STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055531	A. Building B. Wing	11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beachside Post Acute	22520 Maple Avenue Torrance, CA 90505

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46537 Based on observation, interview, and record review, the facility failed to ensure the call light device was within reach for one of five sampled residents (Resident 8). This failure had the potential to prevent Resident 8 from receiving the necessary care and services timely. Findings: During a review of Resident 8's Admission Record, the Admission Record indicated, Resident 8 was initially admitted to the facility on [DATE] and the last readmission was on 9/20/2024 with diagnoses including left leg above knee amputation (surgical removal of the portion of the left leg above the knee joint), muscle weakness, dependence on supplemental oxygen (a colorless, odorless gas element that sustains life), and pressure ulcer/injury (damage to skin and tissue underneath the skin caused by unrelieved pressure) stage 3 (Full-thickness loss of skin. Dead and black tissue may be visible) of sacral region (the portion of the spine between lower back and tailbone). During a review of Resident 8's History and Physical (H&P), dated 10/9/2024, the H&P indicated, Resident 8 had the capacity to understand and make decisions. During a review of Resident 8's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 10/11/2024, the MDS indicated Resident 8 required maximal assistance (Helper does more than half the effort) from one staff for toileting transfer, sit to stand, and moderate assistance (Helper does less than half the effort) from one staff for roll left and right, sit to lying, lying to sitting on side of bed. (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: 055531	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/01/2024
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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 10/29/2024, at 12:10 p.m., with Resident 8 in Resident 8's room, Resident 8 was sitting on a wheelchair next to the right-side of the foot of the bed and her nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) was connected to a portable oxygen tank that was behind her wheelchair. Resident 8 was hyperventilating (rapid or deep breathing) and seemed very anxious (experiencing worry, unease, or nervousness). Resident 8's call light was clipped on the left side of her bed near the upper siderail, and Resident 8 was unable to reach the call light. Resident 8 stated, she believed her oxygen was almost out because she was barely feeling air coming out from her nasal cannula. Resident 8 stated, she was afraid because she was having shortness of breath (difficulty breathing) and she was not able to reach the call light. Resident 8 stated, she was has been hospitalized multiple times due to breathing issue. Resident 8 stated, she felt helpless not being able to call for help. During an interview on 10/29/2024, at 12:13 p.m., with Licensed Vocational Nurse (LVN) 1 in Resident 8's room, LVN 1 stated, the call light was not placed within reach, and it should have been within reach at all times. LVN 1 stated, Resident 8's oxygen tank indicated 400 pounds per square inch (PSI- the pressure that results when a 1-pound force is applied to a unit area of 1 square inch) which was low pressure and needed to be changed. LVN 1 stated, Resident 8 has had many episodes of difficulty breathing and nursing staff should have placed the call light within reach in case of emergency. During an interview on 11/1/2024, at 10:23 a.m., with the Director of Staff Development (DSD), the DSD stated, the call light should be within reach to accommodate residents' needs in a timely manner. The DSD stated, Resident 8 could have gone into respiratory distress (a person having trouble breathing or not getting enough oxygen) if she was not able to reach call light to alert someone that her oxygen supply is running out. During an interview on 11/1/2024, at 11:12 a.m., with the Director of Nursing (DON), the DON stated call lights should always be accessible and within the resident's reach. The DON stated that if the call light was not within the resident's reach, the resident would be unable to call for assistance to get his or her needs met. During a review of Resident 8's untitled Care Plan (CP), revised 9/3/2024, the CP Focus indicated, Resident 8 was at risk for fall related to impaired balance and poor safety awareness. The CP Interventions indicated, keep call light and bed controls within easy reach. During a review of the facility's policy and procedure (P&) titled, Answering the Call Light, revised 10/2010, the P&P indicated, Purpose: The purpose of this procedure is to respond to the resident's requests and needs. General Guidelines . 5. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36943 Based on observation, interview, and record review, the facility failed to monitor range of motion ([ROM] full movement potential of a joint [where two bones meet]) in both legs for one of eight sampled residents (Resident 49) with limited range of motion and mobility (ability to move) by failing to perform an annual Joint Mobility Screen ([JMS] brief assessment of a resident's range of motion in both arms and both legs) on 4/18/2024 in accordance with the facility's policy titled, Resident Mobility and Range of Motion. This failure had the potential for Resident 49 to develop further ROM limitations in both legs due to the lack of monitoring for potentially 21 months from Resident 49's Physical Therapy ([PT] profession aimed in the restoration, maintenance, and promotion of optimal physical function) discharge on 7/25/2023 to 4/2025 (next annual JMS). Findings: During a review of Resident 49's Admission Record, the Admission Record indicated the facility initially admitted Resident 49 on 12/11/2019 and readmitted the resident on 7/15/2023. The Admission Record indicated Resident 49's diagnoses included dementia (a progressive state of decline in mental abilities), functional quadriplegia (paralysis from the neck down, including the arms and legs), and contractures (stiffening/shortening at any joint that reduces the joint's range of motion) in both shoulders, left elbow, and both hands. During a review of Resident 49's PT Evaluation and Plan of Treatment, dated 7/19/2023, the PT Evaluation indicated Resident 49's ROM in both hips, knees, and ankles were impaired. The PT Evaluation indicated Resident 49's ROM limitations included right hip flexion (bending the leg at the hip joint toward the body) 0 to 35 degrees (0-35 degrees, normal 0-120 degrees), left hip flexion 10-60 degrees, right knee flexion (bending the knee) 0-10 degrees (normal 0-135 degrees), left knee flexion 10-60 degrees, both ankles dorsiflexion (bending the ankle toward the body) 0-5 degrees (normal 0-20 degrees), both ankles plantarflexion (bending the ankle away from the body) 0-10 degrees (normal 0-45 degrees). The PT Evaluation indicated Resident 49 had rigid (stiff) muscle tone (amount of tension in the muscle) in both legs, including the right knee which was difficult to bend. During a review of Resident 49's PT Discharge Summary, dated 7/28/2023, the PT Discharge Summary indicated the Restorative Nursing Aide ([RNA] certified nursing aide program that helps residents to maintain their function and joint mobility) provided a 100 percent [%] return demonstration for performing passive range of motion ([PROM] movement of joint through the ROM from an external force with no effort from the person) exercises to Resident 49's left leg, right hip, and right ankle. The PT Discharge Summary Recommendations indicated for the RNA to provide PROM to both legs. During a review of Resident 49's physician orders, dated 7/25/2023, the physician orders indicated for the RNA to perform PROM to both legs except the right knee, five times per week as tolerated. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 49's Minimum Data Set ([MDS] a federally mandated resident assessment tool), dated 1/18/2024, the MDS indicated Resident 49 had no speech, rarely/never expressed ideas and wants, rarely/never understood verbal content, and was severely impaired for daily decision making. The MDS indicated Resident 49 had ROM impairments in both arms and legs. The MDS also indicated Resident 49 was dependent (helper does all of the effort or the assistance of two or more helpers is required for the resident to complete the activity) for dressing, showering, toileting, rolling to both sides in bed, and chair/bed-to-chair transfers. During a review of Resident 49's annual JMS, dated 4/18/2024, the JMS indicated Resident 49 had moderate (26-50% ROM loss) ROM limitations in the left elbow and severe (more than 50% ROM loss) ROM limitations in both shoulders, right elbow, and both hands. The JMS was blank (no assessment) for both legs. During a review of Resident 49's MDS, dated [DATE], 7/12/2024, and 10/11/2024, the MDS indicated Resident 49 had ROM limitations in both arms and legs. The MDS also indicated Resident 49 was dependent for dressing, showering, toileting, rolling to both sides in bed, and chair/bed-to-chair transfers. During an interview on 10/30/2024 at 9:36 a.m., with the Director of Rehabilitation (DOR), the DOR stated the JMS was performed upon a resident's (in general) admission, readmission, change of condition, and annually. The DOR stated the JMS were performed to assess a resident's ROM. During a concurrent observation and interview on 10/31/2024 at 9:42 a.m., in Resident 49's room, Resident 49 was awake while lying in bed with the head-of-bed elevated. Resident 49 was observed with a fully bent right elbow, right wrist bent downward, and both hands were positioned in closed fists. Resident 49's legs were resting straight on the bed. Restorative Nursing Aide 1 (RNA 1) provided PROM to both arms and legs except the right knee. RNA 1 stated Resident 49's right knee did not bend. During a concurrent interview and record review on 10/31/2024 at 1:29 p.m., with the Director of Rehabilitation (DOR), Resident 49's PT Evaluation, dated 7/19/2023, and PT Discharge Summary, dated 7/25/2023, were reviewed. The DOR stated the PT Evaluation indicated Resident 49 had spasticity (stiffness) into extension on both legs, making it difficult to bend both legs. The DOR stated the PT Discharge Summary, dated 7/25/2023, included recommendations to perform PROM to the left leg, right hip, and right ankle, five times per week. The DOR stated the recommendation did not include Resident 49's right knee since it remained in extension. The DOR stated the PT did not provide Resident 49 with any intervention since discharge from PT on 7/25/2023. During a concurrent interview and record review on 11/1/2024 at 1:30 p.m., with the MDS Coordinator (MDSC) and the MDS Assistant (MDS 2), Resident 49's MDS, dated [DATE], was reviewed. The MDSC stated Resident 49's MDS indicated Resident 49 had ROM impairments in both arms and legs. The MDSC stated Resident 49's MDS did not indicate the location and severity of Resident 49's ROM impairments. During an interview on 11/1/2024 at 1:32 p.m. with the MDSC and MDS 2, the MDSC stated the facility could not use the MDS (in general) to track a resident's ROM limitations since the MDS indicated the presence of ROM limitations but did not indicate the location and severity. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 11/1/2024 at 2:47 p.m., with the DOR and the Director of Nursing (DON), Resident 49's annual JMS, dated 4/18/2024, was reviewed. The DOR stated the JMS (in general) was completed to track any decline in ROM to prevent the development of contractures, pressure injuries (pressure-related damage to skin and/or underlying tissue), and pain. The DOR reviewed Resident 49's annual JMS, dated 4/18/2024, and stated Resident 49's ROM in both legs were not assessed. The DOR stated Resident 49 had an increased potential for decline in ROM since both legs were not assessed since discharge from PT services (on 7/25/2023). During a concurrent interview and record review on 11/1/2024 at 2:57 p.m., with the DOR and the Director of Nursing (DON), Resident 49's annual JMS, dated 4/18/2024, was reviewed. The DON stated it was the facility's policy to perform the JMS annually for each resident. The DOR stated Resident 49's next annual JMS would have been in 4/2025 in accordance with the facility's policy. The DON stated Resident 49 would have gone 21 months (7/25/2023 to 4/2025) without an assessment of both legs, which the DON stated was a long period of time. During a review of the facility's policy and procedure (P&P) titled, Resident Mobility and Range of Motion, revised 7/2017, the P&P indicated resident with limited ROM and mobility will receives appropriate services, equipment and assistance to maintain or improve mobility. The P&P further indicated the rehabilitation screening will be completed upon admission and yearly.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. 49573 Based on observation, interview and record review, the facility failed to provide prompt dental services after dentures were lost on 9/10/24 and provide documentation of what they did to ensure resident could still eat and drink adequately while awaiting dental services for one of two sample residents (Resident 30). This deficient practice resulted in Resident 30 not being able to eat the mechanical soft diet without the dentures until replacement was delivered on 10/31/24. During a review of Resident 30's Admission Record, the Admission Record indicated Resident 30 was admitted to the facility under Hospice (that provides medical, emotional, and spiritual support for people who are terminally ill and nearing the end of their life) on 8/2/2024 with diagnoses included dementia (a progressive state of decline in mental abilities), anemia (a condition where the body does not have enough healthy red blood cells), heart failure (a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), anxiety disorder (a group of mental health conditions that cause fear, dread and other symptoms that are out of proportion to the situation), palliative care (specialized medical care for people living with a serious illness providing relief from the symptoms and stress of the illness). During a review of Resident 30's Minimum Data Set ([MDS], a federally mandated resident assessment tool), dated 8/8/2024, the MDS indicated Resident 30 was severely impaired in cognitive skills (thought process) skills for daily decision-making and was dependent (helper does all of the effort to complete activities, the assistance of two or more helpers is required) on self-care abilities such as eating, oral hygiene, toileting, shower/bathing, upper and lower body dressing and mobility functions such as rolling left and right, sitting to lying, lying to sitting, bed to chair transfers and shower transfers. During a review of Resident 30's Order Summary Report, the Order Summary Report indicated there was no dental consult ordered. During a review of Resident 30's Order Summary Report, the Order Summary Report indicated fortified diet (foods that have been enhanced with additional nutrients, such as vitamins, minerals, protein, carbohydrates, or fats), mechanical soft texture (foods that are soft and easy to chew, less chewing than regular foods), regular liquid consistency ordered on 8/15/2024. During a review of Resident 30's Social Services Note dated 9/11/2024, the Social Service Note indicated Resident 30 was referred to a Dentist today 9/11/2024. The social Service note indicated that family was made aware and will follow up as needed. During a review of Resident 30's Dental Progress Notes, dated 9/25/2024, the Dental Progress Notes indicated Resident 30 has full lower dentures (FLD) only and no treatment indicated due to Resident 30's medical condition. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 30's Social Services Note dated 9/30/2024, the Social Service Note indicated Resident 30 was seen the Dental Care agency on 9/25/2024 to continue with treatment plan. Resident did not express having any trouble eating or drinking, or pain or discomfort. Will follow up as needed. Family also made aware of visit. During a review of Resident 30's Interdisciplinary Team (IDT-team members from different departments working together with a common purpose to set goals and make decisions that ensure the resident received the best care) Care Conference Summary dated 10/16/2024, the IDT Care Conference Summary indicated Resident 30's diet remained the same as mechanical soft consistency since 8/15/2024 and resident was last seen by dentist on 9/25/2024 for new dentures. The IDT Care Conference Summary indicated Resident 30 had poor oral intake of 25-50%, there was significant weight loss noted in two months, Dietary team will continue to monitor, and Registered Dietitian as needed. During a review of Resident 30's Dental Progress Notes dated 10/16/2024, the Dental Progress Notes indicated Resident 30 had missing full upper dentures (FUD), new FUD requested by facility. Resident 30 was informed of new FUD, impressions (imprints of your teeth and mouth) taken with Resident 30's consent. During a review of Resident 30's Social Services Note dated 10/16/24, the Social Service Note indicated Resident 30 was seen on 9/25/2024 and on 10/16/2024 for dental services to continue with treatment. Family made aware and was very thankful. During a review of Resident 30's Dental Progress Notes dated 10/24/24, the Dental Progress Notes indicated try in new FUD, recommend repair for lower denture. During an observation and interview on 10/29/2024 at 12:55 p.m., with Certified Nursing Assistant (CNA) 2 in Resident 30's room, CNA 2 stated the dentures at Resident 30's bedside did not fit the resident anymore. CNA 2 stated Resident 30 cannot really talk without her dentures. Resident 30 was observed eating lunch with no dentures. Resident 30 was observed eating potatoes but only ate one small bite and did not want to eat anymore. During a telephone interview on 10/30/2024 at 10:45 a.m., with Resident 30's Responsible Party (RP), the RP stated the facility lost Resident 30's upper dentures. The RP stated the dental consult saw Resident 30 last week to take impressions of her mouth. During a review of Resident 30's Dental Progress Notes dated 10/30/24, the Dental Progress Notes indicated delivered new FUD. During a concurrent interview and record review on 10/31/2024 at 2:00 p.m. with the Social Service Director (SSD), the SSD stated Resident 30's date of lost dentures was on 9/10/2024 and dental services came to see Resident 30 on 9/25/2024. The SSD stated there was an IDT Care Conference meeting on 10/16/2024, Resident 30's lost dentures were discussed during the meeting, but interventions were already in place to replace the lost dentures. There was no discussion about Resident 30's diet consistency even though there was weight loss and no dentures so no ability to chew. The SSD stated the replacement dentures arrived today and will check to see if it fits Resident 30's mouth. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 30's Social Services Note dated 10/31/2024, the Social Service Note indicated that the Social Service Director (SSD) met with Resident 30 to see how she was doing and how her new dentures were fitting. Resident 30 stated that she is doing fine and that they fit okay. Resident 30 did not express any concerns or discomfort. The SSD will follow up as needed. During a concurrent telephone interview and record review on 10/31/2024 at 2:19 p.m. with the Registered Dietitian (RD), the RD stated she did not get informed that Resident 30 did not have her dentures. The RD stated if Resident 30 had a chewing problem, the RD would have downgraded the diet to lower-level diet consistency like a puree diet which did not require chewing. The RD stated if a resident cannot consume the diet consistency, the outcome when a diet was not tolerated by a resident was weight loss. The RD stated that Resident 30 did not verbalize any chewing or swallowing issues during visits the RD made with Resident 30 but since Resident 30 had diagnosis of dementia, what Resident 30 says might not be valid. During an interview on 11/1/2024 at 5:04 p.m. with the Director of Nursing (DON), the DON stated she was aware Resident 30 did not have her dentures. The DON stated Resident 30 did not want to wear dentures during meals. The DON stated she does not know how the dentures got lost when Resident 30 did not want to wear the dentures during meals. The DON stated there was no discussion to change the diet consistency during the time Resident 30 did not have her dentures. The DON stated the replacement dentures arrived yesterday. During a review of the facility's policy and procedure (P/P) titled Availability of Services, Dental, revised August 2017, the P/P indicated oral healthcare and dental services will be provided to each resident dental services are available to all residents requiring routine and emergency dental care . social services will be responsible for making necessary dental appointments .all requests for routine and emergency dental services should be directed to Social Services to assure that appointments can be made in a timely manner . residents with lost or damaged dentures will be promptly referred to a dentist.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 45891 Based on observation, interview, and record review the facility failed to ensure kitchen staff including the dietary supervisor assistant (DSA) and dietary aide (DA 1) were competent regarding their food thawing policies. These deficient practices had the potential to result in pathogen (germ) exposure and placed 99 out of 106 total residents at risk for developing foodborne illness (food poisoning) with symptoms including upset stomach, stomach cramps (a type of abdominal pain that feel like contractions and can vary in intensity, nausea (a feeling of sickness or discomfort in the stomach that may come with an urge to vomit), vomiting (stomach pain with urge to expel contents through the mouth) , diarrhea (Loose, watery stools that occur more frequently than usual), and fever (elevated body temperature indicating illness) and can lead to other serious medical complications and hospitalization . Findings: During an observation on 10/30/2024 at 11:02 a.m., there was a box of frozen chicken sitting by the food preparation sink in the kitchen, the chicken appeared to have soft pliable skin and appeared partially thawed. The cardboard box had become wet from the thawing chicken juice. The dietary supervisor assistant (DSA) informed dietary aide (DA 1) that they were no longer going to use the chicken for the next day. The DSA instructed DA 1 to place the chicken back into the main freezer located outside of the kitchen. During an observation on 10/30/2024 at 11:09 a.m., DA 1 placed the partially thawed box of chicken back into the facility's main freezer. During an observation on 10/30/2024 at 11:18 a.m., the DSA instructed staff to remove the partially thawed chicken from the facility's main freezer and place it back into the food preparation sink for thawing. During an observation on 10/30/2024 at 11:27 a.m., the chicken that was thawing in the food preparation sink on 10/30/2024 at 11:02 a.m., for thawing, was now sitting in the food preparation sink again to continue thawing without running water over it. During an observation on 10/30/2024 at 11:30 a.m., the DSA walked over to the food preparation sink and turned the water on to run over the thawing chicken. During an observation on 10/30/2024 at 11:31 a.m., the dietary supervisor (DS) came into the kitchen and stated, I told you people that you can't refreeze chicken. During an interview on 10/30/2024 at 11:33 a.m., the DS stated when the kitchen staff decided they were no longer going to use the chicken for the intended meal they should have placed the partially thawed chicken into the refrigerator to continue thawing (good for 3 days) instead of placing the chicken back into the freezer. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 11/1/2024 at 1:51 p.m., DA 1 stated thawed items should never be put back in the freezer but she did not want to question her supervisor (DSA)'s orders. During an interview on 11/1/2024 at 1:59 p.m., the DSA stated they were not allowed to put partially thawed items back in the freezer (unknown reason why it was done on 10/30/2024). The DSA stated food could not just sit in the sink to thaw, it had to be under running water. The DSA stated if food was not thawed properly there was the potential outcome of food contamination because bacteria begin to grow on the food. During a review of the facility's policy and procedure (P/P) titled Food Receiving and Storage dated 11/2022, the P/P indicated refrigerated foods were to be labeled, dated and monitored so they are used by their use-by date. Frozen foods were to be maintained at a temperature to keep food frozen solid. During a review of the facility's P/P titled Food Preparation and Service dated 11/2022, the P/P indicated food was not to be thawed at room temperature and food being thawed by water need to be completely submerged in cold running water that is running fast enough to agitate and remove loose ice particles. During A review of the 2022 U.S. Food and Drug Administration food Code, Code # 3-501.11 Frozen Food; 3. 501.12 Time/Temp Control for Safety Food, Slacking and 3-501.13 Thawing, Indicated, Freezing prevents microbial growth in foods, but usually does not destroy all microorganisms. Improper thawing provides an opportunity for surviving bacteria to grow to harmful number and produce toxins. If the food is then refrozen, significant number of bacteria and toxins are preserved.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055531	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/01/2024
NAME OF PROVIDER OR SUPPLIER Beachside Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 22520 Maple Avenue Torrance, CA 90505	

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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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 49573 Based on observation, interview and record review, the facility failed to ensure one of three sampled residents (Resident 30) received food according to her preferences. This deficient practice resulted in Resident 30 not eating her preferred diet potentially resulting in decrease meal intake, weight loss, and malnutrition (lack of proper nutrition, caused by not eating enough). Findings: During a review of Resident 30's Admission Record, the Admission Record indicated Resident 30 was admitted to the facility under a Hospice (an agency that provides medical, emotional, and spiritual support for people who are terminally ill and nearing the end of their life) agency on 8/2/2024 with diagnoses included dementia (a progressive state of decline in mental abilities), anemia (a condition where the body does not have enough healthy red blood cells), heart failure (a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), anxiety disorder (a group of mental health conditions that cause fear, dread and other symptoms that are out of proportion to the situation), palliative care (specialized medical care for people living with a serious illness providing relief from the symptoms and stress of the illness). During a review of Resident 30's Minimum Data Set ([MDS], a federally mandated resident assessment tool), dated 8/8/2024, the MDS indicated Resident 30 was severely impaired in cognitive skills (thought process) skills for daily decision-making and was dependent (helper does all of the effort to complete activities, the assistance of two or more helpers is required) on self-care abilities such as eating, oral hygiene, toileting, shower/bathing, upper and lower body dressing and mobility functions such as rolling left and right, sitting to lying, lying to sitting, bed to chair transfers and shower transfers. During a review of Resident 30's Order Summary Report, the Order Summary Report indicated fortified diet (foods that have been enhanced with additional nutrients, such as vitamins, minerals, protein, carbohydrates, or fats), mechanical soft texture (foods that are soft and easy to chew, less chewing than regular foods), regular liquid consistency (unmodified for thickness), ordered on 8/15/2024. During an observation and interview on 10/29/2024 at 12:55 p.m., with Certified Nursing Assistant (CNA) 2 in Resident 30's room, CNA 2 stated Resident 30 liked the potatoes on the meal tray. CNA 2 stated the potatoes were soft and started cutting Resident 30's potatoes into smaller pieces. Resident 30 had no teeth, took one small bite of the potatoes, and did not want to eat anymore after that. CNA 2 stated that Resident 30 liked the soups that the family would bring in for her. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/29/2024 at 1:00 p.m., with Licensed Vocational Nurse (LVN) 5, LVN 5 stated Resident 30 tends to not eat solid food and preferred to eat puree food (food that have a soft, pudding-like consistency) and gets a nutritional Supplement. The LVN 5 stated Resident 30 was admitted with a mechanical soft diet on hospice. LVN 5 stated there was no discussion about possibly changing Resident 30's diet to a puree diet, the hospice team kept the same diet consistency since admission to the facility. LVN 5 stated Resident 30 ate about 25% of her meals and that Resident 30's intake was very low. During a concurrent telephone interview and record review on 10/31/2024 at 2:19 p.m. with the Registered Dietitian (RD), the RD stated there were no notes from the CNA or LVN about Resident 30's preferred diet consistency of puree diet. The RD stated if Resident 30 had a chewing problem, the RD would have downgraded the diet to lower-level diet consistency like a puree diet. The RD stated if a resident cannot consume the diet, because the diet cannot be tolerated by a resident, the resident was at risk for weight loss. The RD stated that Resident 30 did not verbalize any chewing or swallowing issues but since Resident 30 had a diagnosis of dementia, what Resident 30 says might not be valid. During an interview on 11/1/2024 at 2:30 p.m., with CNA 1, CNA 1 stated Resident 30 does not eat a lot during mealtimes. CNA 1 stated Resident 30 ate well this morning with breakfast, over 50% of food eaten since breakfast was puree diet and it was Resident 30's favorite meal, oatmeal. CNA 1 stated Resident 30 did not eat too much food when the diet was mechanical soft diet but Resident 30 ate a lot more with this puree diet. During an interview on 11/1/24 at 5:04 p.m. with the Director of Nursing (DON), the DON stated she did not know Resident 30 preferred a puree diet and if that was what Resident 30 preferred to eat, the speech language pathologist ([SLP], a professional who assesses and treats communication disorders) would have been consulted right away to evaluate Resident 30 and the RD can get the diet order changed to what Resident 30 wanted. A review of facility's policy and procedure (P/P) titled, Resident Food Preferences, revised July 2017, the P/P indicated staff will interview the resident directly to determine current food preferences based on history and life patterns related to food and mealtimes .nursing staff will document the resident's food and eating preferences in the care plan the dietitian and nursing staff will identify any nutritional issues and dietary recommendations that might be in conflict with the resident's food preferences the dietitian will discuss with the resident or representative the rationale of any prescribed therapeutic diet. The physician (another term for medical doctor, a health professional who practices medicine) and dietitian will communicate the risk and benefits of specialized therapeutic versus liberalized diets therapeutic diets will be ordered only after the resident/representative agrees with and consents to such diet.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45891 Based on observation, interview, and record review, the facility failed to store food in a sanitary manner to prevent growth of microorganisms (an organism that can be seen only through a microscope [a scientific magnifying device]) that could cause food borne illness (food poisoning: any illness resulting from the food spoilage of contaminated [something that has been made impure or unfit for use by contact with something harmful] food for 99 out 106 total residents in the facility by not ensuring: a.Cottage cheese in the reach-in refrigerator was not past the use by date. b.The temperature log for the walk-in refrigerator was filled out twice daily c. Food such as raw chicken and frozen waffles were not thawed and then returned to the freezer. d.Proper thawing techniques by not having running water over thawing chicken in the sink. e.The facility ice machine was maintained in a clean and sanitary way. f. There was a cleaning log kept for the upper portion of the ice machine. These deficient practices had the potential to result in pathogen (an organism that can cause illness) exposure and placed residents at risk for developing foodborne illness (food poisoning) with symptoms including upset stomach, stomach cramps (a type of abdominal pain that feel like contractions and can vary in intensity, nausea (a feeling of sickness or discomfort in the stomach that may come with an urge to vomit), vomiting (stomach pain with urge to expel contents through the mouth) , diarrhea (Loose, watery stools that occur more frequently than usual), and fever (elevated body temperature indicating illness) and can lead to other serious medical complications and hospitalization . Findings: During an observation on 10/29/2024 at 8:47 a.m., with the dietary supervisor (DS), the reach in refrigerator contained a container labeled cottage cheese and labeled with a use by date of 10/27/2024. During an observation and concurrent interview on 10/29/2024 at 8:52 a.m., with the DS, the facility's main freezer located outside of the kitchen contained frozen Waffles that were thawed for breakfast that morning and then placed back in the refrigerator after not being used. The DS stated it was not facility procedure to put thawed items back into the freezer. During an observation on 10/30/2024 at 11:02 a.m., there was a box of frozen chicken sitting by the food preparation sink in the kitchen, the chicken was partially thawed. The cardboard box had become wet from the thawing chicken juice. The dietary supervisor assistant (DSA) informed dietary aide (DA 1) that they were no longer going to use the chicken for the next day and if DA 1 could place the chicken back into the main freezer located outside of the kitchen. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 10/30/2024 at 11:09 a.m., DA 1 placed the partially thawed box of chicken back into the facility's main freezer. During an observation on 10/30/2024 at 11:18 a.m., the DSA instructed staff to remove the partially thawed chicken from the facility's main freezer and place it back into the food preparation sink for thawing. During an observation on 10/30/2024 at 11:21 a.m., the temperature log for the walk-in refrigerator was missing the documented temperature for the morning of 10/30/2024. During an observation on 10/30/2024 at 11:27 a.m., the chicken that was thawing in the food preparation sink for thawing was now sitting in the food preparation sink to continue thawing without running water over it. During an observation on 10/30/2024 at 11:30 a.m., the DSA walked over to the food preparation sink and turned the water on to run over the thawing chicken. During an observation on 10/30/2024 at 11:31 a.m., the DS came into the kitchen and stated, I told you people that you can't refreeze chicken. During an interview on 10/30/2024 at 11:33 a.m., the DS stated when the kitchen staff decided they were no longer going to use the chicken for the intended meal they should have placed the partially thawed chicken into the refrigerator to continue thawing (good for 3 days) instead of placing the chicken back into the freezer. During an observation and concurrent interview on 10/31/2024 at 12:10 p.m., the maintenance supervisor (MS) opened the top panel of the ice machine. There was dust around the edges of the ice machine behind the upper panel and covering the inside of the upper portion of the ice machine. A black substance was growing where condensation (water which collects as droplets on a cold surface when humid air is in contact with it) was collecting on the water lines in the upper portion of the ice machine. The MS stated it was a black substance growing in the upper portion of the ice machine and there was a layer of dust in there. The maintenance supervisor stated he cleaned the upper portion of the ice machine every 6 months, but he did not keep record of the cleaning log when he performed the cleaning. During an interview on 11/1/2024 at 1:51 p.m., DA 1 stated all items in the refrigerator past the use by date needed to be thrown out and it was everyone's responsibility to check the dates. DA 1 stated thawed items should never be put back in the freezer but she did not want to question her supervisor (DSA)'s orders. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 11/1/2024 at 1:59 p.m., the DSA stated she saw the upper portion of the ice machine when the MS opened it on 10/31/2024 and it was dirty, she saw dust and dark colors in there. The DSA stated it was facility policy to clean the upper portion of the ice machine at least every 6 months and there should have been a log to keep track of the cleaning frequency because if there was no record they would not know how frequently the ice machine was being cleaned. The DSA stated there was a potential that cross-contamination for the ice if the upper portion of the ice machine was dirty. The DSA stated it was important to ensure items were not past the use by date to protect the residents from food poisoning. The DSA stated it was important to check the temperature logs for the refrigerator to ensure it was functioning properly and the food would not spoil. The DSA stated they were not allowed to put partially thawed items back in the freezer (unknown reason why it was done on 10/30/2024). The DSA stated food could not just sit in the sink to thaw, it had to be under running water. The DSA stated if food was not thawed properly there was the potential outcome of food contamination because bacteria begin to grow on the food. During an interview on 11/1/2024 at 4:45 p.m., the infection preventionist nurse (IPN) stated if the upper portion of the ice machine was not clean, there was a potential that residents could get sick. The IPN stated if there was no cleaning log for the upper portion of the ice machine, there was no evidence that it had ever been cleaned. During a review of the facility's policy and procedure (P/P) titled Ice Machines and Ice Storage Chests undated, the P/P indicated information regarding the cleaning and care of the ice machine was to be obtained in the owner's manual. During a review of the user's manual for the Ice Machine Installation and User's [NAME] undated, the user's manual indicated the ice machine should be cleaned and sanitized every six months or more frequently as needed. During a review of the facility's P/P titled Food Receiving and Storage dated 11/2022, the P/P indicated refrigerated foods were to be labeled, dated and monitored so they are used by their use-by date. Frozen foods were to be maintained at a temperature to keep food frozen solid. During a review of the facility's P/P titled Food Preparation and Service dated 11/2022, the P/P indicated food was not to be thawed at room temperature and food being thawed by water need to be completely submerged in cold running water that is running fast enough to agitate and remove loose ice particles. During A review of the 2022 U.S. Food and Drug Administration food Code, Code # 3-501.11 Frozen Food; 3. 501.12 Time/Temp Control for Safety Food, Slacking and 3-501.13 Thawing, Indicated, Freezing prevents microbial growth in foods, but usually does not destroy all microorganisms. Improper thawing provides an opportunity for surviving bacteria to grow to harmful number and produce toxins. If the food is then refrozen, significant number of bacteria and toxins are preserved.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36943 45891 Based on observation, interview, and record review, the facility failed to ensure the clinical records were complete and accurately documented by: a. failing to ensure the documentation for one out of six sampled residents (Resident 84) related to Resident 84's intravenous (IV, administered into a vein) access and IV fluids (liquids that are injected into a vein to prevent or treat dehydration [occurs when the body loses more fluids than it takes in]) was accurate. This deficient practice had the potential to reflect inaccurate hydration for Resident 84 b.failing to ensure one of eight sampled residents (Resident 49) with limited range of motion ([ROM] full movement potential of a joint [where two bones meet]) and mobility (ability to move) concerns had complete clinical records for the provision of Restorative Nursing Aide ([RNA] certified nursing aide program that helps residents to maintain their function and joint mobility) services. This failure resulted in Resident 49's records being incomplete regarding the provision of RNA in April 2024. Findings: a.During a review of Resident 84's admission record, the admission record indicated Resident 84 was admitted to the facility 8/9/2024 with diagnoses of seizures (a temporary episode of abnormal electrical activity in the brain that causes a sudden change in behavior, movement, or consciousness), acute kidney failure (a sudden loss of kidney function that can be life-threatening if left untreated), and nontraumatic intracerebral hemorrhage (bleeding in the brain). During a review of Resident 84's minimum data set (MDS, a federally mandated resident assessment tool) dated 8/13/2024, the MDS indicated Resident 84 had severe cognitive (ability to make decisions of daily living) impairment. During a review of Resident 84's Situation, Background, Assessment, and Recommendation (SBAR) Communication Form dated 10/28/2024, the SBAR indicated Resident 84 had inadequate hydration with elevated blood urea nitrogen (BUN, a blood test related to kidney function) and creatinine (a blood test related to kidney function). During a review of Resident 84's Physician's orders, the Physician's orders indicated IV fluids and IV site access was ordered on 10/28/2024, the orders read: 1). 1/2 Normal Saline (a solution used to treat cellular dehydration) at 40 milliliters (ml, a unit of measurement of volume) per hour for 500 ml only, for elevated BUN and creatinine every shift for 1 day. 2.) monitor IV access site based on phlebitis scale (measures any signs of irritation at the IV access site). The Physician's orders indicated the 1/2 NS hydration solution to be completed on 10/29/2024 at 8:49 a.m. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 84's Post change of condition (COC)/ SBAR note dated 10/30/2024 at 9:54 p.m., the note indicated Resident 84 was on monitoring for elevated BUN/ creatinine and Resident 84 continued to have 1/2 NS running at 40 ml/ hr. in the left upper arm (LUA) and it was infusing well. The note indicated Resident 84's IV site was intact (in place) and was not swollen or bleeding. There was another COC/SBAR note dated 10/31/2024 at 7:10 a.m., indicating Resident 84 was still on IV fluids for hydration and the IV site in the LUA was intact, this information was struck out (removed from documentation) on 10/31/2024 at 11:24 p.m. due to error in documentation. During a review of Resident 84's Nurse Progress Note dated 10/31/2024 at 11:55 a.m., the progress note indicated it was a late entry note (entered at a later time) for 10/29/2024 at 11:00, the note indicated Resident 84's IV fluids were completed, and the treatment nurse (TXN 1) removed the IV site from the LUA. During an observation on 10/30/2024 at 9:33 a.m., Resident 84 was in bed with no IV fluids infusing at bedside and no IV access. During an observation on 10/31/2024 at 10:20 a.m., Resident 84's body was assessed by licensed vocational nurse (LVN 6), LVN 6 stated Resident 84 did not have IV access and there was only a gauze (a thin, loosely woven fabric) dressing covering the old IV access site. During a concurrent interview and record review on 10/31/2024 at 10:28 a.m., with registered nurse supervisor (RNS 1) of Resident 84's post COC/SBAR notes from 10/20/2024 and 10/31/2024, RN 1 stated Resident 84 completed his IV fluid infusion on 10/29/2024 and his IV access was removed the same day. RNS 1 stated Resident 84's post COC/ SBAR notes from 10/30/2024 and 10/31/2024 documentation was inaccurate because he did not have IV access or IV hydration anymore. RNS 1 stated it was important to have accurate documentation because if he still had IV access it was a risk for infection (IV access only good for 72 hours before needing to change site) and it was important to reflect accurate hydration. RNS 1 stated the inaccurate documentation suggested that the licensed nurses were not doing a complete assessment on Resident 84's body. During an interview on 11/1/2024 at 3:51 p.m., the director of nursing (DON) stated the importance of accurate documentation was to reflect the residents actual care and needs. b.During a review of Resident 49's Admission Record, the Admission Record indicated the facility initially admitted Resident 49 on 12/11/2019 and readmitted the resident on 7/15/2023. The Admission Record indicated Resident 49's diagnoses included dementia (a progressive state of decline in mental abilities), functional quadriplegia (paralysis from the neck down, including the arms and legs), and contractures (stiffening/shortening at any joint that reduces the joint's range of motion) in both shoulders, left elbow, and both hands. During a review of Resident 49's physician orders, dated 7/25/2023, the physician orders indicated for the RNA to perform passive range of motion (PROM) to both legs except the right knee, five times per week as tolerated. A review of Resident 49 physician orders, dated 7/31/2023, indicated for the RNA to perform PROM to both arms, five times per week, to apply both elbow extension splints (material used to restrict, protect, or immobilize a part of the body to support function, assist and/or increase range of motion) for four to six hours, five times per week, and to apply carrot splints (hand splint shaped like a carrot to position the fingers away from the palm for severe hand contractures) to both hands for four to six hours, five times per week. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 49's MDS, dated [DATE], the MDS indicated Resident 49 had no speech, rarely/never expressed ideas and wants, rarely/never understood verbal content, and was severely impaired for daily decision making. The MDS indicated Resident 49 had ROM impairments in both arms and legs. The MDS also indicated Resident 49 was dependent (helper does all of the effort or the assistance of two or more helpers is required for the resident to complete the activity) for dressing, showering, toileting, rolling to both sides in bed, and chair/bed-to-chair transfers. During an observation on 10/31/2024 at 9:42 a.m., in Resident 49's room, Resident 49 was awake while lying in bed with the head-of-bed elevated. Resident 49 was observed with a fully bent right elbow, right wrist bent downward, and both hands were positioned in closed fists. Resident 49's legs were resting straight on the bed. Restorative Nursing Aide 1 (RNA 1) performed PROM to both arms, applied both elbow splints, and applied both carrot splints. RNA 1 then performed PROM to both legs except the right knee. During a review of Resident 49's Restorative Nursing (RNA) flow sheets (record of RNA sessions) from 12/2023 to 11/2024, the RNA flow sheet for 4/2024 was not included in Resident 49's clinical record. During a concurrent interview and record review on 11/1/2024 at 2:47 p.m., with the Director of Rehabilitation (DOR) and the DON, Resident 49's RNA flow sheets were reviewed. The DOR and DON were unable to locate Resident 49's RNA flow sheet for 4/2024. The DON stated the RNAs were supposed to submit the residents' RNA flow sheets to the facility's Director of Medical Records (DMR). The DON stated Resident 49's clinical records were incomplete since the RNA flow sheets were missing for 4/2024. During a review of the facility's undated policy and procedure (P&P) titled, Charting and Documentation, the P&P indicated all services provided to the resident shall be documented in the resident's medical record. The P&P indicated the resident's medical record should be complete and accurate.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46537 Based on observation, interview and record review, the facility failed to implement infection control measures by failing to: A. Ensure Resident 260's visitor was wearing Personal Protective Equipment (PPE - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) and Licensed Vocational Nurse (LVN) 2 and LVN 3 were doffing (removing PPE in a way that avoids self-contamination) PPE properly without self-contamination after caring for Resident 260 who was on Enhanced Barrier Precautions (EBP- an infection control intervention designed to reduce transmission of multidrug-resistant organisms). B. Ensure LVN 1, LVN 4, and Certified Nurse Assistant (CNA) 1 were wearing proper PPE during the care of Resident 8 who was on EBP. C. Ensure the duct tape (a water resistant tape that is not waterproof and will eventually break down and allow water to pass) placed on 4 out of 22 sampled resident's (Resident 16, Resident 54, Resident 59, and Resident 84) beds' padded side rails (a raised side fitted to a bed) was not cracked or pealing, revealing the foam (a soft porous material, and the degree of porosity can vary depending on the type of foam) underneath the duct tape to ensure proper disinfection of the side rails. These deficient practices resulted in facility staff not following infection prevention protocols and had the potential to spread infection amongst residents, staff, and visitors. Findings: A. During a review of Resident 260's Admission Record, the Admission Record indicated, Resident 260 was admitted to the facility on [DATE] with diagnoses including gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), and pressure ulcer/injury (damage to skin and underlying tissue caused by unrelieved pressure) unstageable (full thickness tissue loss but is either covered by extensive dead tissue) of sacral region (the portion of the spine between lower back and tailbone). During a review of Resident 260's History and Physical (H&P), dated 10/28/2024, the H&P indicated, Resident 260 had the capacity to understand and make decisions. During a review of Resident 8's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 10/31/2024, the MDS indicated Resident 260 required dependent assistance (Helper does all of the effort) from two or more staff for roll left and right, sit to lying, and lying to sitting on side of bed. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Beachside Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 22520 Maple Avenue Torrance, CA 90505	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 10/29/2024, at 10:21 a.m., with Visitor 1 in Resident 260's room, there was signage that indicated Resident 260 was on EBP. Visitor 1 was not wearing a gown or gloves. Visitor 1 was stroking Resident 260's hair and fixing his blanket with bare hands. Visitor 1 was leaning over the left bed siderail. Visitor 1 stated, she did not know about EBP and did not know she needed to wear PPE. Resident 260 pressed the call light to be re-positioned. LVN 2 and LVN 3 answered the call light and donned PPE, but they did not ask Visitor 1 to wear PPE. Visitor 1 stated, nursing staff saw her not wearing PPE, but they did not say anything to her. During a concurrent observation and interview on 10/29/2024, at 10:24 a.m., with LVN 2 and LVN 3 in Resident 260's room, LVN 2 and LVN 3 were doffing their PPE after providing direct care for Resident 260. LVN 2 and LVN 3 were still wearing their gloves when they untied their gowns. LVN 2 and LVN 3's gloves were touching the back side of their work uniforms near the necks. They took off the gowns then took off the gloves last. LVN 2 stated, she always took off her gloves last. LVN 2 stated, she did not realize that there was signage for how to remove PPE and the gloves should be off before removing other PPE. LVN 2 stated, she should have taken off her gloves first to prevent self- contamination. LVN 3 stated, she also realized they were doffing PPE incorrectly and had contaminated themselves without knowing. LVN 2 and LVN 3 stated, incorrect donning and doffing of PPE would spread infection to the vulnerable residents of the facility. During a review of Resident 260's untitled Care Plan (CP), revised 10/28/2024, the CP Focus indicated, Resident 260 was on EBP. The CP Interventions indicated, Care team to provide teaching and education regarding care. Staff will perform hand hygiene, wear PPE before and after high contact care activities. According to the Centers for Disease Control (CDC a national public health agency), a review of a document titled, How to safely remove personal protective equipment (CS250672-E), indicated to remove PPE before leaving the resident's room, and to remove gloves first because the outside of the gloves are contaminated. (https://www.cdc.gov) B. During a review of Resident 8's Admission Record, the Admission Record indicated, Resident 8 was initially admitted to the facility on [DATE] and last readmitted on [DATE] with diagnoses including aquired absence of left leg above the knee, gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), dependence on supplemental oxygen (odorless colorless gas that sustains life), and pressure ulcer/injury stage 3 (Full-thickness loss of skin. Dead and black tissue may be visible) of sacral region (the portion of the spine between lower back and tailbone). During a review of Resident 8's H&P, dated 10/9/2024, the H&P indicated, Resident 8 had the capacity to understand and make decisions. During a review of Resident 8's MDS, dated [DATE], the MDS indicated Resident 8 required maximal assistance (Helper does more than half the effort) from one staff for toileting transfer, sit to stand, and moderate assistance (Helper does less than half the effort) from one staff for roll left and right, sit to lying, lying to sitting on side of bed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 10/29/2024, at 12:13 p.m., in Resident 8's room, there was signage that indicated Resident 8 was on EBP. Resident 8 was sitting in a wheelchair next to her bed and was complaining that her oxygen tank needed to be replaced. LVN 1 came in to Resident 8's room without wearing PPE . LVN 1 grabbed the handle of Resident 8's wheelchair and pulled out the portable oxygen tank from the back of Resident 8's wheelchair. LVN 1 called Certified Nursing Assistant 1(CNA 1) to bring a new oxygen tank. CNA 1 brought the new oxygen tank and did not donn PPE before entering the room. LVN 1 changed the oxygen tank and adjusted Resident 8's nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) without wearing gloves while CNA 1 was helping Resident 8 to adjust her posture. LVN 1 asked LVN 4 who was assigned to Resident 8 to adjust the oxygen flow level. LVN 4 donned gloves, but he did not wear the gown. LVN 4 adjusted Resident 8's oxygen level and re-adjusted Resident 8's nasal cannula. LVN 4's uniform was touching Resident 8's wheelchair while he was providing care. During an interview on 10/29/2024, 12:17 p.m., with LVN 1, LVN 1 stated, they should have worn PPE before providing care for Resident 8 to prevent spreading infection. LVN 1 stated, wearing proper PPE was important to protecting residents and staff from infection. During a review of Resident 8's untitled CP, revised 10/21/2024, the CP Focus indicated, Resident 8 was on EBP due to gastrostomy and open wounds. The CP Interventions indicated, Care team to provide teaching and education regarding care. Staff will perform hand hygiene, wear PPE before and after high contact care activities. During an interview on 11/1/2024, at 10:23 a.m., with the Director of Staff Development (DSD), the DSD stated, he mentioned to staff that glove should be the last PPE to put on and first one to take off after providing care during the in-service. The DSD stated, following proper donning and doffing of PPE could protect residents and staff both. During an interview on 11/1/2024, at 10:49 a.m., with the Infection Preventionist Nurse (IPN), IPN stated, PPE should have worn before caring the resident who was on EBP to prevent cross contamination (the physical movement or transfer of harmful bacteria from one person, object or place to another). IPN stated, LVN 4 was wearing gloves, but he did not realize that he had indirect contact with Resident 8. IPN stated, PPE was applicable to the visitors and EBP signage indicated wearing PPE was for everyone. IPN stated, staff should have asked Visitor 1 to wear PPE and provided education. During an interview on 11/1/2024, at 11:12 a.m., with Director of Nursing (DON), the DON stated, the staff should follow EBP guidelines and wear proper PPE when indicated for infection control to protect themselves and vulnerable residents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's Policy and Procedure (P&P) titled, Enhanced Barrier Precautions, revised 8/2022, the P&P indicated, Policy Statement: Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents. Policy Interpretation and Implementation: 1. Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organisms (MDROs) to residents. 2. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. a. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room) .3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include . g. device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.); and h. wound care (any skin opening requiring a dressing) . 5. EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of [NAME] colonization . 12. Residents, families and visitors are notified of the implementation of EBPs throughout the facility. During a review of the facility's Policy and Procedure (P&P) titled, Personal Protective Equipment, revised 10/2018, the P&P indicated, Policy Interpretation and Implementation . 5. Training on the proper donning, use and disposal of PPE is provided upon orientation and at regular intervals. 6. Employees who fail to use personal protective equipment when indicated may be disciplined in accordance with personnel policies. 7. Visitors and residents who are asked to comply with transmission-based precautions are educated on the proper use of PPE and provided with equipment at no charge. C. During a review of Resident 16's admission record, the admission record indicated Resident 16 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of quadriplegia (unable to move all four limbs), dementia (a chronic condition that causes a decline in cognitive abilities, such as thinking, remembering, and reasoning, that interferes with daily life), and osteoporosis (weak bones). During a review of Resident 16's MDS dated [DATE], the MDS indicated Resident 16 had severe cognitive impairment (a condition that makes it very difficult for a person to remember things, learn new things, concentrate, or make decisions). During a review of Resident 16's physician's orders dated 9/22/2024, the Physician order indicated Resident 16 may have padded bilateral grab bars (smaller side rails) as an enabler for positioning and supporting during care. During a review of Resident 54's admission record, the admission record indicated resident 54 was admitted to the facility 4/29/2019 with diagnoses of hemiplegia (can not move one side of the body) affecting the right side and epilepsy (a chronic brain disorder that causes seizures, which are episodes of abnormal electrical activity in the brain). During a review of Resident 54's Physician's orders dated 11/2/2023, the physician order indicated Resident 54 may have left side 1/2 padded side rails as enabler for bed mobility and for seizure precaution. During a review of Resident 54's MDS dated [DATE], the MDS indicated Resident 54 had severe cognitive impairment. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 59's admission record, the admission record indicated Resident 59 was admitted to the facility on [DATE] with diagnoses of dementia and history of falling. During a review of Resident 59's physician orders dated 5/16/2024, the physician order indicated Resident 59 may have bilateral (both sides) grab bars as enablers for bed mobility. During a review of Resident 59's MDS dated [DATE], the MDS indicated Resident 59 had severe cognitive impairment. During a review of Resident 84's admission record, the admission record indicated Resident 84 was admitted to the facility on [DATE] with diagnoses of seizures, history of falling, and nontraumatic intracerebral hemorrhage (bleeding in the brain). During a review of Resident 84's MDS dated [DATE], the MDS indicated Resident 84 had severe cognitive impairment. During a review of Resident 84's physician's orders dated 10/17/2024, the physicians order indicated Resident 84 may have bilateral padded grab bars up as enablers for turning and repositioning and for seizure precaution. During an observation on 10/29/2024 at 9:40 a.m., Resident 16's bilateral grab bars were wrapped with duct tape, the duct tape was cracked exposing the black foam padding underneath the duct tape. During an observation on 10/29/2024 at 10:05 a.m., Resident 59's bilateral grab bars were covered in duct tape with some sections of duct tape that had pealed off exposing the black foam padding underneath. During an observation on 10/29/2024 at 10:19 a.m., Resident 54's right side 1/2 padded side rail was covered with duct tape that was cracked and pealing exposing the black foam padding underneath. During an observation on 10/29/2024 at 10:35 a.m., Resident 84's bilateral grab bars only had duct tape wrapped around the top of the grab bars and the rest of the black foam padding was exposed. During an interview on 10/29/2024 at 3:21 p.m., the maintenance supervisor (MS) stated they wrapped the grab bars with duct tape to secure the foam padding to the bed rails. The MS stated the purpose of the duct tape was so housekeeping could clean and sanitize the bed rails because they couldn't clean the foam and they couldn't find a cover, so the facility decided to use duct tape. The MS stated the manufacture fo the bed did not recommend for the bed rails to be wrapped in duct tape. The MS stated nursing staff was to alert him when the tape was cracked or pealing so he could fix it because the black foam padding should not be exposed because it could not be sanitized. The MS checked the duct tape on the bed rails for Resident 16, Resident 54, Resident 59, and Resident 84. The MS stated that the duct tape on both siderails of Resident 16's bed was cracked, exposing the black foam. The MS stated that Resident 84's grab bars were not fully covered in duct tape. The MS stated Resident 54's tape on the right-side rail was cracked and pealing and Resident 59's duct tape on the bilateral grab bars was cracked. The MS said the duct tape should not be that way and it needed to be fixed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/1/2024 at 2:23 p.m., the housekeeping supervisor (HKS) stated they used a brand name disinfectant for all cleaning in the facility including the bed rails with padding and duct tape. The HKS stated if the black foam padding was exposed under the duct tape there was a risk for infection because bacteria (microscopic organisms that can make you sick) can live in the cracks (pores) of the foam. The HKS stated the duct tape was not a hard, nonporous surface. During an interview on 11/1/2024 at 4:45 p.m., the IPN stated there was a potential for bacteria to grown and build up if the duct tape was broken or missing exposing the black foam padding on the bed rails. During a review of the literature for brand name disinfectant used by the facility, undated, the literature indicated the product was to be used as part of a simple and effective cleaning and disinfection program for facilities on hard, non-porous surfaces.