licensed nurses after each use and upon removal of the CPAP mask in the morning. The DSD stated the CPAP masks should be rinsed with warm water and pat dry daily, after every use, for infection control purposes. The DSD stated the oxygen tubings should be changed and labeled every seven days and when not in use, the CPAP masks and tubing should be stored inside a storage bag for infection control. The DSD also stated, the cleaning of the CPAP machine and the CPAP mask should be documented in either the progress notes or the MAR. The DSD reviewed Resident 12's medical record and verified there were no orders for the cleaning of Resident 12's CPAP machine and its components, there were no documentation of the cleaning of Resident 12's CPAP machine and its components, and Resident 12's care plan addressing his CPAP therapy did not specify the CPAP settings, or did not include the interventions for the cleaning of the CPAP machine and its components. On 12/4/24 at 0900 hours, a concurrent interview and observation was conducted with the DSD at Resident 12's bedside. The DSD verified the above findings. When asked about the oxygen tubing connecting the oxygen concentrator to the CPAP mask, the DSD verified the oxygen tubing was not labeled and stated he did not know how long the oxygen tubing have been in use. The DSD stated the oxygen tubings should be changed and labeled every seven days. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/5/24 at 1511 hours, an interview was conducted with the DON. The DON stated both the CNAs and the LVNs could clean the CPAP mask, however, it should be documented on the MAR by the licensed nurses, to monitor the cleaning of the CPAP machine and its components. The DON stated the CPAP mask and machine should be cleaned routinely, and when not in use, the CPAP make should be stored in a storage bag for infection control purposes. On 12/5/24 at 1701 hours, the Administrator and the DON were informed and acknowledged the above findings.

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Newport Nursing and Rehabilitation Center	1555 Superior Avenue Newport Beach, CA 92663

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882 Based on interview, medical record review, and facility P&P review, the facility failed to ensure the appropriate pain management for two of two final sampled residents (Residents 12 and 599) reviewed for pain management. * The facility failed to administer pain medication according to the physician's order for Resident 12 and failed to ensure non-pharmacological interventions for pain (NPI) were provided/documented prior to the administration of pain medications. * The facility failed to ensure Resident 599 was consistently provided non-pharmacological interventions for pain prior to the administration of narcotic pain medication. These failures put Residents 12 and 599 at risk for ineffective pain management. Findings: Review of the facility's P&P titled Administering Medications revised 9/2019 showed the medications are administered in accordance with the prescriber orders, including any required time frame. Review of the facility's P&P titled Pain Assessment and Management revised 10/2022 showed non-pharmacological interventions may be appropriate alone or in conjunction with medications. Pharmacological interventions may be prescribed to manage pain, however; they do not usually address the cause of pain and can have adverse effects on the resident. When opioids are used for pain management, the resident is monitored for medication effectiveness, adverse effects, and potential overdose. The medication regimen is implemented as ordered. Results of the interventions are documented and communicated directly to the provider when appropriate. 1. On 12/2/24 at 0900 hours, an interview was conducted with Resident 12. Resident 12 stated he was at the facility following a surgery on his left shoulder. Resident 12 stated he had pain in his left shoulder and the facility was administering the oxycodone (opioid) and Tylenol (analgesic) for his pain. Medical record review for Resident 12 was initiated on 12/2/24. Resident 12 was admitted the facility on 10/14/24 with the diagnoses including presence of a left artificial shoulder joint and aftercare following joint replacement surgery. Review of Resident 12's MDS assessment dated [DATE], showed Resident 12 had moderately impaired cognition. Further review of the MDS assessment showed Resident 12 was coded for occasional moderate pain. Review of Resident 12's Order Summary Report dated 12/3/24, showed the following physician's orders: - dated 10/14/24, the resident was capable of understanding his rights, responsibilities, and informed consent. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 10/14/24, to administer acetaminophen 500 mg two tablets by mouth every eight hours as needed for mild pain (pain level of 1-3 out of 10). - dated 10/14/24, to record the NPI every shift, using the 0 to 10 scale which was coded as follows: was coded as follows: 0 = no non-drug intervention needed, 1 = re-positioning/limb elevation, 2 = reassurance/emotional support, 3 = provide distraction/diversionary activities, 4 = exercise/ROM/ambulation/stretching, 5 = rest period/quiet environment, 6 = deep breathing/relaxation exercises, 7 = guided imagery/meditation, 8 = laughter/socialization, 9 = music, 10 = other, specify - dated 10/15/24, to monitor for the presence of verbal/nonverbal pain, every shift using the pain scale 0 to 10, 0 for no pain, 1-3 for mild pain, 4-6 for moderate pain, 7-9 for severe pain, 10/10 for very severe pain. - dated 10/22/24, to administer oxycodone 5 mg, to give 1/2 (half) tablet by mouth every four hours as needed for moderate pain (pain level 4-6 out of 10). - dated 10/22/24, to administer oxycodone 5 mg, to give one tablet by mouth every four hours as needed for severe to very severe pain (pain level 7-10 out of 10). Review of Resident 12's plan of care showed a care plan problem initiated on 10/15/24, addressing Resident 12's risk for pain related to generalized body pain, neuropathy, and left shoulder arthroplasty. The interventions showed to monitor for the presence of pain every shift, to administer analgesia medications as ordered by the physician, and to provide non-pharmacological pain interventions every shift. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 12's MAR for November and December 2024 showed Resident 12 was administered the acetaminophen medication 500 mg, two tablets by mouth every eight hours as needed for mild pain (pain level of 1-3/10) on the following dates and times when the resident's pain level was not within the pain levels of 1-3 as ordered: - On 11/7/24 at 1539 hours, a pain level of 4. - On 11/8/24 at 0719 hours, a pain level of 4. - On 11/11/24 at 0530 hours, a pain level of 4. - On 11/26/24 at 1709 hours, a pain level of 0. - On 11/30/24 at 0327 hours, a pain level of 5. Further review of the MAR for November and December 2024 showed Resident 12 was administered the following medications on the following dates and times, for the following pain levels: * Resident 12 was administered the acetaminophen medication 500 mg, two tablets by mouth every eight hours as needed for mild pain (pain level of 1-3/10): - on 11/12/24 at 0500 hours, for a pain level of 3. - on 11/13/24 at 0600 hours, for a pain level of 3. - on 11/14/24 at 0515 hours, for a pain level of 3. - on 11/15/24 at 0500 hours, for a pain level of 3. - on 12/1/24 at 0900 hours, for a pain level of 3. * Resident 12 was administered the oxycodone medication 5 mg, 1/2 (half) tablet every four hours as needed for moderate pain: - on 11/13/24 at 0045 hours, for a pain level of 6. - on 11/22/24, at 1600 hours, for a pain level of 7. Further review of Resident 12's MAR for November and December 2024 showed the following NPIs documented for the following dates and shifts: - from 11/11/24 to 11/15/24, for the NOC shift (from 2300 to 0700 hours), the NPI was documented as 0, - on 11/22/24, for the evening shift (from 1500 to 2300 hours), the NPI was documented as 0, and - on 12/1/24, for the day shift (from 0700 to 1500 hours), the NPI was documented as 0. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/4/24 at 1445 hours, an interview was conducted with CNA 4. CNA 4 stated Resident 12 was alert and oriented and was able to verbalize his needs. CNA 4 stated whenever Resident 12 complained of pain in his shoulder, CNA 4 would inform the nurse and the nurse would administer the pain medication to the resident. On 12/ 5/24 at 1031 hours, a concurrent interview and medical record review for Resident 12 was conducted with LVN 2. LVN 2 stated upon notification of a resident's pain, LVN 2 would assess the resident's pain and attempt to offer the NPIs prior to the administration of the pain medication. LVN 2 further stated the NPIs provided and the effectiveness of the interventions were documented in the MAR. LVN 2 stated for the administration of the pain medications, the pain medications should be administered as ordered by the physician and within the ordered pain parameters. LVN 2 stated, if the pain medications were administered outside of the ordered parameters, the physician should be informed, and the nurse should document in the resident's progress notes. LVN 2 reviewed Resident 12's MAR and verified the above findings. LVN 2 stated if pain medications were administered, there should be documentation of the NPIs that were implemented. LVN 2 stated the NPI should not be documented as 0 and if NPIs were refused by the resident then there should be documentation of the resident's refusal in the resident's medical record. LVN 2 further reviewed Resident 12's medical record and stated there were no documentation the physician was informed Resident 12 was administered the pain medication outside of the ordered pain parameter on the above dates and no documentation Resident 12 refused offered NPIs prior to the administration of pain medications for the above dates. 2. On 12/2/24 at 0840 hours, an interview was conducted with Resident 599. Resident 599 stated she had a bedsore on her butt that had developed during her stay at the facility. Resident 599 stated the facility administered the pain medications whenever she informed them of her pain. Medical record review for Resident 599 was initiated on 12/2/24. Resident 599 was admitted to the facility on [DATE]. Review of Resident 599's MDS dated [DATE], showed Resident 599 was cognitively intact. Review of Resident 599's Order Summary Report dated 12/3/24, showed the following physician's orders: - dated 11/8/24, to administer acetaminophen tablet 325 mg, to give two tablets by mouth every six hours as needed for mild pain (pain level of 1-3 out of 10), not to exceed three grams in 24 hours. - dated 11/8/24, to monitor for the presence of verbal/nonverbal pain, every shift, using the pain scale 0 to 10, 0 for no pain, 1-3 for mild pain, 4-6 for moderate pain, 7-9 for severe pain, and 10/10 for very severe pain. - dated 11/8/24, to record the NPIs every shift, using the 0 to 10 scale which was coded as follows: 0 = no non-drug intervention needed, 1 = re-positioning/limb elevation, 2 = reassurance/emotional support, (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3 = provide distraction/diversionary activities, 4 = exercise/ROM/ambulation/stretching, 5 = rest period/quiet environment, 6 = deep breathing/relaxation exercises, 7 = guided imagery/meditation, 8 = laughter/socialization, 9 = music, 10 = other-specify - dated 11/14/24, to administer Roxicodone (narcotic) 5 mg, one tablet every four hours as needed for moderate to severe pain (pain level of 4 to 10 out of 10). Review of Resident 599's plan of care showed a care plan problem initiated on 11/8/24, addressing Resident 599's risk for pain related to generalized body pain. The interventions showed to provide NPIs every shift. Review of Resident 599's MAR for November 2024, showed Resident 599 was administered Roxicodone 5 mg, one tablet every four hours as needed for moderate to severe pain on the following dates: - on 11/12/24 at 0300 hours, a pain level of 7. - on 11/13/24 at 0155 hours, a pain level of 7. - on 11/14/24 at 0500 hours, a pain level of 7. - on 11/15/24 at 0615 hours, a pain level of 7. - on 11/15/24 at 1342 hours, a pain level of 6. - on 11/15/24 at 2022 hours, a pain level of 6. - on 11/16/24 at 1330 hours, a pain level of 4. - on 11/19/24 at 0200 hours, a pain level of 7. - on 11/22/24 at 1905 hours, a pain level of 7. - on 11/23/24 at 0912 hours, a pain level of 7. - on 11/26/24 at 0500 hours, a pain level of 7. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident 599's MAR for November 2024 failed to show the documented evidenced the non-pharmacological interventions were attempted prior to the administration of the Roxicodone pain medication on the above listed dates. On 12/5/24 at 1031 hours, a concurrent interview and medical record review for Resident 599 was conducted with LVN 2. LVN 2 verified the above findings. On 12/5/24 at 1511 hours, an interview was conducted with the DON. The DON stated medications should be administered to the residents as ordered by the physician. The DON stated for the administration of the pain medication, the licensed nurses were expected to assess the resident's pain, to implement and document the non-pharmacological interventions prior to the administration of the pain medication, and to administer the pain medications as ordered by the physician and within the ordered parameters. When asked, the DON stated if the residents requested for the pain medication and refused the offered non-pharmacological interventions, the nurse should document the refusal. On 12/5/24 at 1701 hours, the Administrator and DON were informed and acknowledged the above findings.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to provide the pharmacy services as per the facility P&P for seven nonsampled residents (Residents 14, 42, 302, 303, 305, 601, and 602). * LVN 2 failed to ensure the medications scheduled for 0900 hours were administered timely within the 60 minutes of the scheduled time for two nonsampled residents (Residents 601 and 602). This failure had the potential to place the residents at risk for delays in treatment and increased risk of adverse events. * LVN 4 failed to ensure the resident medications scheduled for 12/4/24 at 0900 hours, were administered timely within the 60 minutes of the scheduled time for three nonsampled residents (Residents 42, 302, and 305). This failure had the potential to place the residents at risk for delays in treatment and increased risk of adverse events. * The facility failed to ensure the accurate documentation of three controlled medications on the Drug Control Receipt/ Record/ Disposition Form for three nonsampled residents (Residents 14, 302, and 303). This failure had the potential for drug diversion (illegal distribution or abuse of prescription drugs or their use for unintended purposes) of controlled medications. Findings: Review of the facility's P&P titled Administering Medications revised 4/2019 showed the medications are administered in accordance with prescriber orders, including any required time frame. The medications are administered within one hour of their prescribed time unless otherwise specified (for example, before and after meal orders). 1a. On 12/3/24 at 1030 hours, a concurrent observation and interview was conducted with LVN 2. LVN 2 stated she had seven residents remaining to pass morning medications. On 12/3/24 at 1040 hours, a medication administration observation for Resident 601 was conducted with LVN 2. LVN 2 prepared and administered the following medications to Resident 601: - one tablet of amlodipine (to treat high blood pressure) 5 mg, - one tablet of carvedilol (to treat high blood pressure) 3.125 mg, - one tablet of Eliquis (anticoagulant) 5 mg, - one tablet of hydralazine (vasodilator) 100 mg, - one tablet of Jardiance (antidiabetic) 10 mg, - one tablet of clonidine (antihypertensive) 0.1 mg, and (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- one tablet of isosorbide mononitrate (to treat high blood pressure) 120 mg. On 12/13/24 at 1103 hours, an interview was conducted with LVN 2. LVN 2 stated the morning medications were usually scheduled at 0900 hours, and the nurses have a window for the administration of 0900 hours medication between 0800 to 1000 hours. LVN 2 stated the medications administration for Resident 601 was considered late. LVN 2 stated Resident 601 recently had a stroke and was administered medications to control her blood pressure and thin her blood. LVN 2 further stated it was important to administer Resident 601's medications on time to ensure her blood pressure was regulated and to prevent the occurrence of another stroke. On 12/3/24 at 1112 hours, an interview was conducted with Resident 601. Resident 601 stated she recently had a stroke and was taking Eliquis to thin her blood and taking blood pressure medications to control her blood pressure. Resident 601 further stated it was important for her to take her medications on time. Medical record review for Resident 601 was initiated on 12/2/24. Resident 601 was admitted to the facility on [DATE]. Review of Resident 601's Order Summary Report dated 12/3/24, showed a physician's order dated 11/21/24, showed the resident was capable of understanding rights, responsibilities, and informed consent. Review of Resident 601's Medication Administration Audit Report dated 12/4/24, showed on 12/3/24 for the 0900 hours scheduled medications, the following medications were not administered as ordered: amlodipine, carvedilol, Eliquis, hydralazine, Jardiance, and clonidine. Review of Resident 601's Progress Notes showed a Health Status Note dated 12/4/24 at 1238 hours, documentation for 12/3/24 for the 0900 hours, showed the medications were given at 1108 hours due to unexpected circumstances. The physician was made aware with no new orders. b. On 12/3/24 at 1158 hours, a medication administration observation for Resident 602 was conducted with LVN 2. During the medication administration, Resident 602 asked LVN 2 why he was getting his morning medications at noon. LVN 2 informed Resident 602 she had interruptions and had to deal with a resident emergency this morning. On 12/3/24 at 1203 hours, an interview was conducted with Resident 602. Resident 602 was asked about his expectations for the administration of his medications and Resident 602 stated he expected to have his medications administered on time. Medical record review for Resident 602 was initiated on 12/3/24. Resident 602 was admitted to the facility on [DATE]. Review of Resident 602's H&P examination dated 11/29/24, showed Resident 602 had the capacity to understand and make decisions. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 602's Medication Administration Audit Report dated 12/4/24, showed on 12/3/24 for the 0900 hours scheduled medications, the following medications were not administered as ordered: lidocaine external patch (analgesic), vitamin C (supplement), tamsulosin (to treat symptoms of enlarged prostate), clopidogrel (antiplatelet), ferrous sulfate (iron supplement), aspirin (anti-inflammatory), allopurinol (to treat gout), [NAME]-Vite (supplement), and Senna S (laxative). Review of Resident 602's Progress Notes dated 12/3/24 at 1304 hours, showed the physician was made aware about medications not given on time. On 12/3/24 at 1550 hours, an interview was conducted with the DON. The DON stated the licensed nurses were expected to administer the scheduled medications on time, within the appropriate window. On 12/5/24 at 1701 hours, the Administrator and the DON were informed and acknowledged the findings. 37726 2. On 12/4/23 at 1007 hours, a concurrent observation and interview was conducted with LVN 4. LVN 4 was observed administering medications to the facility residents. LVN 4 stated she had seven residents (which included Residents 42, 302, and 305) remaining who had yet to receive their morning medications, which were scheduled to be administered at 0900 hours . LVN 4 stated in accordance with the facility's P&P, resident medications were to be administered within one hour of their prescribed time. LVN 4 stated she was unable to administer the morning medications scheduled for 0900 hours, to Residents 42, 302, and 305, due to having to provide nursing care to a resident (Resident 43) who had an episode of vomiting. a. Review of Resident 42's Order Summary Report dated 12/2024, showed the following medications were ordered to be administered on 12/4/24 at 0900 hours: - Lidoderm Patch 5% (analgesic), apply to right knee topically once a day for pain management, - Cardizem extended release (antihypertensive) 120 mg tablet orally once a day for hypertension, - divalproex sodium extended release (anticonvulsant) 500 mg tablet orally once a day for mood disorder, - telmisartan (antihypertensive) 80 mg tablet orally twice a day for hypertension, and - sertraline (antidepressant) 50 mg tablet orally once a day for depression. Review of Resident 42's Medication Administration Audit Report dated 12/4/2024, showed the above listed medications were administered on 12/4/24 at 1341 hours. b. Review of Resident 305's Order Summary Report dated 12/2024, showed the following medications were ordered to be administered on 12/4/24 at 0900 hours: -Clonidine 0.1 mg tablet orally twice a day for hypertension, (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Ascorbic acid (Vitamin C) 500 mg tab orally once a day for supplement, -Ferrous Sulfate 325 mg tablet orally once a day for supplement, -Vitamin D3 25 mcg tablet orally once a day for supplement, -Azllsartan Medoxomil (antihypertensive) 40 mg tablet orally twice a day for hypertension, and -Aspirin tablet 81 mg orally twice a day for DVT prophylaxis. Review of Resident 305's Medication Administration Audit Report dated 12/4/24, showed the above listed medications were administered on 12/4/24 at 1040 hours. c. Review of Resident 302's Order Summary Report dated 12/2024, showed the following medications were ordered to be administered on 12/4/24 at 0900 hours: - carvedilol 3.125 mg tablet orally twice a day for hypertension, - furosemide (diuretic) 40 mg tablet orally once a day for congestive heart failure, - Solifenacin (bladder relaxant) 10 mg tablet orally once a day for urinary retention, - Farxiga (used to treat heart failure) 10 mg tablet orally once a day for congestive heart failure, - lisinopril (used to treat high blood pressure) 20 mg tablet orally once a day for hypertension, and - spironolactone (diuretic) 50 mg tablet orally once a day for congestive heart failure. Review of Resident 302's Medication Administration Audit Report dated 12/4/24, showed the above listed medications were administered on 12/4/24 between 1024 hours and 1027 hours. 47474 3a. Review of the facility's P&P titled Controlled Substances dated 2001 showed the controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/ diversion, and detection/follow up. The system of reconciling the receipt, dispensing and disposition of controlled substances includes the following: A. Records of personnel access and usage; B. Medication administration records; C. Declining inventory records; and D. Destruction, waste and return to pharmacy records. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medical record review for Resident 14 was initiated on 12/2/24. Resident 14 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident 14's Order Summary Report for December 2024 showed a physician's order dated 10/8/24, for hydrocodone-acetaminophen oral tablet 5-325 mg (opoid) give one tablet by mouth every four hours as needed for severe to very severe pain (7-10, using the pain scale from 0 to 10 with 0 = no pain and 10 = worst pain). Review of Resident 14's bubble pack for hydrocodone/ APAP 5-325 mg showed a count of 12 tablets. However, review of Resident 14's Drug Control Receipt/ Record/ Disposition Form for hydrocodone/ APAP 5-325 mg showed there were 13 tablets remaining. The document failed to show the date, time, and licensed nurse's signature for the removal of one hydrocodone/ APAP 5-325 mg tablet, after the entry on 11/29/24 at 0744 hours. On 12/5/24 at 0831 hours, a concurrent interview and document review of the Drug Control Receipt/ Record/ Disposition Form for Hydrocodone/ APAP 5-325 mg for Resident 14 was conducted with the DON. The DON verified the above findings. The DON was asked about her expectations of the staff for removal of the narcotics and controlled drugs for administration. The DON stated the nurse was expected to record and sign on the narcotic count sheet after removal of the controlled drugs and to ensure the narcotic count sheet and bubble pack for the medication matched. b. Medical record review for Resident 302 was initiated on 12/2/24. Resident 302 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident 302's Order Summary Report for December 2024 showed a physician's order dated 11/22/24, for oxycodone HCL oral tablet 5 mg (analgesic) give one tablet by mouth every four hours as needed for moderate to very severe pain (4-10, using the pain scale level 0 meaning no pain and 10 meaning worst pain). Review of Resident 302's bubble pack for oxycodone IR 5 mg showed a count of five tablets. However, review of Resident 302's Drug Control Receipt/ Record/ Disposition Form for Oxycodone IR 5 mg showed there were six tablets remaining. The document failed to show the date, time, and licensed nurse's signature for the removal of one oxycodone IR 5 mg tablet, after the netry on 12/1/24 at 1738 hours. On 12/5/24 at 0831 hours, a concurrent interview and document review of the Drug Control Receipt/ Record/ Disposition Form for oxycodone IR 5 mg for Resident 302 was conducted with the DON. The DON acknowledged the above findings. The DON was asked about her expectations of the staff for removal of the narcotics and controlled drugs for administration. The DON stated the nurse was expected to record and sign on the narcotic count sheet after removal of the controlled drugs and to ensure the narcotic count sheet and bubble pack for the medication matched. c. Medical record review for Resident 303 was initiated on 12/2/24. Resident 303 was admitted to the facility on [DATE]. (continued on next page)

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Newport Nursing and Rehabilitation Center	1555 Superior Avenue Newport Beach, CA 92663

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 303's Order Summary Report for December 2024 showed a physician's order dated 11/18/24, for Pregabalin oral capsule 75 mg (nerve pain medication) give one capsule by mouth three times a day for neuropathy pain. Review of Resident 303's bubble pack for pregabalin 75 mg showed a count of 21 capsules. However, review of Resident 303's Drug Control Receipt/ Record/ Disposition Form for pregabalin 75 mg showed there were 22 tablets remaining. The document failed to show the date, time, and licensed nurse's signature for the removal of one pregabalin 75 mg tablet; after the entry on 12/1/24 at 1700 hours. On 12/5/24 at 0831 hours, a concurrent interview and document review of the Drug Control Receipt/ Record/ Disposition Form for pregabalin 75 mg for Resident 303 was conducted with the DON. The DON acknowledged the above findings. The DON was asked about her expectations of the staff for removal of the narcotics and controlled drugs for administration. The DON stated the nurse was expected to record and sign on the narcotic count sheet after removal of the controlled drugs and to ensure the narcotic count sheet and bubble pack for the medication matched.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the medication error rate was below 5%. The facility's medication error rate was 16.13%. * LVN 2 failed to administer three medications as ordered by the physician for Resident 602. * Resident 301 had a physician's order for Calcitriol 0.25 micrograms two capsules orally one time a day for supplement, however, LVN 4 administered two capsules of Calcitriol 0.5 micrograms orally (twice the ordered dose). * Resident 301 had a physician's order for Lidocaine 4% external patch to apply to the right hip and right foot topically for pain management, apply two patches one time a day at the same time, however, LVN 4 applied one lidocaine 4% external patch to Resident 301's hip. These failures had the potential to negatively affect the residents' health. Findings: Review of the facility's P&P titled Administering Medications revised 4/2019 showed the medications are administered in accordance with the prescriber orders, including any required time frame. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). 1. On 12/3/24 at 1137 hours, a medication administration observation for Resident 602 was conducted with LVN 2. LVN 2 prepared and administered the following medications to Resident 602: - one 1/2 (half) tablet of allopurinol (to treat gout) 100 mg, - one tablet of clopidogrel (anti-platelet) 75 mg, - two capsules of tamsulosin (to treat symptoms of an enlarged prostate) 0.4 mg, - one 1/2 tablet of vitamin C (supplement) 500 mg, - one tablet of Senna S (laxative) 50 mg-8.6 mg, - one tablet of [NAME]-Vite (supplement) - one tablet of aspirin (anti-inflammatory) 81 mg, - one tablet of ferrous sulfate (iron supplement) 325 mg, and - one patch of lidocaine (analgesic) 4 %. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the medication administration for Resident 602, LVN 2 applied one lidocaine 4% external patch to Resident 602's right posterior neck area. Medical record review for Resident 602 was initiated on 12/3/24. Resident 602 was admitted to the facility on [DATE]. Review of Resident 602's Order Summary Report showed the following active physician's orders: - dated 11/28/24, to administer calcium carbonate-vitamin D (supplement) 500-5 mg one tablet orally one time a day for supplement, - dated 11/28/24, to swab povidone-iodine (antiseptic) 10%, one swab in each nostril two times a day every Monday, Tuesday, Wednesday, Thursday, and Friday for prophylaxis, - dated 11/29/24, to apply lidocaine 4% external patch to the affected area topically for pain management, to apply two patches one time a day and remove per the schedule. However, LVN 2 was observed applying only one lidocaine 4% external patch, and did not administer the calcium carbonate-vitamin D 500-5 mg and the povidone-iodine swabs to Resident 602 during the medication administration observation. On 12/3/24 at 1309 hours, a concurrent interview and medical record review for Resident 602 was conducted with LVN 2. LVN 2 verified the above findings. LVN 2 verified she applied the one patch instead of two lidocaine 4% external patches, did not administer the povidine-idoine swabs, and did not administer the calcium carbonate-vitamin D 500-5 mg during the medication administration observation. LVN 2 stated she did not have the correct calcium carbonate-vitamin D dose in her medication cart or central supply and did not know when the facility ran out of the medication. LVN 2 further stated the physician have been informed and have made changes to the order. On 12/5/24 at 1701 hours, the Administrator and the DON were informed and acknowledged the above findings. 37726 2. Medical record review for Resident 301 was initiated on 12/2/24. Resident 301 was admitted to the facility on [DATE]. On 12/4/24 at 0821 hours, a medication administration observation for Resident 301 was conducted with LVN 4. LVN 4 prepared and administered Resident 301's medications. During the medication administration for Resident 301, LVN 4 administered two capsules of calcitriol 0.5 micrograms orally. LVN 4 also applied one lidocaine 4% external patch to Resident 301's hip. Review of Resident 301's active physician's orders showed the following two orders: - dated 11/20/24, for calcitriol 0.25 micrograms two capsules orally one time a day for supplement, and (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 11/21/24, for lidocaine 4% external patch, apply two patches one time a day at the same time to the right hip and right foot topically for pain management. On 12/4/24 at 1108 hours, a concurrent interview and medical record review was conducted with LVN 4. LVN 4 reviewed Resident 301's active medication orders. LVN 4 verified Resident 301's physician's order showed to administer two capsules of calcitriol 0.25 micrograms orally; however, LVN 4 administered two capsules of calcitriol 0.5 micrograms orally (twice the ordered dose). LVN 4 then verified Resident 301's order for the lidocaine 4% external patch, showed to apply two patches one time a day at the same time to the right hip and right foot topically for pain management. LVN 4 verified she applied one lidocaine 4% external patch to Resident 301's hip. Cross reference to F656, example #2.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47474 Based on observation, interview, and facility P&P review, the facility failed to store the drugs, biologicals, and medical supplies in a safe manner as evidenced by the following: * The facility failed to ensure the opened medical supplies in Medication Carts B and C were properly disposed. * The facility failed to ensure the discontinued medications were properly disposed. These failures had the potential for the drug diversion and to result in an unsafe handling and storage of the residents' medications. Findings: 1a. Review of the facility's P&P titled Discarding and Destroying Medications dated 2001 showed for unused, non-hazardous controlled substances that are not disposed of by an authorized collector, the EPA recommends destruction and disposal of the substance with other solid waste following the steps below: a. Take the medication out of the original containers. b. Mix medication, either liquid or solid, with an undesirable substance. Undesirable substances include sand, coffee grounds, kitty litter, or other absorbent materials. Place the waste mixture in a sealable bag, empty can, or other container to prevent leakage. On 12/2/24 at 0823 hours, a concurrent inspection of Medication Cart B and interview was conducted with LVN 5. One sterile glove was opened and observed in the cart. LVN 5 verified the above findings and stated sterile glove should not be in the cart, it was unsealed and considered not sterile. b. On 12/2/24 at 0835 hours, a concurrent inspection of Medication Cart C and interview was conducted with LVN 5. The following was observed: - One optiform non adhesive foam dressing (a foam dressing that has a silicone adhesive border) was opened (breaking sterility). - One abdominal pad dressing was opened. - One xeroform petrolatum (non-adhering protective dressing consisting of absorbent, fine-mesh gauze impregnated with a petrolatum blend) dressing was opened. - One foam wound dressing was opened. - One 15 Fr urethral catheterization tray was opened. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LVN 5 verified the above findings and stated all licensed nurses are responsible in cleaning the cart, opened items were compromised, should have been discarded, all dressings and treatment items should have been sealed. 2. On 12/2/24 at 0807 hours, a concurrent observation and interview was conducted with LVN 5 in Medication room [ROOM NUMBER]. One medication disposal bin was noted with multiple whole pills not fully dissolved, one unidentified bottle, two insulin pens, nasal spray, inhaler and four syringes. LVN 5 acknowledged the medication disposal bin had medications not fully dissolved and the lid was removable. LVN 5 stated liquids should have been emptied and container should have been disposed, whole pills and narcotics should have been crushed. On 12/5/24 at 0831 hours, an interview was conducted with the DON. The DON was informed and verified the above findings. The DON acknowledged the pills in the medication disposal bin were to be fully diluted. The DON stated liquids should have been poured and the bottles should have not been kept in the medication disposal bin.

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F 0807 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. 48882 Based on observation, interview, facility document review, and facility P&P review, the facility failed to accommodate the drink preferences for one of 13 sampled residents (Resident 12). * Resident 12 was not served milk for his lunch meal. This failure had the potential to affect the resident's overall meal intake and nutritional status. Findings: Review of the facility's P&P titled Systems for Recording Food Preferences dated 2023 showed the food and beverage preference notes must be kept on file, recorded on the meal identification card/ticket or kept in an electronic format. For meal identification cards, to note the food and beverage preferences on the individuals' meal identification card/ticket. Review of the facility's document titled Generations Health Care Menu Week 1, showed the following entrees to be served for lunch on Monday 12/2/24: Roast Pork Loin, Poultry Gravy, Roasted Potatoes, Capri Mixed Vegetables, Applesauce Bar, Milk, and choice of beverage. On 12/2/24 at 1234 hours, a concurrent lunch observation and interview was conducted with Resident 12 in his room. Resident 12 was observed sitting in his wheelchair with a lunch tray in front of him. Resident 12's lunch tray was observed with a plate of chicken salad, a cup of water, a cup of cranberry juice, a chocolate ice cream, and an applesauce bar. Review of Resident 12's lunch meal ticket (used to identify the resident's diet, allergies, and food preferences) showed a standing order for four ounces of whole milk for the lunch meal. Resident 12's lunch tray was not observed with the milk. Resident 12 was interviewed and stated he would like to have the milk with his lunch. On 12/2/24 at 1239 hours, a concurrent observation and interview was conducted with CNA 5. CNA 5 stated the standing order section of the resident's meal ticket indicated an item the resident requested for or the preferences the resident would like for the meal. CNA 5 verified the above findings and informed Resident 12 she would get his milk. On 12/2/24 at 1245 hours, Resident 12 was observed with a carton of whole milk. On 12/4/24 at 1212 hours, an interview was conducted with the DSS. The DSS stated if the milk was included on the resident's meal ticket, then the milk should have been included on the resident's meal tray. On 12/5/24 at 1701 hours, the ADM and the DON were informed and acknowledged the above findings.

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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** 43119 Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the sanitary requirements were met in the kitchen as evidenced by: * The facility failed to ensure the ice machine utilized for the residents and staff was maintained in a sanitary condition. * The facility failed to ensure the microwave utilized to warm up the food was in sanitary condition and free of food residue. * The facility failed to ensure the sanitary condition of the hood over the stove was maintained. * The facility failed to ensure the kitchen utensils had a smooth cleanable surface and in good condition. * The facility failed to ensure the kitchenware and kitchen utensils were clean and free of food particle or residue. * The facility failed to ensure the cutting board was kept in a sanitary condition and with cleanable surface. * The facility failed to ensure the countertop mounted can opener was in sanitary condition and free of residue. * The facility failed to ensure the heavy-duty blender used for puree preparation and the stainless-steel bucket were cleaned and air dried prior to storing. * The facility failed to ensure the expired foods were discarded. These failures had the potential for cross contamination and foodborne illnesses to the residents consuming the foods prepared in the facility's kitchen. Findings: Review of the facility's Patient Diet List dated [DATE], showed 39 of 41 residents consumed the foods prepared in the kitchen. 1. Review of the facility's P&P titled Ice Machine and Storage Chests revised date ,d+[DATE] showed the ice machines and ice storage/ distribution chests will be used and maintained to assure a safe and sanitary supply of ice. Clean and sanitize the ice machine per manufacturer's guidelines. The Maintenance Director/ designee will maintain a copy of these procedures; including a cleaning log. According to the USDA Food Code 2017, Section ,d+[DATE].11, the equipment food-contact surfaces and utensils shall be clean to sight and touch. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 0850 hours, during the initial kitchen tour, a concurrent observation and interview was conducted with the Environmental Services Director. The ice machine's interior top portion to the water curtain located directly above the ice bin, was observed with pinkish residue. The Environmental Services Director acknowledged the findings and stated was unknown what the pink residue from, and the ice would not be used because it was dirty and to prevent cross contamination. 2. Review of the facility's P&P titled Cleaning Instructions: Microwave Oven dated 2023 showed the microwave oven will be kept clean, sanitized, and odor free. The microwave oven interior should be cleaned after each use as needed, and at minimum, after each meal service. According to the USDA Food Code 2017, Section ,d+[DATE].11, Multiuse, Characteristics, materials that are used in the construction of utensils and food contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be durable, corrosion-resistant, nonabsorbent, finished to have a smooth, easily cleanable surface, and resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition. On [DATE] at 0905 hours, during the initial kitchen tour, a concurrent observation and interview was conducted with the Dietary Supervisor. The microwave on a stainless-steel shelf was observed dirty with dry, crusted food residue inside the microwave's door and had dry food residue inside the microwave. The Dietary Supervisor verified the findings and stated the microwave should have been clean daily after each used and deep cleaned weekly by the Dietary staff. 3. Review of the facility's P&P titled General Food Preparation and Handling dated 2023 showed all food service equipment should be cleaned, sanitized, air-dried and reassembled after each use. According to the USDA Food Code 2022 Section ,d+[DATE].11 Ventilation Hood Systems, Drip Prevention. The dripping of grease or condensation onto food constitutes adulteration and may involve contamination of the food with pathogenic organisms. Equipment, utensils, linens, and single service and single use articles that are subjected to such drippage are no longer clean. On [DATE] at 0905 hours, during the kitchen tour, a concurrent observation and interview was conducted with the Dietary Supervisor. The kitchen hood over the stove had black, grease residue. The Dietary Supervisor acknowledged the findings and stated the dietary staff member cleaned the hood once a week to prevent grease residue from dropping into the food and cleaned every six months by an outside company and was last serviced on [DATE]. 4. Review of the facility's P&P titled General Food Preparation and Handling dated 2023 showed the plastic-ware or dishware that has lost its glaze or is chipped or cracked must be disposed of. According to the USDA Food Code 2022 Section ,d+[DATE].11 Good Repair and Calibration, (A) Utensils shall be maintained in a state of repair and condition that complies with the requirements specified under Parts ,d+[DATE] and ,d+[DATE] or shall be discarded. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the USDA Food Code 2022, Section ,d+[DATE].11, Multiuse, Characteristics, materials that are used in the construction of utensils and food contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be durable, corrosion-resistant, nonabsorbent, finished to have a smooth, easily cleanable surface, and resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition. On [DATE] at 0752 hours, during the initial kitchen tour, a concurrent observation and interview was conducted with the Dietary Supervisor. The following was observed and verified by the Dietary Supervisor: - Two stainless whisk with gray/ purple handles were worn out, rubber handles were chipped and cracked. - One white basting brush used for butter was worn out and bristles was frayed. - Three mesh strainers were deformed and worn out with rusty discoloration. - One black rolling pin used to make pizza had degraded coating, handles peeling and worn out. - One black egg slicer was worn out, discolored, dirty, and had dry crusted food residue. - Three rubber spatulas with red handles were dirty, discolored and had chipped edges. - One stainless steel spatula with black handle was partially burnt. - One stainless steel spatula with wooden handle discolored and partially burnt. - One dough cutter/ scraper with wooden handle was worn out, discolored and had uneven edges. The Dietary Supervisor acknowledged the above findings and stated all should not be use, will be discarded and replaced because it could get mix with the food and cause cross contamination. 5. Review of the facility's P&P titled General Food Preparation and Handling dated 2023 showed all the food service equipment should be cleaned, sanitized, air-dried and reassembled after each use. Review of the facility's P&P titled Handling Clean Equipment and Utensils dated 2023 showed clean equipment and utensils will be handled properly to prevent contamination. According to the USDA Food Code 2022, ,d+[DATE].11 Equipment, Food - Contact Surfaces, Nonfood Contact Surface, and Utensils, the equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations; and the nonfood- contact surface of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. According to the USDA Food Code 2017, ,d+[DATE].13, Non- Contact Surfaces, nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 0905 hours, during the initial kitchen tour, a concurrent observation and interview was conducted with the Dietary Supervisor. The following was observed and verified by the Dietary Supervisor: - One stainless whisk with gray/ purple handle had dry, crusted black residue. - Three rubber spatulas with red handles were dirty and had dry food residue. - Two stainless steel slotted spoons were dirty and had dry, crusted residue. - Two cutting knives with black handles were dirty, fuzzy with cloudy stains on the blades. - One stainless steel spatula with wooden handle was dirty and had dry water spots. - One black egg slicer was dirty and had dry food residue. - One small size stainless steel bucket was dirty and had dry water spots. The Dietary Supervisor acknowledged the above findings and stated it needed to be washed to prevent from residue getting mix with food, prevent food contamination and some needed to be discarded and replaced. 6. Review of the facility's P&P titled General Food Preparation and Handling dated 2023 showed separate the cutting boards for raw and uncooked food and for raw fruits and vegetables will be used. The cutting boards should be of hard rubber construction (not wood) and must be dishwasher safe. The cutting boards should be cleaned and sanitized after each use, following the dish machine or three compartment sink method and will be air dried before storing. According to the USDA Food Code 2022, Section ,d+[DATE].12, Cutting Surfaces, for surfaces such as cutting boards and blocks that become scratched and scored may be difficult to clean and sanitize. As a result, pathogenic microorganisms transmissible through food may build up or accumulate. These microorganisms may be transferred to the foods that are prepared on such surfaces. On [DATE] at 0752 hours, during the initial kitchen tour, a concurrent observation and interview was conducted with the Dietary Supervisor. The white and green cutting boards were observed discolored, fuzzy, heavily marred and had deep groves. The Dietary Supervisor verified the findings and stated the cutting boards were not acceptable and should have been discarded and replaced. 7. Review of the facility's P&P titled Cleaning Instructions: Can Opener dated 2023, showed the can opener will be cleaned after each use. According to the USDA Food Code 2017, Section ,d+[DATE].11, Multiuse, Characteristics, materials that are used in the construction of utensils and food contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be durable, corrosion-resistant, nonabsorbent, finished to have a smooth, easily cleanable surface, and resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 0905 hours, during the initial kitchen tour, a concurrent observation and interview was conducted with the Dietary Supervisor. The countertop mounted can opener had rusty discoloration on the blade and peeled coating. The Dietary Supervisor verified the findings and stated the can opener would not be used to avoid food contamination. 8. Review of the facility's P&P titled General Food Preparation and Handling dated 2023 showed all food service equipment should be cleaned, sanitized, air-dried and reassembled after each use. According to the USDA Food Code 2022, ,d+[DATE].11, Equipment and Utensils, Air-Drying Required, that after cleaning and sanitizing, equipment, and utensils shall be air-dried or used after adequate draining before getting in contact with food. According to the USDA Food Code 2022, ,d+[DATE].11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles, cleaned equipment and utensils shall be stored in a self-draining position that allows air drying. On [DATE] at 0905 hours, during the initial kitchen tour, a concurrent observation and interview was conducted with the Dietary Supervisor. The following was observed and verified by the Dietary Supervisor: - One heavy-duty blender stored on the counter shelf was still wet with visible water inside and had white food residue inside. - One medium size stainless steel bucket stored wet. The Dietary Supervisor acknowledged the above findings and stated it needed to be washed and air dried to prevent bacteria growth and food contamination. 9. Review of the facility's P&P titled Food Storage dated 2023 showed all foods should be covered, labeled and dated and routinely monitored to assure that foods (including leftovers) will be consumed by their use by dates, or frozen (where applicable) or discarded. According to the FDA Food Code 2017, Section ,d+[DATE].17 Ready-To-Eat, Time/Temperature Control for Safety Food, Date Marking: Marking the date or day the original container is opened with a procedure to discard the food on or before the last date by which the food must be consumed. On [DATE] at 0752 hours, during the initial kitchen tour, a concurrent observation and interview was conducted with the Dietary Supervisor. The following was observed and verified by the Dietary Supervisor: - One small bowl of egg salad stored in the refrigerator dated [DATE]. - Multiple individual fruit cups covered w/ saran wrap all placed in a gray serving tray stored in the refrigerator with label showed, Item: Fruit, Prep date [DATE] and use by date [DATE]. - Multiple styrocups w/ prunes and apple sauce all placed in a gray serving tray stored in the refrigerator with label showed, Item: Prunes & Apple sauce, Prep date [DATE] and use by date [DATE]. (continued on next page)

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	055518	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Newport Nursing and Rehabilitation Center	1555 Superior Avenue Newport Beach, CA 92663

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Multiple styrocups w/ pudding all placed in a gray serving tray stored in the refrigerator with label showed: Item: Reg pudding, Prep date [DATE] and use by date [DATE]. The Dietary Supervisor verified the above findings and stated above items should have been labeled accurately and expired items should have been discarded. On [DATE] at 1700 hours, the DON and the Administrator was informed and acknowledged the above findings.

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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** 48882 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to maintain the infection control practices to prevent the development and transmission of diseases and infections. * The facility failed to show documentation of the Legionella facility risk assessment and testing protocols for Legionella and other opportunistic waterborne pathogen. * CNA 1 failed to remove the gown and gloves and perform hand hygiene after touching Resident 498 and before touching Resident A's environment. * The facility failed to ensure a N95 respirator was stored in a sanitary manner, at the entrance to a resident COVID-19 isolation room. * CNA 6 placed Resident 298's shower bin (which contained a clean towel and bathrobe belt) on top of a soiled linen cart during Resident 298's shower. * The residents' clean linen cart was observed with several bath robe belts lying on top of the clean linen cart. These failures had the potential to result in the transmission of infection to a vulnerable population of residents in the facility. Findings: 1. According to the CMS QSO 17-30 titled Requirement to Reduce Legionella Risk in Healthcare Facility Water Systems to Prevent Cases and Outbreaks of Legionnaire's Disease dated 6/2/17, the facilities must develop and adhere to the policies and procedures that inhibit microbial growth in building water systems that reduce the risk of growth and spread of Legionella and other opportunistic pathogens in building water systems. These facilities must have water management plans and documentation that, at a minimum, ensure each facility: - Conducts a facility risk assessment to identify where Legionella and other opportunistic waterborne pathogens (e.g. Pseudomonas, Acinetobacter, Burkholderia, Stenotrophomonas, nontuberculous mycobacteria, and fungi) could grow and spread in the facility water system; - Develops and implements a water management program that considers the ASHRAE (American Society of Heating Refrigerating and Air-Conditioning Engineers) industry standards and the CDC (Centers for Disease Control and Prevention) toolkit; and - Specifies testing protocols and acceptable ranges for control measures and documents the results of testing and corrective actions when control limits are not maintained. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's P&P titled Legionella Water Management Program revised 9/2022 showed as part of the infection prevention and control program, the facility has a water management program. The purposes of the water management program were to identify areas in the water system where Legionella bacteria can grow and spread, and to reduce the risk of Legionnaire's disease. Further review of the facility's P&P showed the water management program includes the following elements: b. A detailed description and diagram of the water system in the facility, including the following: 1. Receiving; 2. Cold water distribution; 3. Heating; 4. Hot water distribution; and 5. Waste. c. The identification of areas in the water system that could encourage the growth and spread of Legionella or other waterborne bacteria, including the following: 1. Storage tanks; 2. Water heaters; 3. Filters; 4. Aerators; 5. Showerheads and hoses; 6. Misters, atomizers, air washers and humidifiers, 7. Hot tubs; 8. Fountains; and 9. Medical devices such as CPAP machines, hydrotherapy equipment, etc.; d. The identification of situations that can lead to Legionella growth; e. Specific measures used to control the introduction and/or spread of Legionella; f. The control limits or parameters that are acceptable and that are monitored; g. A diagram of where control measures are applied; h. A system to monitor control limits and the effectiveness of control measures; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	i. A plan for when control limits are not met and/or control measures are not effective; and j. Documentation of the program. The facility failed to show documentation a facility risk assessment was conducted to identify, test, and prevent Legionella and other opportunistic waterborne pathogens in the facility. On 12/5/24 at 1416 hours, the Administrator was asked about the facility's diagram of the water system entering the facility and identified areas of potential pathogen growth and spread. The Administrator stated the facility did not have a flow chart of the water system entering the facility and the water fountain located outside the facility was the only identified risk. On 12/5/24 at 1435 hours, an interview was conducted with the EVS Director. The EVS Director stated his role in the water management program was to check and clean the water fountain weekly. The EVS Director stated the facility had four water heaters, two shower rooms with two shower heads in each room, and an ice machine. The EVS Director stated an outside source comes to the facility to test the water fountain and stated the company did not test any other areas in the facility. The EVS Director was asked if he tested for Legionella or other potential pathogens in areas that are potential risks for standing water and the EVS Director stated he did not conduct any testing protocols. On 12/5/24 at 1612 hours, a follow-up interview was conducted with the Administrator. The Administrator stated the purpose of the water management program was to monitor for and check surfaces/areas in the facility that have the potential to have Legionella growth. The Administrator reviewed the facility's P&P and CDPH's AFL 18-39 and verified the above findings. On 12/5/24 at 1701 hours, the Administrator and DON were informed and acknowledged the above findings. 2. Medical record review for Resident 498 was initiated on 12/2/24. Resident 498 was admitted to the facility on [DATE]. Review of Resident 498's Order Summary Report showed a physician's order dated 11/26/24, to provide EBP for high contact resident care activities related to indwelling medical devices: g-tube; Foley catheter; to perform hand hygiene and apply PPE: gloves, gown and/or goggle/face shield worn if risk of splash or spray during high contact resident care activities; to remove PPE and perform hand hygiene prior to exiting the room to prevent the transmission of MDROs. On 12/2/24 at 0935 hours, a concurrent observation and interview was conducted with CNA 1 in Resident 498's room. CNA 1 was observed wearing a gown and gloves and touched Resident 498's arm to check for Resident 498's identification verification band. CNA 1 verified Resident 498 was not wearing an ID band and was observed placing the ID band on Resident 498. CNA 1 was then observed going to Resident A's bedside to remove the diaper from the diaper package and was observed touching Resident A's bed linen. CNA 1 was not observed removing her gown or gloves after contact with Resident 498 and before coming in contact with Residents A's environment. CNA 1 verified she did not change her gown and gloves and did not perform hand hygiene before assisting Resident A. CNA 1 stated she needed to change the PPEs and perform hand hygiene between the residents to avoid contamination. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/4/24 at 1517 hours, an interview was conducted with the IP. The IP stated for the residents placed on enhanced barrier precautions, the staff members were expected to perform hand hygiene and don gown and gloves for high contact activities, when changing linen/perineal care, transferring, or during contact with the resident, to prevent the transfer of MDROs. The IP stated the staff member were expected to change gown and gloves in between the residents and if the gown and gloves were not changed in between the residents, there may be the risk of transmission of infection. On 12/5/24 at 0947 hours, an interview was conducted with the DON. The DON stated for the residents on enhanced barrier precautions, gowns and gloves were needed when touching the resident or their linens. The DON stated staff members were expected to remove the gown and gloves before working with another resident to prevent the contamination from one resident to the next. On 12/5/24 at 1701 hours, the Administrator and the DON were informed and acknowledged the above findings. 37726 3. On 12/2/24 at 0825 hours, a concurrent observation and interview was conducted with RN 2. Resident Room A was observed with a plastic container (which contained PPE) located at the entrance of the room. An N95 respirator was observed unpackaged lying on top of the plastic PPE container. RN 2 stated Resident Room A was currently being used to isolate residents who tested positive for COVID-19. RN 2 was asked to whom the N95 respirator belonged and if it was used or unused. RN 2 stated she did not know if the N95 respirator belonged to a resident, a resident family member, or a facility staff member. RN 2 stated she was uncertain as to whether the N95 respirator had been used or not. RN 2 stated if the N95 respirator had been used it should not be stored on top of the plastic PPE container and should have been discarded, to ensure infection control. Furthermore, RN 2 stated if the N95 respirator had not been used it needed to be stored in a clean package and should not be stored on top of the plastic PPE container, for infection control. On 12/5/24 at 1337 hours, an interview was conducted with the IP. The IP stated the used N95 respirators needed to be discarded. The IP stated clean N95 respirators needed to be stored in the original packaging or when distributed for staff use, the N95 respirator would be stored in a clean bag. The IP stated these facility practices were to avoid the transfer of pathogens. 4. On 12/2/24 at 0755 hours, a concurrent observation and interview was conducted with CNA 6. CNA 6 was observed inside the residents' shower room. CNA 6 stated she had just finished assisting Resident 298 take a shower. Resident 298's plastic bin was observed lying on top of the soiled linen cart. CNA 6 verified Resident 298's plastic bin contained a clean towel and a clean bathrobe belt. CNA 6 stated she had placed Resident 298's plastic bin on top of the soiled linen cart while assisting Resident 298 with his shower. CNA 6 stated the soiled linen cart was located close to the location where Resident 298 had showered, which allowed her access to the contents of Resident 298's bin throughout his shower. CNA 6 verified the soiled line cart contained soiled linen. On 12/5/24 at 1337 hours, an interview was conducted with the IP. The IP stated the resident's shower bins which contained clean linens (towels, resident bath robes, and bath robe belts) should not be stored on top of the soiled linen cart 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	5. On 12/2/24 at 0755 hours, a concurrent observation and concurrent interview was conducted with CNA 6. A clean linen cart which contained clean resident towels, bathrobes, and bathrobe belts was observed inside of the shower room. Several bathrobe belts were observed lying on top of the clean linen cart. CNA 6 verified the findings and stated the resident bathrobe belts had yet to be used by the residents and should have been stored inside the clean linen cart for infection control. On 12/5/24 at 1337 hours, an interview was conducted with the IP. The IP stated the clean residents bathrobe belts should not be stored on top of the clean linen cart for infection control.