STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055526	A. Building B. Wing	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Inglewood Health Care Center	100 S. Hillcrest Blvd Inglewood, CA 90301

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 46832

Based on interview and record review, the facility failed to ensure Certified Nurse Assistant 5 (CNA 5) was not assigned to one out of five sampled residents (Resident 195) after the resident's family member (FM 1) filed a grievance regarding CNA 5's loud and rude behavior.

This deficient practice had the potential to affect Resident 195's sense of self-worth and self-esteem.

Findings:

During a review of Resident 195's face sheet (front page of the chart that contains a summary of basic information about the resident), the admission record indicated Resident 195 was admitted to the facility on [DATE]. The face sheet indicated Resident 195's diagnoses included displaced fracture of the upper end of the left humerus (a broken left upper arm bone), displaced fracture of the lower end of right humerus (a broken right upper portion of the elbow), displaced intertrochanteric fracture of the left femur (a broken thigh bone), and unspecified fracture of the left patella (a break in the kneecap).

During a review of Resident 195's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 10/2/2024, the MDS indicated Resident 195's cognitive skills was intact. The MDS also indicated Resident 195 was fully dependent on staff with toileting, showering, upper and lower body dressing, and eating.

During a record review of the facility's grievances log, the log indicated Resident 195's family member (FM 1), filed a grievance (a wrong or hardship suffered, real or supposed, which forms legitimate grounds of complaint) on 9/28/2024, stating Resident 195 was not treated with respect by Certified Nurse Assistant 5 (CNA 5).

During an interview on 10/17/2024, at 12:02 p.m., with Resident 195, Resident 195 stated she felt CNA 5 had been rude to her two days after she was admitted to the facility. Resident 195 denied being called any derogatory names (a word or phrase that is intended to belittle, disparage, or detract from someone or something). Resident 195 stated the CNA 5 was rude to the resident with the tone of her voice used. Resident 195 stated CNA 5 had spoken loudly to her, but she could not understand what was being said, as there was a language barrier. Resident 195 stated FM 1 filed a grievance against CNA 5. Resident 195 stated she felt safe then began to cry.

(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: 055526	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER: Inglewood Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 100 S. Hillcrest Blvd Inglewood, CA 90301	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 10/17/2024, at 12:02 p.m., with the Social Services Director (SSD), the SSD stated she was aware of the grievance FM 1 filed on 9/28/2024. The SSD stated the family and staff had an Interdisciplinary Team (IDT- a team that brings together knowledge from different healthcare disciplines to help patients receive the care they need) meeting regarding dignity concerns such as not knocking and loud talking for Resident 195. The SSD stated staff should have not yelled or became loud when care was provided towards Resident 195. The SSD stated the risk of not providing residents with dignity and respect could result in disturbing a resident, causing a resident to feel intimated and afraid. The SSD stated, It is a dignity issue. During an interview and record review, on 10/17/2024, at 3:16 p.m., with Registered Nurse Supervisor (RN 1), RN 1 stated she was aware of the grievance filed by FM 1. RN 1 stated the interventions for the 9/28/2024 grievance included removing CNA 5 from providing care to Resident 195. RN 1 stated the intervention of removing CNA 5 from providing care to Resident 195 was not implemented. RN 1 stated CNA 5 worked with Resident 195 on 10/7/2024, 10/9/2024 and 10/10/2024 for a total of 3 days after she was to be removed from the assignment for Resident 195. RN 1 stated the risk of not providing residents with dignity and respect could result in the fear of retaliation and inadequate care. During an interview on 10/17/2024, at 3:42 p.m., with the Director of Staff Development (DSD), the DSD stated Resident 195 informed her that she was not comfortable with the care provided by CNA 5. The DSD stated Resident 195 stated CNA 5 was loud while in the resident's room. The DSD stated a 1:1 in-service regarding customer care, dignity and respect was provided for CNA 5 on 9/30/2024. The DSD stated CNA 5 should have been removed from providing care for Resident 195 after the grievance was filed. The DSD stated CNA 5 was not removed. The DSD stated the risk of not providing residents with dignity and respect could result in a resident becoming fearful and uncomfortable. During an interview on 10/17/2024, at 4:16 p.m., with the Human Resources Staffing Coordinator (HRSC), the HRSC stated she was the one who coordinated the staffing assignment. The HRSC stated CNA 5 worked with Resident 195 for 3 days after she was to be removed from her care. The HRSC stated CNA 5 should not have been assigned to work with Resident 195. The HRSC stated the risk of not providing dignity and respect could result in fear. The HRSC stated It's not good, you don't want to see anyone that you're afraid of. I'm sorry about that. During a review of the facility's policy and procedures (P&P), titled Quality of Life-Dignity, undated, the P&P indicated Staff speak respectfully to residents at all times, including addressing the resident by his or her name of choice and not labeling or referring to the resident by his or her room number, diagnosis or care needs.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 46144 Based on interview and record review, the facility failed to ensure one out of five sampled residents (Resident 81) was notified her missing Electronic Benefit Transfer ([EBT]- to access benefits for food and cash aid) card was found. This deficient practice of not notifying Resident 81 the EBT card was found had the potential to cause distress for Resident 81. Findings: During a review of Resident 81's Admission Record (Face Sheet), the Face Sheet indicated Resident 81 was admitted to the facility on [DATE]. Resident 81's diagnoses included metabolic encephalopathy (a brain dysfunction caused by a chemical imbalance in the blood that affects the brain), chronic kidney disease (a condition where the kidneys do not work as well as they should), and dementia (a progressive state of decline in mental abilities). During a review of Resident 81's History and Physical (H&P), dated 9/11/2024, the H&P indicated Resident 81 had fluctuating capacity to understand and make decisions. During a review of Resident 81's Minimum Data Set ([MDS] a federally mandated assessment tool), dated 9/16/2024 the MDS indicated, Resident 81's cognition (ability to learn, reason, remember, understand, and make decisions) was severely impaired. The MDS indicated Resident 81 required substantial assistance from staff for personal hygiene, showering, and dressing. During a review of Residents 81's inventory list titled, Inventory of Personal Effects, dated 9/10/2024, the Inventory of Personal Effects indicated Resident 81 had an identification (ID) pack with an EBT card from the resident's family. During an interview on 10/16/2024 at 10:39 a.m. with Resident 81's Responsible Party (RP) 1, RP 1 stated while visiting Resident 81, Certified Nursing assistant (CNA) 2 told him Resident 81's EBT card was missing. RP 1 stated the EBT card had a value of 190 dollars. RP 1 stated the EBT card had not been found. During an interview on 10/17/2024 at 12:00 p.m. with Resident 81, Resident 81 stated her EBT card was missing and did not know what happened to the EBT card. Resident 81 stated she was worried about her EBT card. During an interview on 10/17/2024 at 1:52 p.m. with CNA 2, CNA 2 stated Resident 81's EBT card was missing on 10/12/2024. CNA 2 stated she looked everywhere for the EBT card and was not able to locate the EBT card. CNA 2 stated once she could not locate Resident 81's EBT card she notified the registered nurse supervisor. CNA 2 stated Resident 81 was worried about the missing EBT card. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/17/2024 at 4:07 p.m. with Registered Nurse (RN) 1, RN 1 stated she was not aware Resident 81's EBT card was missing. RN 1 stated it was important to be notified of the missing EBT card so the staff could continue to look for the EBT card. RN 1 stated the administrator and social worker should have been notified so the EBT card could be replaced. RN 1 stated the staff not notifying each other of Resident 81's missing EBT card delayed the finding of the EBT card and caused more distress for Resident 81. During an interview on 10/17/2024 at 4:17 p.m. with the Activities Director (AD), the AD stated Resident 81's EBT card was located in the activity room on 10/14/2024. The AD stated she put the EBT card in her office and did not notify the staff or Resident 81 the EBT card was located. The AD stated it was important to notify the staff, Resident 81, and return the EBT card to eliminate distress. During a review of the facility's policy and procedure (P&P) titled, Residents and Personal Property, date unknown, the P&P indicated, residents are permitted to retain use of personal possessions, appropriate clothing, and as space permits. Reports of misappropriation or mistreatment of resident property are to be investigated through the resident theft/loss/grievance process and documented in the progress notes or through the grievance process.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46144 Based on interview and record review, the facility failed to ensure one out of five sampled residents (Resident 81) was offered an opportunity to file a grievance (a complaint) for a missing Electronic Benefit Transfer ([EBT]- to access benefits for food and cash aid) card. This deficient practice of not allowing Resident 81 to file a grievance for missing the EBT card had the potential to cause distress for Resident 81. Findings: During a review of Resident 81's Admission Record (Face Sheet), the Face Sheet indicated Resident 81 was admitted to the facility on [DATE]. Resident 81's diagnoses included metabolic encephalopathy (a brain dysfunction caused by a chemical imbalance in the blood that affects the brain), chronic kidney disease (a condition where the kidneys do not work as well as they should), and dementia (a progressive state of decline in mental abilities). During a review of Resident 81's History and Physical (H&P), dated 9/11/2024, the H&P indicated Resident 81 had fluctuating capacity to understand and make decisions. During a review of Resident 81's Minimum Data Set ([MDS] a federally mandated assessment tool), dated 9/16/2024 the MDS indicated, Resident 81's cognition (ability to learn, reason, remember, understand, and make decisions) was severely impaired. The MDS indicated Resident 81 required substantial assistance from staff for personal hygiene, showering, and dressing. During a review of Residents 81's inventory list titled, Inventory of Personal Effects, dated 9/10/2024, the Inventory of Personal Effects indicated Resident 81 had an identification (ID) pack with an EBT card from her family. During an interview on 10/16/2024 at 10:39 a.m. with Resident 81's Responsible Party (RP) 1, RP 1 stated while visiting Resident 81, Certified Nursing assistant (CNA) 2 told him Resident 81's EBT card was missing. RP 1 stated the EBT card had a value of 190 dollars. RP 1 stated the EBT card had not been found. During an interview on 10/17/2024 at 12:00 p.m. with Resident 81, Resident 81 stated her EBT card was missing and did not know what happened to the EBT card. Resident 81 stated she worried about her EBT card. During an interview on 10/17/2024 at 3:55 p.m. with the Social Services Director (SSD), the SSD stated she was not aware Resident 81's EBT card was missing. The SSD stated the process was to investigate and allow Resident 81 to file a grievance for the missing EBT card. The SSD stated if she knew Resident 81's EBT card was missing she would have initiated to have the EBT card replaced. The SSD stated the grievance process was not followed. The SSD stated not allowing Resident 81 to file a grievance could cause distress for the resident. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/17/ 2024 at 4:05 p.m. with the Director of Nursing (DON), the DON stated she was not aware Resident 81's EBT card was missing. The DON stated the process was for Resident 81 to file a grievance as staff continued to look for the EBT card. The DON stated Resident 81's lost EBT card could cause Resident 81 to have emotional distress and may cause anxiety (a feeling of fear, dread, and uneasiness). During a review of the facility's policy and procedure (P&P) titled, Grievances and Complaints, date unknown, the P&P indicated, to support each resident's right to voice grievances and to ensure that after a grievance has been received, the company will actively resolve the issue and communicate the resolution's progress to the resident and or resident's family in a timely manner. The P&P indicated the written grievance is to be forwarded to the company's grievance official within 24 hours of receipt.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47923 Based on interview and record review, the facility failed to accurately complete the Minimum Data Set ([MDS]- a federally mandated resident assessment tool) Section A for the level II Preadmission Screening and Resident Review ([PASRR] a tool to determine if the person had or was suspected of having a mental illness or intellectual disability) condition for two out of five sampled residents (Resident 42 and 85). This deficient practice resulted in incorrect data transmitted to the Centers for Medicare and Medicaid Services (CMS) and had the potential to result in inaccurate care and services for Resident 42 and 85. Cross Reference F644. Findings: a. During a review of Resident 42's Admission Record (Face Sheet - front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 42 was admitted to the facility on [DATE]. The admission record indicated Resident 42's diagnoses included schizophrenia (a mental illness that is characterized by disturbances in thought), dementia (a progressive state of decline in mental abilities), osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) of the left shoulder and anemia (a condition where the body does not have enough healthy red blood cells). During a review of Resident 42's MDS, dated [DATE], the MDS indicated Resident 42's cognitive skills was severely impaired (ability to think and reason). The MDS indicated Resident 42 was dependent on staff with toileting, showering, upper and lower body dressing, and eating. The MDS also indicated Resident 42 did not have a diagnosis of schizophrenia. During a concurrent interview and record review, on 10/18/2024, at 9:39 a.m., with the MDS Nurse, the MDS Nurse stated Resident 42 had a diagnosis of schizophrenia. The MDS Nurse stated the MDS Assessment regarding mental health disorders did not acknowledge Resident 42's diagnosis. The MDS Nurse stated Resident 42's MDS was inaccurate. The MDS Nurse stated the risk of having inaccurate assessments could result in poor quality of care. The MDS Nurse stated, It should have reflected her having a mental illness. b. During a review of Resident 85's Face Sheet, the Face Sheet indicated, Resident 85 was admitted to the facility on [DATE]. Resident 85's diagnoses included schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), chronic kidney disease ([CKD]- a condition where the kidneys are damaged and can't filter blood properly), and dysphagia (difficulty of swallowing). During a review of Resident 85's History and Physical (H&P), dated 6/6/2024, the H&P indicated, Resident 85 did not have the capacity for medical decision making. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 10/18/2024 at 11:43 a.m., with the MDS nurse, Resident 85's MDS assessment, dated 6/11/2024 was reviewed. The MDS nurse stated Resident 85's cognitive skills for daily decision making was severely impaired. The MDS nurse stated Resident 85's MDS section A1500 (Preadmission Screening and Resident Review) assessment and A1510 (Level II Preadmissions Screening and Resident Review Conditions) were completed inaccurately. The MDS nurse stated Resident 85's MDS assessment section A1500 should had been coded as 1 and not 0. The MDS nurse stated Resident 85's MDS assessment section A1510 (Level II Preadmissions Screening and Resident Review Conditions) should have a checked on the box for serious mental illness since Resident 85 had a diagnosis of schizoaffective disorder. The MDS nurse stated accuracy of assessment in the MDS was essential because it involves the care provided by facility staff to the residents. During a review of the facility's undated policy and procedure (P&P) titled, Certifying Accuracy of the Resident Assessment, the P&P indicated, Any person completing a portion of the Minimum Data Set/MDS (Resident Assessment Instrument) must sign and certify the accuracy of that portion of the assessment.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47923 Based on interview and record review, the facility failed to ensure a Preadmission Screening and Resident Review ([PASRR] a tool to determine if the person had or was suspected of having a mental illness or intellectual disability) was resubmitted for two out of five sampled residents (Resident 42 and 85). This deficient practice had the potential to result in Residents 42 and 85 not receiving the necessary mental health care and services needed. Cross Reference F641. Findings: a. During a review of Resident 42's admission record (face sheet), the admission record indicated Resident 42 was admitted to the facility on [DATE]. The admission record indicated Resident 42's diagnoses included schizophrenia (a chronic mental disorder that affects how people think, feel, and behave), dementia (a group of thinking and social symptoms that interferes with daily functioning), osteoarthritis (a chronic degenerative joint disease that occurs when the cartilage in a joint breaks down and becomes rough) of the left shoulder, and anemia (a condition where the body doesn't have enough healthy red blood cells or the red blood cells aren't functioning properly). During a review of Resident 42's Minimum Data Set (MDS- a federally mandated assessment tool), dated 8/9/2024, the MDS indicated Resident 42's cognitive skills for daily decision making was severely impaired (ability to think and reason). The MDS indicated Resident 42 was dependent on staff with toileting, showering, upper and lower body dressing, and eating. During a record review of Resident 42's diagnosis list, the diagnosis list indicated Resident 42 was diagnosed with schizophrenia on 9/20/2021. During a concurrent interview and record review, on 10/18/2024, at 9:39 a.m., with the MDS Nurse, the MDS Nurse stated PASRR's were completed before a resident was admitted to the facility. The MDS Nurse stated if a resident had a mental illness diagnosis, the PASARR process was to be completed. The MDS Nurse stated Resident 42 had a diagnosis of schizophrenia and a PASRR should have had been resubmitted for Resident 42. The MDS Nurse stated the risk of not resubmitting a PASRR could result in a decline in a resident's mental health, and not receiving the additional resources provided by PASRR. b. During a review of Resident 85's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated, Resident 85 was admitted to the facility on [DATE]. Resident 85's diagnoses included schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), chronic kidney disease ([CKD]- a condition where the kidneys are damaged and can't filter blood properly), and dysphagia (difficulty of swallowing). During a review of Resident 85's History and Physical (H&P), dated 6/6/2024, the H&P indicated, Resident 85 did not have the capacity for medical decision making. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 85's MDS, dated [DATE], the MDS indicated, Resident 85's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 85 required supervision (helper provides verbal cues as resident completes activity) from staff with toileting hygiene and personal hygiene. During a review of Resident 85's Order Summary Report (a document containing active orders), dated 10/17/2024, the Order Summary Report indicated, Resident 85 had a physician's order of aripiprazole (medication that treats several kinds of mental health conditions) 2 milligrams ([mg] unit of measurement) 1 tablet once a day at bedtime for schizoaffective disorder. During a concurrent interview and record review on 10/18/2024 at 11:43 a.m., with the MDS Nurse, Resident 85's PASRR level 1 screening completed and submitted by the general acute care hospital (GACH) on 6/5/2024 was reviewed. The PASRR level 1 screening indicated, Resident 85 had no serious mental illness mental diagnosis and was not receiving psychotropic medications (any drug that affects brain activities associated with mental processes and behavior) for mental illness. The PASRR level 1 screening also indicated Resident 85's case was closed, and a PASRR level 11 mental health evaluation was not required. The MDS nurse stated the PASRR level 1 was not completed accurately since Resident 85 had a diagnosis of schizoaffective disorder and was receiving psychotropic medication. The MDS nurse stated the facility should have completed and resubmitted a new PASRR level 1 screening for Resident 85 to indicate the serious mental illness diagnosis and use of psychotropic medication in order to trigger a PASRR level 11 evaluation and redetermination so Resident 85 could be evaluated and possibly receive appropriate treatment recommendations for schizoaffective disorder. During a review of the facility's undated policy and procedure (P&P) titled, Preadmission Screening and Resident Review, the P&P indicated, The facility's designated staff will review the PASSR from the acute hospital and determine if there is a required follow-up such as a level 11 referral.

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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** 47923 Based on interview and record review, the facility failed to develop a person-centered care plan for two of five sampled residents (Resident 83 and Resident 195) by failing to: 1. Develop a comprehensive care plan addressing Resident 83's smoking. 2. Develop a care plan after Resident 195 filing of two grievances (a wrong or hardship suffered, real or supposed, which forms legitimate grounds of complaint). These deficient practices had the potential to negatively affect the delivery of necessary care and services for Resident 83 and Resident 195. Findings: a. During a review of Resident 83's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated, Resident 83 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 83's diagnoses included major depressive disorder (a mental health condition characterized by a depressed mood or loss of interest in activities for a prolonged period of time), anxiety disorder (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness) and mental disorder (a condition that affect your thinking, feeling, mood, and behavior). During a review of Resident 83's History and Physical (H&P), dated 8/9/2024, the H&P indicated, Resident 83 had a capacity for medical decision making. During a review of Resident 83's Minimum Data Set ([MDS] - a federally mandated resident assessment tool), dated 8/13/2024, the MDS indicated, Resident 83's cognitive (ability to think and reason) skills for daily decision making was intact. The MDS indicated Resident 83 required setup assistance (helper assist only prior to or following the activity) from staff with eating, oral hygiene, and personal hygiene. During a concurrent interview and record review on 10/17/2024 at 2:38 p.m., with the MDS Nurse (MDS Nurse), Resident 83' smoking assessment and evaluation, dated 8/8/2024 was reviewed. The MDS Nurse stated Resident 83's smoking assessment and evaluation indicated, Resident 83 was a smoker and needed supervision in smoking. The MDS Nurse stated Resident 83 had no comprehensive care plan for smoking in his clinical records. The MDS Nurse stated comprehensive care plans should be developed by the interdisciplinary team ([IDT] team members from different disciplines who come together to discuss resident care) upon admission, quarterly and as needed. The MDS Nurse stated a care plan was a communication tool among staff so they would know how to manage and meet the needs of the resident. The MDS Nurse stated it was important to develop a comprehensive care plan addressing Resident 83's smoking for the safety of the staff and other residents. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. During a review of Resident 195's Face Sheet, the Face Sheet indicated Resident 195 was admitted to the facility on [DATE]. Resident 195's diagnoses included displaced fracture of the upper end of the left humerus (a broken left upper arm bone), displaced fracture of the lower end of right humerus (a broken right upper portion of the elbow), displaced intertrochanteric fracture of the left femur (a broken thigh bone), and unspecified fracture of the left patella (a break in the kneecap). During a review of Resident 195's MDS, dated [DATE], the MDS indicated Resident 195's cognitive skills was intact. The MDS also indicated Resident 195 was fully dependent on staff with toileting, showering, upper and lower body dressing, and eating. During a record review of the facility's grievances log, the log indicated Resident 195's family member (FM 1), filed a grievance on 9/28/2024, indicating Certified Nurse Assistant 5 (CNA 5) was loud and rude while providing resident care to Resident 195. During a review of Resident 195's care plans, the care plans indicated there was no care plan regarding the incident between CNA 5 and Resident 195. During a concurrent interview and record review, on 10/17/2024, at 3:16 p.m., with Registered Nurse 1 (RN 1), RN 1 stated care plans were completed upon a resident's admission, change of condition, transfer, or discharge. RN 1 stated there was not a care plan regarding a grievance filing for Resident 195. RN 1 stated the risk could result in delay of care such as inadequate care for a resident. During a review of the facility's undated policy and procedure (P&P) titled, Comprehensive Plan of Care, the P&P indicated, Each resident will have a comprehensive care plan developed that includes goals, measurable objectives, and timetables to meet their medical, nursing, mental, and psychosocial needs identified during the comprehensive assessment. The P&P also indicated Care plan evaluation must occur in response to changes in the resident's physical, emotional, psychosocial, or communicative status as they occur, as well as following the RAI guidelines.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46144 Based on observation, interview, and record review, the facility failed to ensure one out of six sampled residents (Resident 32) dentures were cleaned daily. This deficient practice of not cleaning Resident 32s dentures daily made Resident 32 feel frustrated. Findings: During a review of Resident 32's Admission Record (Face Sheet), the Face Sheet indicated Resident 32 was initially admitted to the facility on [DATE] and last readmitted on [DATE]. Resident 32's diagnoses included chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing), heart failure (a heart disorder which causes the heart to no pump the blood efficiently, sometimes resulting in leg swelling), and blindness (the inability to see or a lack of vision). During a review of Resident 32's History and Physical (H&P), dated 11/10/2023, the H&P indicated Resident 32 had fluctuating capacity to understand and make decisions. During a review of Resident 32's Minimum Data Set ([MDS] a federally mandated assessment tool), dated 8/4/2024 the MDS indicated, Resident 32's cognition (ability to learn, reason, remember, understand, and make decisions) had the ability to understand and be understood. The MDS indicated Resident 32 vision was severely impaired. The MDS indicated Resident 32 required substantial assistance from staff for personal hygiene and showering. During a review of Resident 32's Lumina Healthcare, dated 6/13/2024, the Lumina Healthcare dental service indicated, Resident 32 did not use the dentures because it was hard for the resident to put them in (as the resident was blind). During an interview on 10/15/2024 at 10:19 a.m. with Resident 32, Resident 32 stated his dentures were not cleaned daily. Resident 32 stated the staff did not clean nor put them on the table within reach before eating. Resident 32 stated since he was blind it was hard for the resident to keep track if the dentures were cleaned or not. During an interview on 10/16/2024 at 11:45 a.m. with Resident 32, in his room, Resident 32 stated the staff did not offer to clean his dentures. Resident 32 stated he did not wear them because he did not know if they were clean or not. Resident 32 stated it was frustrating because he was blind and when the dentures were in his mouth, they felt dirty. During an interview on 10/17/2024 at 4:46 p.m. with the Director of Nursing (DON), the DON stated the certified nursing assistants (CNA) were to soak the dentures at night and clean them in the morning. The DON stated after the dentures were cleaned the CNAs were to place the dentures within reach. The DON stated since Resident 32 was blind the CNAs should explain that the dentures were cleaned and offered to put the dentures in the resident's mouth. The DON stated not cleaning Resident 32's dentures could cause emotional stress due to the lack of not listening to the resident's concerns. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview with Resident 32 on 10/17/2024 at 8:30 a.m., in Resident 32's room, there were no dentures observed. Resident 32 stated the dentures were not offered for breakfast. Resident 32 stated it would be easier to eat the food with dentures. During a concurrent observation and interview on 10/18/2024 at 9:37 a.m. with Certified Nursing Assistant (CNA) 7, CNA 7 stated Resident 32's dentures were in the drawer and not within reach for the resident to eat his breakfast. CNA 7 stated the dentures were to be cleaned daily and placed on the resident bedside table. CNA 7 stated Resident 32 was blind, and the dentures should be offered so the resident could chew his food. During a review of the facility's policy and procedure (P&P) titled, Assisting the Resident to Eat, date unknown, the P&P indicated, to assist the resident to eat. The P&P indicated, assist the resident with hand washing and oral hygiene or dentures. The P&P indicated, identify food and location on the tray for residents with visual problems. During a review of the facility's policy and procedure (P&P) titled, Denture Care date unknown, the P&P indicated, to remove soft plaque deposits and calculus and to reduce mouth odor. The P&P indicated to wash with warm water and place dentures in a clean denture cup. The P&P indicated to encourage resident to wear dentures to enhance appearance, facilitate eating, and speaking, and prevent change in gum line that may affect denture fit.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47923 Based on interview and record review, the facility failed to ensure a follow-up cataract (a medical condition in which the lens of the eye becomes cloudy) and glaucoma (group of eye conditions that can cause blindness and gradual loss of sight) appointment was scheduled for one of three sampled residents (Resident 85). This deficient practice had the potential to result in Resident 85's worsening vision that would negatively affect his quality of life. Findings: During a review of Resident 85's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 85 was admitted to the facility on [DATE]. Resident 85's diagnoses included schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), chronic kidney disease ([CKD]- a condition where the kidneys are damaged and can't filter blood properly), and dysphagia (difficulty of swallowing). During a review of Resident 85's History and Physical (H&P), dated 6/6/2024, the H&P indicated Resident 85 did not have the capacity for medical decision making. During a review of Resident 85's Minimum Data Set ([MDS]- a federally mandated resident assessment tool), dated 9/11/2024, the MDS indicated Resident 85's cognitive (ability to think and reason) skills for daily decision making was severely impaired. The MDS indicated Resident 85's vision was impaired. During a review of Resident 85's Eye Consultation Record, dated 9/9/2024, the eye consultation record indicated Resident 85 required an ophthalmology (a branch of medical science dealing with the structure, functions, and diseases of the eye) referral to evaluate for cataracts and glaucoma. During an interview on 10/15/2024 at 11:01 a.m., with Resident 85, in Resident 85's room, Resident 85 stated he had blurry vision on his right eye and had difficulty in reading the newspaper. Resident 85 stated he was waiting for his new prescription of eyeglasses. Resident 85 stated he was seen by a physician last month and recommended for the resident to be seen by an eye specialist because of his poor vision. Resident 85 stated he did not want to lose his eyesight. During an interview and record review on 10/17/2024 at 2:31 p.m. with the Social Service Director (SSD), Resident 85's clinical records were reviewed. The SSD stated she was responsible for scheduling ophthalmology appointments for all residents. The SSD stated she was not aware Resident 85 needed an ophthalmology appointment to evaluate his cataracts and glaucoma. The SSD stated there was no documentation or follow up by staff that Resident 85 was referred to see an ophthalmologist. The SSD stated the risk of not following up on Resident 85's eye appointment could result in delay of care and treatment, and blindness that would affect his quality of life. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's undated policy and procedure (P&P) titled, Social Services Program, the P&P indicated, General services which a social service department may assist, oversee, or manage could include making referrals and arrangement for and obtaining services from outside referrals including vision, hearing, dental care, and podiatry. During a review of the facility's undated P&P titled, Quality of Care, the P&P indicated, Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents choices.

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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** 46144 Based on observation, interview, and record review, the facility failed to ensure one out of six residents (Resident 84) had the correct low air loss (LAL) mattress (an air mattress with small holes that helps prevent pressure wounds and keeps the skin dry and cool) setting to prevent pressure ulcer development (localized injuries to the skin and soft tissue caused by prolonged pressure on the skin). This deficient practice of not having the correct LAL mattress settings had the potential for Resident 84 to develop a pressure ulcer. Findings: During a review of Resident 84's Admission Record (Face Sheet), the Face Sheet indicated Resident 84 was initially admitted to the facility on [DATE] and last readmitted on [DATE]. Resident 84's diagnoses included failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity), dementia (a progressive state of decline in mental abilities), and chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing). During a review of Resident 84's History and Physical (H&P), dated 9/11/2024, the H&P indicated Resident 84 did not have the capacity to understand and make decisions. The H&P indicated Resident 84 had rashes, ulcers, and blanchable redness (when redness on the skin temporarily disappears when light pressure is applied) to the left heel. During a review of Resident 84's Minimum Data Set ([MDS] a federally mandated assessment tool), dated 5/12/2024, the MDS indicated, Resident 84's cognition (ability to learn, reason, remember, understand, and make decisions) was severely impaired. The MDS indicated Resident 84 was at risk of developing pressure ulcers. The MDS indicated Resident 84 required substantial assistance from staff for personal hygiene, showering, and dressing. The MDS indicated Resident 84 was dependent to roll left and right. During a concurrent observation and interview on 10/16/2024 at 3:56 p.m. with Licensed Vocational Nurse (LVN) 1, in Resident 84's room, Resident 84's LAL mattress setting was set at 400 pounds. LVN 1 stated the setting was incorrect and it should be set at Resident 84's weight of 101 pounds. LVN 1 stated the LAL mattress was used for skin wound management to prevent skin breakdown. LVN 1 stated if the settings were not set correct it could put the resident at risk for skin breakdown. During an interview on 10/17/2024 at 1:08 p.m. with the Minimum Data Set (MDS) Nurse, the MDS Nurse stated the LAL mattress was used to reduce the pressure on the skin for residents who were at high risk for skin breakdown. The MDS Nurse stated Resident 84 was at high risk for skin breakdown. The MDS Nurse stated it was important to have the correct settings on the LAL mattress to uphold Resident 84's skin integrity and to help with circulation. The MDS Nurse stated if the LAL mattress settings were not set properly set; it had the potential to place Resident 84 at risk for pressure ulcers. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Low Air Loss Therapy Bed, date unknown, the P&P indicated low air loss therapy beds consist of segmented, air-filled cushions that provide surface area for pressure relief. The P&P indicated low air loss therapy beds inflate to specific pressures based on the height and weight of the patient.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46144 Based on observation, interview, and record review, the facility failed to ensure one out of six sampled residents (Resident 32) had the correct diet texture when not wearing dentures. This deficient practice of not providing the correct diet texture had the potential for Resident 32 to not properly chew his food. Findings: During a review of Resident 32's Admission Record (Face Sheet), the Face Sheet indicated Resident 32 was initially admitted to the facility on [DATE] and last readmitted on [DATE]. Resident 32's diagnoses included chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing), heart failure (a heart disorder which causes the heart to no pump the blood efficiently, sometimes resulting in leg swelling), and blindness (the inability to see or a lack of vision). During a review of Resident 32's History and Physical (H&P), dated 11/10/2023, the H&P indicated Resident 32 had fluctuating capacity to understand and make decisions. During a review of Resident 32's Minimum Data Set ([MDS] a federally mandated assessment tool), dated 8/4/2024 the MDS indicated, Resident 32's had the ability to understand and be understood. The MDS indicated Resident 32 vision was severely impaired. The MDS indicated Resident 32 required substantial assistance from staff for personal hygiene and showering, and supervision with eating and oral hygiene. During a review of Resident 32's Lumina Healthcare document dated 6/13/2024, the Lumina Healthcare dental service indicated, Resident 32 did not wear dentures because it was hard for the resident to put them in. During a review of Resident 32's Physician Order Report, dated 10/2024, the Physician order Report indicated a low sodium (salt) regular diet. During an interview on 10/15/2024 at 10:19 a.m. with Resident 32, Resident 32 stated I am blind, and the staff do not offer my dentures while I'm eating. Resident 32 stated the food texture sometimes made it difficult to chew his food without dentures. Resident 32 stated he was frustrated when meat was served because it was hard to chew. During a concurrent interview and record review on 10/16/14 at 4:46 p.m. with the Registered Dietitian (RD), Resident 32's Physician Order Report, dated 10/2024 was reviewed. The Physician Order Report indicated, Resident 32 was on a low sodium regular diet. The RD stated the diets were reviewed quarterly and as needed. The RD stated Resident 32's textured food should correlate with him not wearing dentures. The RD stated it was important to assist Resident 32 at all-times with wearing dentures due to his blindness. The RD stated if the texture of the food was too hard for the resident to chew without dentures than it placed him at risk for weight loss. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 10/18/14 at 10:29 a.m. with the Minimum Data Set (MDS) Nurse, Resident 32's Physician Order Report, dated 10/2024 was reviewed. The Physician Order Report indicated, Resident 32 was on a low sodium regular diet. The MDS Nurse stated Resident 32 was on a low sodium diet. The MDS Nurse stated Resident 32's diet needed to be downgraded to fit a diet texture to match that the resident was not wearing dentures. The MDS Nurse stated Resident 32 needed to be screened for the correct texture diet to prevent choking. During a review of the facility's policy and procedure (P&P), Registered Dietician, date unknown, the P&P indicated, plans, organizes, coordinates, and evaluates nutritional component of food services for the facility. The P&P indicated plans menus and diets for special nutritional requirements. During a review of the facility's policy and procedure (P&P), Nutrition Policy, date unknown, the P&P indicated, residents maintain acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible. The P&P indicated the company provides special eating equipment and utensils for resident who need them.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47923 Based on observation, interview, and record review, the facility failed to ensure one of one sample resident (Resident 83) with post traumatic stress disorder ([PTSD] - a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event) received informed trauma care ([TIC] - an intervention and approach that focuses on how trauma may affect an individual's life and his or her response to behavioral health) per their policy. This deficient practice had the potential for the staff's inability to identify possible triggers that could result in re-traumatization (the reactivation of trauma symptoms via thoughts, memories, or feelings related to the past traumatic experience) for Resident 83. Cross Reference F745. Findings: During a review of Resident 83's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated, Resident 83 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 83's diagnoses included major depressive disorder (a mental health condition characterized by a depressed mood or loss of interest in activities for a prolonged period of time), anxiety disorder (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness) and mental disorder (a condition that affect your thinking, feeling, mood, and behavior). During a review of Resident 83's History and Physical (H&P), dated 8/9/2024, the H&P indicated Resident 83 had a capacity for medical decision making. During a review of Resident 83's Minimum Data Set ([MDS] - a federally mandated resident assessment tool), dated 8/13/2024, the MDS indicated, Resident 83's cognitive (ability to think and reason) skills for daily decision making was intact. The MDS indicated Resident 83 required setup assistance (helper assist only prior to or following the activity) from staff with eating, oral hygiene, and personal hygiene. During a review of Resident 83's care plan titled, Resident with emotional and psychological deficit due to depression, dated 8/8/2024, the care plan indicated the goal was to maximize the resident's functional potential and well-being. Staff interventions included to identify depressive symptoms and situations that might trigger depressive symptoms to occur and to provide psychosocial treatment. During a review of Resident 83's Trauma-Informed Care Observation record, dated 8/10/2024, the Trauma-Informed Care Observation record indicated, Resident 83 experienced and witnessed a life-threatening illness when his wife passed away with cancer. The Trauma-Informed Care Observation record also indicated Resident 83 felt sad always thinking about his wife and the event still bothered him. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 10/16/2024 at 1:53 p.m., with Resident 83, in Resident 83's room, Resident 83 was observed teary eyed. Resident 83 stated he lost his wife 11 months ago after suffering a long battle with cancer. Resident 83 stated he was there from the beginning to end until she passed away holding her hands. Resident 83 stated it was the worst experience and traumatic event in his life. Resident 83 stated none of the staff visited him to provide psychosocial support. Resident 83 stated he wanted to join group therapy so he could share his thoughts and experience with others. Resident 83 stated group therapy was not offered to him by staff. During an interview on 10/17/2024 at 11:39 a.m., with the Social Service Director (SSD), the SSD stated it was a federal requirement to screen all residents for history of trauma. The SSD stated it was important to know what traumatic event Resident 83 experienced for staff to know the triggers to prevent re-traumatization. The SSD stated losing a family member was a traumatic event. The SSD stated Resident 83's trauma triggering event would affect his activities of daily living ([ADL's] routine tasks/activities such as bathing, dressing, and toileting a person performs daily to care for themselves) and his quality of life. The SSD stated the facility did not address Resident 83's past traumatic experience and did not provide any interventions to alleviate his trauma. During a review of the Facility Assessment titled Caring for Residents with Trauma and PTSD, revised 9/7/2024, the Facility Assessment indicated, To utilize customized behavioral management techniques that cater to the individual resident's specific requirements and preferences, emphasizing positive reinforcement, redirection, and de-escalation methods. During a review of the facility's policy and procedure (P&P) titled, Trauma Informed Care, dated 8/23/2024, the P&P indicated, To develop an organizational culture that supports trauma-informed care. The P&P also indicated to develop relationship with community support organizations for services, referrals, training and information. During a review of the facility's P&P titled, Psychosocial Wellbeing-Behavioral Health Services, dated 8/11/2024, the P&P indicated, Residents who exhibit signs of emotional/psychosocial distress receive services and support that address their individual needs and goals of care. The P&P also indicated behavioral health services are provided by staff who are qualified and competent in behavioral health and trauma-informed care.

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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 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46144 Based on observation, interview, and record review, the facility failed to ensure the staff was following the physician orders for the correct oxygen settings for one out five sampled Residents (Resident 12). This deficient practice of not following the physician orders had the potential to worsen Resident 12's health. Findings: During a review of Resident 12's Admission Record (Face Sheet), the Face Sheet indicated Resident 12 was admitted to the facility on [DATE]. Resident 12's diagnoses included emphysema (a chronic lung disease that damages the air sacs in the lungs, making it hard to breathe), end stage renal disease (irreversible kidney failure), and heart failure (a heart disorder which causes the heart to no pump the blood efficiently, sometimes resulting in leg swelling). During a review of Resident 12's History and Physical (H&P), dated 8/17/2024, the H&P indicated Resident 12 did not have the capacity to understand and make decisions. During a review of Resident 12's Minimum Data Set ([MDS] a federally mandated assessment tool), dated 8/21/2024 the MDS indicated, Resident 12's cognition (ability to learn, reason, remember, understand, and make decisions) was severely impaired. The MDS indicated Resident 12 required substantial assistance from staff for personal hygiene, showering, and dressing. During an observation on 10/16/2024 at 8:09 a.m. in Residents 12's room, Resident 12's oxygen concentrator (medical device that supplies oxygen-enriched air to help people breathe easier) was set at three liters (a metric unit of volume) per minute. During a review of Resident 12's Physician Order Report, dated 10/2024, the Physician Order Report indicated, Resident 12 may have continuous oxygen at two liters via nasal canula (a medical device that provides supplemental oxygen to patients through two prongs inserted into their nostrils). During a concurrent observation and interview on 10/16/2024 at 3:50 p.m. with Licensed Vocational Nurse (LVN) 1, in Resident 12's room, Resident 12's oxygen setting was observed at three liters. LVN 1 stated Resident 12's oxygen should be set at two liters not at three liters. LVN 1 stated the physician orders were not being followed. LVN 1 stated it was important to follow the physician orders to give the correct dose of oxygen of two liters. LVN 1 stated the higher dose of oxygen could cause direct injury to the lungs and exacerbate (a worsening of a medical condition or its symptoms) Resident 12's emphysema. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 10/18/2024 at 3:21 p.m. with the Minimum Data Set (MDS) Nurse, Resident 12's Physician Order Report, dated 10/2024, was reviewed. The Physician Order Report indicated, Resident 12 may have continuous oxygen at two liters via nasal canula. The MDS Nurse stated the physician order for oxygen was considered a medication. The MDS Nurse stated once the oxygen settings pass two liters the orders were no longer being followed. The MDS Nurse stated it was important to follow the physician orders to give the proper care to Resident 12. During a review of the facility's policy and procedure (P&P) titled, Physician Orders, date unknown, the P&P indicated, physician orders are obtained to provide a clear direction in the care of the resident. During a review of the facility's policy and procedure (P&P) titled, Medication Pass Guidelines, the P&P indicated, to assure the most complete and accurate implementation of physicians' medication orders and to optimize drug therapy for each resident by providing for administration of drugs in an accurate and safe manner. The P&P indicated medications are administrated in accordance with written orders of the attending physician.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 47923 Based on interview and record review, the facility failed to ensure a competency assessment skills check (a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics in performing that an individual need to perform work roles or occupational functions successfully) was performed upon hire and annually for two out of five randomly selected staff. This deficient practice had the potential for the facility to not be able to assess the skills necessary to provide nursing services while assuring resident safety and attaining or maintaining the highest practicable physical, mental, and psychosocial well-being of each resident within the acceptable standards of practice. Findings: During a concurrent interview and record review on 10/17/2024 at 8:45 a.m., with the Director of Staff Development (DSD), Registered Nurse (RN 1), Certified Nurse Assistant (CNA 1), CNA 2, CNA 3, and CNA 4's employee files were reviewed. The DSD stated RN 1, CNA 1, CNA 2, CNA 3, and CNA 4 did not have an annual skills competency assessment check on file. The DSD stated a skills competency assessment check must be performed upon hire and annually. The DSD stated she was not able to complete an annual skills competency assessment for CNA 1, CNA 2, CNA 3, and CNA 4. The DSD stated the Director of Nursing (DON) was not able to complete an annual competency assessment skills for RN 1. The DSD stated the importance of competency assessment skills were to validate the licensed nursing staff and CNA's ability to meet the needs of the resident's health and safety. During an interview on 10/17/2024 at 12:08 p.m., with the Administrator (ADM), the ADM stated it was essential to perform an annual competency assessment skills to make sure all employees were up to date with the state and federal regulations. The ADM stated competency assessment skills of an employee would reflect the care provided to the resident. During a review of the facility's undated Policy and Procedure (P&P) titled, Competency of Nursing Staff, the P&P indicated, Competency skills evaluation will be completed upon orientation and annually thereafter, or when there is a need to evaluate competency of the employee as deemed necessary by the Director of Nursing/Administrator. During a review of the Facility Assessment, dated 9/7/2024, the Facility Assessment indicated, The DSD will provide ongoing training and assess competencies upon hire, annually, as needed, and on demand.

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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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47923 Based on observation, interview, and record review, the facility failed to ensure a resident was provided with medically related social services and emotional support while grieving for one of one sampled resident (Resident 83). This deficient practice placed Resident 83 at risk for further depression (a serious mental illness that can affect how a person feels, thinks, and acts) and ineffective coping ability. Cross Reference F699 Findings: During a review of Resident 83's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 83 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 83's diagnoses included major depressive disorder (a mental health condition characterized by a depressed mood or loss of interest in activities for a prolonged period of time), anxiety disorder (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness) and mental disorder (a condition that affect your thinking, feeling, mood, and behavior). During a review of Resident 83's History and Physical (H&P), dated 8/9/2024, the H&P indicated Resident 83 had capacity for medical decision making. During a review of Resident 83's Minimum Data Set ([MDS] - a federally mandated resident assessment tool), dated 8/13/2024, the MDS indicated, Resident 83's cognitive (ability to think and reason) skills for daily decision making was intact. The MDS indicated Resident 83 required setup assistance (helper assist only prior to or following the activity) from staff with eating, oral hygiene, and personal hygiene. During a review of Resident 83's care plan titled, Resident with emotional and psychological deficit due to depression, dated 8/8/2024, the care plan indicated a goal was to maximize the resident's functional potential and well-being. The staff's interventions indicated to identify depressive symptoms and situations that might trigger depressive symptoms to occur and to provide psychosocial treatment. During a review of Resident 83's Trauma-Informed Care Observation record, dated 8/10/2024, the Trauma-Informed Care Observation record indicated, Resident 83 experienced and witnessed a life-threatening illness when his wife passed away with cancer. The Trauma-Informed Care Observation record also indicated Resident 83 felt sad while always thinking about his wife and the event still bothered him. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 10/16/2024 at 1:53 p.m., with Resident 83, in Resident 83's room, Resident 83 was observed teary eyed. Resident 83 stated he lost his wife 11 months ago after she suffered a long battle with cancer. Resident 83 stated he was there from beginning to end until she passed away holding her hands. Resident 83 stated it was terribly hard for him losing his wife and he was still self-grieving. Resident 83 stated he wanted to join group therapy so he could share his thoughts and experience with others. Resident 83 stated he had not been seen by a psychologist (a person who specializes in the study of mind and behavior or in the treatment of mental, emotional, and behavior disorders) since his admission to the facility. During an interview on 10/17/2024 at 11:39 a.m., with the Social Service Director (SSD), the SSD stated she was responsible in assessing the behavior, mental, and psychosocial issues of all residents. The SSD stated she could not provide any documentation that daily supportive visits, emotional support, and other interventions such as group therapy were offered to Resident 83. The SSD stated she had no reason as to why Resident 83 was not referred to the psychologist. The SSD stated Resident 83 would think he was left out and that none of the staff cared about him. The SSD stated by not providing psychosocial services to Resident 83 he would be more at risk for further depression. During a review of the facility's undated policy and procedure (P&P) titled, Social Services Program, the P&P indicated, A resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem. During a review of the facility's P&P titled, Psychosocial Wellbeing-Behavioral Health Services, dated 8/11/2024, the P&P indicated, Residents will receive behavioral health services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47923 Based on interview and record review, the facility failed to ensure a pharmacy consultant (a professional responsible for reviewing each resident's medication profile monthly to identify and report changes) recommendation to consider a trial reduction of psychotropic medication (drug that affects behavior, mood, thoughts, or perception) was acknowledged and acted upon for one out of five sampled residents (Resident 83). This deficient practice had the potential to result in Resident 83 receiving unnecessary medication. Findings: During a review of Resident 83's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated, Resident 83 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 83's diagnoses included major depressive disorder (a mental health condition characterized by a depressed mood or loss of interest in activities for a prolonged period of time), anxiety disorder (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness) and mental disorder (a condition that affect your thinking, feeling, mood, and behavior). During a review of Resident 83's History and Physical (H&P), dated 8/9/2024, the H&P indicated, Resident 83 had capacity for medical decision making. During a review of Resident 83's Minimum Data Set ([MDS] - a federally mandated resident assessment tool), dated 8/13/2024, the MDS indicated Resident 83's cognitive (ability to think and reason) skills for daily decision making was intact. The MDS indicated Resident 83 required setup assistance (helper assist only prior to or following the activity) from staff with eating, oral hygiene, and personal hygiene. During a review of Resident 83's Order Summary Report (a document containing active orders), dated 10/16/2024, the Order Summary Report indicated, Resident 83 had a physician's order of Seroquel (medication that treats several kind of mental health conditions) 25 milligrams ([mg] unit of measurement) 1 tablet once a day at bedtime for paranoia (a mental disorder in which a person has an extreme fear and distrust of others) manifested by talking to self and unseen person. During a review of the consultant pharmacist Medication Regimen Review (MRR), dated 8/12/2024, the MRR indicated the consultant pharmacist made a recommendation to Resident 83's attending physician to consider a trial reduction and to assess continued use of Seroquel 25mg once a day at bedtime. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 10/17/2024 at 11:24 a.m., with the Director of Nursing (DON), Resident 83's clinical records were reviewed. The DON stated the facility failed to take any action on the consultant pharmacist recommendation by not informing Resident 83's physician. The DON stated the pharmacy consultant recommendation note should be signed and dated by Resident 83's physician. The DON stated all pharmacy consultant recommendations should be addressed accordingly to ensure the resident was not receiving unnecessary medications that would result in the resident's decline in physical and mental function. During a review of the facility's undated policy and procedure (P&P) titled, Medication Regimen Review and Reporting, the P&P indicated, Resident-specific MRR recommendations and findings are documented and acted upon by the nursing care center and/or physician. The P&P also indicated the nursing care center follows-up on the recommendations to verify that appropriate action has been taken and shall be acted upon within 30 calendar days.

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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** 46832 Based on observation, interview, and record review, the facility failed to ensure an opened multi-dose tuberculin (a sterile liquid that contains substances taken from the bacterium that causes tuberculosis and is used in the diagnosis of the disease) vial was labeled with an expiration date in the medication storage room. This deficient practice had the potential to result in a medication error and/or administering expired medication. Findings: During a concurrent observation and interview, on [DATE], at 8:53 a.m., with Registered Nurse 1 (RN 1), a multidose vial of tuberculin purified protein derivative vial was observed in the refrigerator with a date of [DATE] and no expiration date. RN 1 stated the vial was just opened and was to be labelled with an expiration date. RN 1 stated the date written on the vial box also could have been confusing and taken as an expiration date instead of an open date. RN 1 stated the risk of not labeling an expiration date on a medication could result in giving expired medication and/or a medication error. During a review of the facility's policy and procedures (P&P), titled Medication Storage, undated, the P&P indicated Refrigerated medications should be kept in closed and labeled containers. 47923

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F 0803

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 49906

b. During an interview with Resident 33 on 10/15/2024, at 10:18 a.m., Resident 33 stated she was a vegetarian but the facility serves her meals that include meat dishes.

A review of Resident 33's diet order indicated a regular diet, no added salt (NAS), reduced concentrated sweets (RCS), jello with all meals, small portion only, salad for lunch [NAME] at patient's request.

During an observation of 10/16/2024, at 12:40 p.m., Resident 33 was served a plate of food with a hamburger bun with a slice of orange cheese and a meat patty on it.

During an interview on 10/16/2024, at 11:40 a.m. with Certified Nursing Assistant (CNA) 8, CNA 8 stated she was aware Resident 33 was a vegetarian.

During an interview on 10/16/2024, at 4:30 pm, with the Director of Dietary Services (DDS), the DDS stated was new to the facility and had not spoken with Resident 33 about her preferences but will interview do so as well as other residents.

During a review of the facility's policy and procedure titled, Nutrition Care, dated 2018, indicated the food preferences should be minimally reviewed quarterly with the resident/patient by the DSS and as needed with a clinical risk. Food preferences are recorded in the medical record, profile, and trade card.

50978

Based on observation, interview and record review, the facility failed to ensure the standardized recipes for lunch menu and food preferences was followed when:

1. 25 of 25 residents who were on mechanical soft diets and 20 of 20 residents who were on puree diets were served using a smaller scoop size of ground/finely chopped meat and squash.

2. One of one resident (Resident 33), who was a vegetarian was served hamburger meat.

This deficient practice resulted in the residents receiving incorrect portion sizes and non-preferred food, which had the potential to affect residents' nutritional intake and result in weight loss.

Findings:

a. During an observation on the tray line service for lunch on 10/16/2024 at 11:18 a.m., the cook (Cook) served residents who were on mechanical soft diet (consists of foods that are moist, or easily mashed requiring little chewing) ground cheeseburger using the #12 scoop yielding 2.7 ounces (oz). The [NAME] served soft mashed squash using the #16 scoop yielding 2 oz or 1/4 cup.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/16/2024 at 12:39 p.m. the [NAME] stated that the green handle was 4 oz and the person who was responsible for set up scoops for food trays was the Dietary Aide (DA 1). During an interview on 10/16/2024 at 12:43 p.m. The DA 1 stated a 2 oz scoop was used to serve soft mash squash instead of a 4 oz scoop. DA 1 could not see what was written on the scoop because of the handle was melted off. DA 1 stated a 4 oz scoop was used to serve ground beef instead of 8 oz. During an interview 10/16/2024 at 12:54 p.m. with the Registered Dietician (RD), the RD stated the portions served to residents were incorrect for cheeseburger and squash. The RD stated there was a potential for the residents to have weight loss if portions are smaller, or maybe too much protein if larger portions were served. The RD stated it had been a while since the last in-service on portion sizes. During a review of the facility's lunch menu for pureed and mechanical soft diet on 10/16/2024, the following items were served for residents on mechanical soft diet including ground cheeseburger 5/8 cup and for residents on pureed diet, pureed squash 1/4 cup. A review of facility's policy titled, Portion Control, undated, indicated, Portion size is determined by the nutritional needs of the residents and federal and state regulations that specify the food group and portion sizes that must be served. Use standardized recipes based on Company census and cycle menus. Serve portion s according to the menu spreadsheet. Use scoops, spoodles, ladles, and scales to serve proper menu portions.

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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. 50978 Based on observation, interview, record review, the facility failed to ensure safe and proper storage of items in the refrigerator when : 1. One frozen bottled water was found not labelled in the freezer. 2. Undated, opened food items were found in the refrigerator and under the food preparation counter. 3. The internal refrigerator fan which was blowing air over uncovered fresh produce had black substances on the fan blades. These deficient practices of not dating and labelling opened food, improper sanitation of equipment for food storage, and food stored in open containers without covers had the potential for harmful bacteria growth and cross-contamination (transfer of harmful bacteria from one place to another) that could lead to food -borne illness. Findings: During an observation on 10/15/2024 at 8:15 a.m., in the kitchen, the following was observed: 1. In freezer #3, a water bottle was on shelf without a label , 2. In refrigerator #1 a bag of white sliced bread loaf, no open date, no use by date 3. Under the food preparation counter, stored foods were observed: Oatmeal, grits, hot sauce bottle and cornstarch had no open date or use by date 4. In refrigerator #4 a container of pickle relish with open date of 5/12/2024, had no use by date, and mayonnaise container had no open date and no use by date. During a concurrent observation and interview with the Director of Dietary Services (DDS) on 10/15/2024 at 8:39 a.m., above the top shelf of refrigerator #4, one internal fan was observed with black substance, the refrigerator had fresh produce located on shelves to the right of fan without covers. The DDS stated, It looks dirty. The DDS stated the fans are not cleaned by maintenance, that the facility calls for service. The DDS stated the dirty fan was an issue because of the potential for cross contamination and how food was stored without lids. During an interview on 10/16/2024 at 12:34 p.m., with the Registered Dietician (RD), the RD stated there was dirt on the fan in the refrigerator and the uncovered fresh produce on shelves. The RD stated the fans in the refrigerator are for circulation and the dirty fan and open containers of produce could potentially give the residents food poisoning. The RD stated the fans should be cleaned on a regular basis and the produce should be covered. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Inglewood Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 100 S. Hillcrest Blvd Inglewood, CA 90301	

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility policy and procedure (P&P) titled Food Storage Principles, undated, the P&P indicated to, Label each package, box, can, etc. with the expiration date, date of receipt, or when the item was stored after preparation. During a review of the facility P&P titled Cold Food Storage Areas, undated, the P&P indicated, Units work effectively and efficiently when maintained, cleaned, and serviced. Maximize air circulation by not overcrowding. Store foods in original packaging and in leak-prof, non-absorbent, sanitary containers with tight-fitting lids. During a review of the facility policy titled Preventative Maintenance Program, undated, the P&P indicated, A company-wide system to communicate issues or items that need attention, repair, or replacement. A schedule for performing preventative maintenance.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 47923 Based on interview and record review, the facility failed to revise and provide an updated accurate resident census in the Facility's Assessment (a process for evaluating a facility's resident population and identifying the resources needed to provide care and services). This deficient practice had the potential to place residents at risk for delay of care and treatment services. Findings: During a review of the facility census for 10/15/2024, indicated 94 residents were residing in the facility. During a concurrent interview and record review on 10/18/2024 at 8:13 a.m., with the Administrator (ADM), the Facility's Assessment was reviewed. The ADM stated the Facility's Assessment was last updated on 9/7/2024. The ADM stated the assessment provided was an average daily census of 88 to 91 residents. The ADM stated the census recorded on the Facility Assessment did not match with the current census. The ADM stated the Facility Assessment did not match the census number and for section for Assistance with Activities of Daily Living ([ADL's] - routine tasks/activities such as bathing, dressing, and toileting a person performs daily to care for themselves) for residents. The ADM stated there were residents who were not accounted for on the Facility Assessment. The ADM stated she was responsible for updating the Facility Assessment. The ADM stated the Facility Assessment was an overview of the services provided by the facility to the resident population. The ADM stated the risk of incorrect documentation on the Facility Assessment could result in not providing quality and standard of care to residents. During a review of the Centers for Medicare and Medicaid Services (CMS), reference QSO-24-13-NH, dated 6/18/2024, titled Revised Guidance for Long-Term Care Facility Assessment Requirements, the CMS QSO-24-13-NH indicated the new requirements specify that the facility assessment must include an evaluation of diseases, conditions, physical or cognitive limitations of the resident population, acuity (the level of severity of residents' illnesses, physical, mental, and cognitive limitations, and conditions) and any other pertinent information about the resident population as a whole that may affect the services the facility must provide. The CMS QSO-24-13-NH indicated the facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations including nights and weekends and emergencies. The CMS QSO-24-13-NH indicated the facility must review and update that assessment, as necessary, and at least annually, and also review and update the assessment whenever there is, or the facility plans, for any change that would require a substantial modification to any part of the assessment.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46144 Based on observation, interview, and record review, the facility failed to ensure the oxygen humidifier (a device that adds moisture to prevent dryness) was dated and labeled for one out of five sampled residents (Resident 12). This deficient practice of not dating and labeling the oxygen humidifier had the potential to cause respiratory infection to Resident 12. Findings: During a review of Resident 12's Admission Record (Face Sheet), the Face Sheet indicated Resident 12 was admitted to the facility on [DATE]. Resident 12's diagnoses included emphysema (a chronic lung disease that damages the air sacs in the lungs, making it hard to breathe), end stage renal disease (irreversible kidney failure), and heart failure (a heart disorder which causes the heart to no pump the blood efficiently, sometimes resulting in leg swelling). During a review of Resident 12's History and Physical (H&P), dated 8/17/2024, the H&P indicated Resident 12 did not have the capacity to understand and make decisions. During a review of Resident 12's Minimum Data Set ([MDS] a federally mandated assessment tool), dated 8/21/2024 the MDS indicated, Resident 12's cognition (ability to learn, reason, remember, understand, and make decisions) was severely impaired. The MDS indicated Resident 12 required substantial assistance from staff for personal hygiene, showering, and dressing. During a concurrent observation and interview on 10/16/2024 at 3:42 p.m. with Licensed Vocational Nurse (LVN) 1, in Resident 12's room, Resident 12's oxygen humidifier observed undated and unlabeled. LVN 1 stated the humidifier was not dated and labeled and should be changed once a week. LVN 1 stated if the humidifier was not dated and labeled Resident 12 was at risk for bacteria in the tubing which could affect Resident 12's respiratory system (the organs that are involved in breathing). LVN 1 stated this would place Resident 12 at risk for a respiratory infection. During an interview on 10/17/2024 at 12:47 p.m. with the Director of Nursing (DON), the DON stated the humidifier should be changed every Sunday or as needed. The DON stated when the humidifier was changed the staff should label and date after it was opened. The DON stated if the humidifier was not labeled and dated the staff did not know when the humidifier was opened. The DON stated it could make Resident 12 sick when the humidifier lasted longer than seven days. During a review of the facility's policy and procedure (P&P) titled, Care and Handling of Respiratory Equipment, date unknown, the P&P indicated, care should be exercised in handling respiratory equipment to prevent contamination. The P&P indicated all respiratory and nursing personnel shall follow a regular schedule for cleaning and maintaining respiratory equipment. The P&P indicated equipment should be changed based on the following schedule change every seven days or when obviously contaminated.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50978 Based on interview, and record review, the facility failed to implement the antibiotic stewardship program (coordinated program that promotes the appropriate use of antibiotics by clinicians) by failing to monitor and address antibiotic (a substance used to kill bacteria or to treat infection) use for one of one sampled resident (Resident 20) who was on antibiotics for urinary tract infection [(UTI) an infection in the bladder/urinary tract] was not evaluated when the resident returned from the hospital. The failure had the potential for Resident 20 to receive an inappropriate antibiotic and develop antibiotic resistance. Findings: During a record review of Resident 20 ' s Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included UTI, sepsis (a life-threatening blood infection) and diabetes mellitus [(DM) a disorder characterized by difficulty in blood sugar control and poor wound healing]. During a record review of Minimum Data Set [(MDS) a federally mandated assessment tool] dated 8/07/2024, the MDS indicated the resident had a moderately impaired cognition (thought process). During a record review of Resident 20 ' s laboratory report dated 10/9/2024, from General Acute Care Hospital (GACH 1), the laboratory report indicated urinalysis values for the following: clarity = turbid, protein = 1+, occult blood (blood in the urine) = 2+, nitrite = positive, and urine microscopic: bacteria 3+ During a record review of Resident 20 ' s Physician ' s Order (prescription) dated 10/10/2024, the order indicated Bactrim DS (sulfamethoxazole-trimethoprim combination, used to treat bacterial infections including urinary tract infections) dated 10/10/2024, oral tablet 800-160 milligrams (mg, unit of weight), 1 tablet to be given by mouth twice a day for 10 days for UTI. The order indicated Bactrim DS end date of 10/19/2024. During a record review of Resident 20 ' s Medication Administration Record (MAR) for 10/01/2024 through 10/17/2024, the MAR indicated Resident 20 was administered Bactrim DS 800-160 mg, one tablet by mouth twice a day for UTI since 10/10/2024. During a record review of Resident 20 ' s Care Plan initiated on 10/10/2024, the Care Plan indicated Resident 20 had presence of UTI. The Care Plan ' s goal indicated the infection will be resolved after a course of treatment, ensure comfort and relief from signs and symptoms of UTI, will be able to complete treatment without complications. The Care Plan ' s interventions included check for signs and symptoms of dehydration, monitor for increased/continuing signs of infection, check for adverse reaction from antibiotic therapy, and obtain a urine test as ordered. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/16/24 at 3:59 p.m. with Infection Preventionist Nurse (IPN), the IPN stated Resident 20 was the only resident at the facility who was on antibiotics and meets the criteria for antibiotic surveillance. The IPN stated she did not fill out the surveillance form for Resident 20 within 3 days of Resident 20 ' s admission per the facility ' s policy. The IPN stated there were no laboratory specimens drawn at the facility since the resident was discharged from the hospital and admitted [DATE]. During an interview on 10/16/24 at 4:43 p.m. with Director of Nursing (DON), the DON stated the antibiotic stewardship program decreases the use of unnecessary use of antibiotics. The DON stated Resident 20 not being surveilled for antibiotics had the potential outcome to cause harm to the resident who does not need it, causing antibiotic resistance, or potential adverse reactions. During a record review of facility ' s policy and procedure (P&P) titled Antibiotic Stewardship Program, the P&P indicated The Infection Preventionist will complete the infection surveillance .a. type of antibiotic ordered, route of administration, antibiotic costs b. whether the order was made by phone, if order was given by attending physician or on-call doctor, c. whether a culture was obtained before ordering antibiotic .