STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055568	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sierra Valley Rehab Center	301 West Putnam Porterville, CA 93257

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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. 42148 Based on interview and record review, the facility failed to accurately complete MDS (Minimum Data Set- A tool used to collect data to establish person-centered care needs) for one of 55 sampled residents (Resident 47). This failure had the potential for Resident 47 to not receive care based on his specific needs. Findings: During a concurrent interview and record review on 2/25/25 at 2:50 p.m. with MDS consultant (MDSC) and MDS nurse (MDSN), Resident 47's, MDS-Section N-Medications (MDS-N), dated 1/6/25, and Medication Administration Record (MAR), dated 2/2025 were reviewed. MDSN was unable to provide documentation Resident 47 was on anticoagulant medications (delay blood clot formation). MDSC stated Resident 47 was prescribed Aspirin (helps prevent blood clots) which should not have been coded as an anticoagulant on the MDS. MDSN stated, It [coding Aspirin as an anticoagulant medication] was a mistake on my part. During a review of Center for Medicare and Medi-Cal (CMS) Resident Assessment Instructions (RAI) Manual Version 3.0 for MDS (CMS RAI), [undated], the CMS RAI indicated, Planning of care: Medications are an integral part of the care provided to residents of nursing homes. They are administered to try to achieve various outcomes, such as curing an illness, diagnosing a disease or condition, arresting or slowing a disease's progress, reducing or eliminating symptoms, or preventing a disease or symptom.Steps for assessment: 1. Review the resident's medical record for documentation that any of these medications were received by the resident and for the indication of their use. Coding Instructions: .Anticoagulant (e.g., warfarin, heparin, or low-molecular weight heparin): Check if an anticoagulant medication was taken by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days). Anticoagulant: Check if there is an indication noted for all anticoagulant medications taken by the resident any time during the observation period (or since admission/entry or reentry if less than 7 days). Do not code antiplatelet medications such as aspirin/extended release. as N0415E, Anticoagulant.

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

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

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F 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** 48901 Based on interview and record review, the facility failed to follow their policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, for one of 55 sampled residents (Resident 329) when communication interventions were not developed and implemented. This failure had the potential for Resident 329's communication and care needs to not be met. Findings: During a review of Resident 329's Care Plan Report (CPR), dated [DATE], the CPR indicated, Communication: [Resident 329] is at risk for impaired communication related to primary language is Spanish. Goal.Will be able to make needs known. Will have needs met. Will have no declines in communication. Interventions [none]. During an interview on [DATE] at 2:30 p.m. with Resident 329, Resident 329 stated she was Spanish speaking only. Resident 329 stated at times English speaking staff did not understand her and she does not understand English. Resident 329 stated staff use an interpreter when they communicated with her. Resident 329 stated the staff would only check her brief and change it when she called for assistance. Resident 329 stated she would have preferred someone who could communicate with her in her language. During an interview on [DATE] at 9:40 a.m. with Registered Nurse Consultant (RNC) 1, RNC 1 stated Resident care plans are required to have interventions listed. During a review of the facility's P&P titled, Care Plans, Comprehensive Person-Centered, dated [DATE], the P&P indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation.4. Each resident's comprehensive person-centered care plan is consistent with the resident's rights to participate in the development and implementation of his or her plan of care, including the right to. g. receive the services and/or items included in the plan of care. 7. The comprehensive, personal-centered care plan.10. When possible, interventions address the underlying source(s) of the problem area(s).

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 41035 Based on observation, interview, and record review the facility failed to follow medication orders for one of 13 residents (Resident 76). These failures had the potential for Resident 76 to not receive the full effect of the medication. Findings: During an observation on 2/26/25 at 2:20 p.m. in the doorway of Resident 76's room, Licensed Vocational Nurse (LVN) 9 was preparing to administer medication to Resident 76. LVN 9 removed a package of Potassium Chloride tablets (medicine to treat or prevent low blood levels of potassium) ER (extended release) 20 MEQ [milliequivalent- unit of measure] from her medication cart and compared the medication package with Resident 76's Medication Administration Record (MAR). LVN 9 removed two Potassium Chloride ER 20 MEQ tablets from the medication package. LVN 9 crushed the two tablets of Potassium Chloride ER 20 MEQ. LVN 9 placed the crushed Potassium Chloride tablets in a small cup of apple sauce. LVN 9 fed Resident 76 the apple sauce with the crushed Potassium Chloride ER 20 MEQ tablets. During a concurrent interview and record review on 2/26/25 at 3:42 p.m. with Director or Nursing (DON), Resident 76's Order Listing Report (OLR), dated 2/27/25 was reviewed. The OLR indicated, Potassium oral tablet (Potassium) give 40 mEq by mouth three times a day for Hypokalemia [low potassium]. Resident 76's MAR, dated 2/2025 was reviewed. The MAR indicated, Potassium oral tablet (Potassium) give 40 mEq by mouth three times a day for Hypokalemia. DON stated the LVN should have clarified why the Potassium oral tablet ER medication package did not match with the MAR and OLR which did not indicate Potassium Chloride ER. Resident 76's Potassium Chloride ER tablet package label was reviewed. The package label indicated Potassium CHL (chloride) ER 20 MEQ. DON stated the pill package label indicated Potassium Chloride ER. DON stated LVN 9 should not have crushed the ER medication. During an interview on 2/26/25 at 3:48 p.m. with Pharmacist, Pharmacist was asked if Potassium ER tablets could be crushed. Pharmacist stated Potassium ER should not be crushed. During a review of a Cleveland Clinic Medication Article (CCMC), [undated], the CCMC indicated, Potassium Chloride Extended-Release Tablet.Take it as directed on the prescription label at the same time every day. Take it with food. Do not cut, crush, chew, or suck this medication. Swallow the capsules whole. During a review of the facility's policy and procedure (P&P) titled, Appendix 6: Medication Crushing Guidelines, dated 2019, the P&P indicated, Medications that should not be crushed or chewed. When a resident's condition prohibits the administration of solid dosage forms (tablets, capsules, etc.) the nurse administering the medication should check to see that there is no contraindication to crushing the medications in question. If crushing is contraindicated, the nurse should consult the pharmacist for assistance to obtaining the medication in liquid form, if possible. The rationale for not crushing some medication includes.Time released tablets are designed to release medication over a sustained period, usually 8 to 24 hours. These formulations are utilized to reduce stomach irritation in some cases and to achieve prolonged medication action. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Administering Medications, revision date 2019, the P&P indicated, The individual administering the medication checks the label three (3) times to verify the right resident, right medication, right dose, right time and right method (route) of administration before giving the medication.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 48901 Based on interview and record review, the facility failed to implement their policy and procedure (P&P) titled, Physician Orders, Accepting, Transcribing, Carrying Out and Implementing (Noting), for one of two sampled residents (Resident 126) when Resident 126's wound treatment orders were not implemented. This failure resulted wound care not being provided for Resident 126's right heel blister which had the potential for development of infection and delayed wound healing. Findings: During a concurrent interview and record review on 2/27/25 at 11:26 a.m. with Registered Nurse Consultant (RNC) 1, Resident 126's SBAR [Situation, Background, Assessment, Recommendation] Communication Form and Progress Note for RNs [Registered Nurse]/LPN [Licensed Practice Nurse]/LVNs [Licensed Vocational Nurse] (SBAR), dated 2/19/25 was reviewed. The SBAR indicated, Resident 126 developed a right heel blister, the primary care clinician was notified and a wound treatment was ordered on 2/19/25. The SBAR indicated, Cleanse [right heel blister] with NS [Normal Saline - irrigating fluid], pat dry, paint with Betadine [antiseptic] BID [twice a day]. RNC 1 stated based on Resident 126's SBAR, the physician ordered a wound treatment for the right heel blister and the physician's order was not recorded in Resident 126's medical record. RNC 1 was unable to provide a physician's order for treatment of Resident 126's right heel blister. RNC 1 stated the Resident 126's physician's treatment order for the right heel blister was not implemented. During a review of the facility's P&P titled, Physician Orders, Accepting, Transcribing, Carrying Out and Implementing (Noting), [undated], the P&P indicated, Licensed nursing personnel will ensure that telephone and verbal orders will be recorded and implemented. All physician orders are to be complete and clearly defined to ensure accurate implementation. Procedure 1. Telephone and Verbal Orders. b) Record the actual order received from the physician with the date and time that the order was received. c) The nurse taking the order will sign with a full signature. Telephone and verbal orders shall be immediately recorded on the resident's Clinical Record. 2. Implementation of Orders. a) Licensed nursing shall verify each order for completeness, clarify and appropriateness of doses and allergies.

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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. 48901 Based on interview and record review, the facility failed to provide hearing aids for one of one sampled resident (Resident 22). This failure had the potential to affect Resident 22's quality of life. Findings: During a review of Resident 22's Initial ENT (Ears, Nose, Throat) Consultant (IENTC), dated 6/11/24, the IENTC indicated, REASON FOR VISIT.#2 Difficulty Hearing. #6 Stuffy Ears. REFERRALS. Audiogram [test for hearing loss] Recommended: Yes - Hearing abnormal by observation and patient also c/o [complain of] hearing problems. During a review of Resident 22's Audiogram, dated 7/10/24, the Audiogram indicated, Qualified Hearing Loss for Hearing Aids: Y [yes]. Eligibility: Y. Recommendation: Hearing Aids. Notes: The patient [Resident 22] has hearing loss significant enough to qualify for hearing aids. The patient has a greater hearing loss at higher frequencies in the right ear, meaning the patient has greater difficulty discriminating between different sounds during conversation and hearing higher-pitched voices and sounds. During an interview on 2/24/25 at 12 p.m. with Resident 22, Resident 22 stated she does not have hearing aids and was not seen by a hearing doctor recently. During an interview on 2/26/25 at 11:52 a.m. with Social Service Director Case Manager (SSDCM), SSDCM stated she was not aware Resident 22's audiogram on 7/10/24 had recommended hearing aids. During an interview on 2/26/25 at 3:09 p.m. with Social Services (SS), SS stated she was unaware Resident 22 needed hearing aids and stated it was her mistake for not following up after Resident 22's audiogram was completed. During a review of the facility's policy and procedure (P&P) titled, Hearing and Vision Services, [undated], the P&P indicated, It is the policy of this facility to ensure that all residents have access to hearing and vision services and receive adaptive equipment as indicated. Policy Explanation and Compliance Guidelines. 3. The social worker/social service designee is responsible for assisting residents, and their families, in locating and utilizing any available resources. for the provision of the vision and hearing services the resident needs. 6. Assistive devices to maintain hearing include, but are not limited to, hearing aids and amplifiers.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. 48901 Based on observation, interview and record review, the facility failed to follow their policy and procedure (P&P) titled, Administration Set/Tubing Changes for one of one sampled resident (Resident 329). This failure had the potential to place Resident 329 at risk for infection. Findings: During a concurrent observation and interview with Licensed Vocational Nurse (LVN) 1 in Resident 329's room, Resident 329's Intravenous (IV-flexible tube is inserted into a vein to administer fluids, medications, or blood products directly into the bloodstream) tubing was not labeled. LVN 1 stated the IV tubing should have been labeled with date and time of when the IV tubing was hung and the initials of who hung the IV tubing. During a review of the facility's P&P titled, Administration Set/Tubing Changes, dated February 2023, the P&P indicated, The purpose of this procedure is to provide guidelines for aseptic administration set changes in order to prevent infections associated with contaminated IV therapy equipment. General Guidelines. 4. Label tubing with date, time and initials. If facility requires, label may include the date and time that tubing was initiated and when tubing should be discontinued or changed. 5. Any tubing that is found not labeled must be changed and then labeled accordingly.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 44134 Based on interview and record review, the facility failed to ensure annual competencies were completed for one of five sampled Certified Nursing Assistants (CNA) 1. This failure had the potential for CNA 1 to not be competent when providing care to residents. Findings: During a concurrent interview and record review on 2/26/25 at 3:47 p.m. with Director of Staff Development (DSD), CNA 1's Employee Orientation Checklist (EOC), undated was reviewed. The EOC indicated, CNA 1 date of hire was 12/26/23. CNA 1's new employee orientation began on 12/26/23 and was completed on 12/27/23. CNA 1's Nurse Assistant Competency Checklist (NACC), [undated] was reviewed. The NACC indicated, CNA 1 had completed the competency checklist on 12/27/23. DSD was unable to provide a 2024 annual competency for CNA 1. DSD stated CNA 1 did not have a current annual competency completed as required. Policy requested from facility and was not provided.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 42148 Based on observation, interview, and record review, the facility failed to follow their policy and procedure (P&P) titled, Food Preparation, for one of one cooks (Cook 1) when [NAME] 1 did not measure recipe ingredients. This failure had the potential for residents' nutritional needs to not be met. Findings: During a review of the facility's RECIPE: ZESTY SPINACH, (RZS) dated 2/24/25, the RZS indicated, add 1 tsp to 1 1/2 tsp of garlic powder, add 1/4 tsp to 3/4 tsp of salt, and add 1/2 tsp to 1 tsp of red pepper flakes. During a concurrent observation and interview on 2/25/25 at 9:14 a.m. with [NAME] 1, Certified Dietary Manager (CDM), and Registered Dietician (RD), in the kitchen, [NAME] 1 was preparing spinach to be pureed. [NAME] 1 poured all the pureed spinach into a larger dish then added unmeasured amounts of garlic powder, iodized salt, chili powder, and melted butter into the spinach. [NAME] 1 stated she does not use the recipe, she went by taste. [NAME] 1 stated she should have measured the seasoning as listed in the RZS. During an interview on 2/25/25 at 3:17 p.m. with CDM, CDM stated [NAME] 1 should have followed the RZA and measured the spices prior to adding to the spinach dish. During a review of the P&P titled, Food Preparation, dated 2023, the P&P indicated, food shall be prepared by methods that conserve nutritive value, flavor, and appearance. 1. The facility will use approved recipes, standardized to meet the resident census. 2. Recipes are specific as to portion yield, method of preparation, quantities of ingredients, and time and temperature guidelines.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41035 Based on observation, interview, and record review, the facility failed to ensure assistive feeding devices were available for one of one sampled resident (Resident 72). This failure had the potential to prevent Resident 72 from maintaining or improving his independence in self-feeding skills when consuming meals and snacks. Findings: During a review of Resident 72's Admission Record (AR), dated 2/27/25, the AR indicated, Resident 72 was readmitted on [DATE] with a diagnosis hemiplegia (inability to move one side of the body) following cerebral infarction (stroke resulting in blockage in the blood vessels supplying blood to the brain) affecting right dominate side. During a concurrent observation and interview on 2/24/25 at 1:34 p.m. with Resident 72 in Resident 72's room, Resident 72's lunch tray had a cup of tea with one handle, four small bowls containing pureed food, and two regular eating spoons. Resident 72's meal ticket was reviewed. The meal ticket indicated ADAP [adaptive] Equip [equipment] 2 Handle sip cup, coated spoon, [NAME] grip spoon. Resident 72 stated she had not received or used a cup with 2-handles or special spoons in a while. During a concurrent interview and record review on 2/26/25 at 3:56 p.m. with Registered Dietician (RD) in the conference room, RD was shown a picture of Resident 72's lunch tray and meal ticket. RD stated the adaptive eating or drinking devices listed on Resident 72's meal ticket was not on Resident 72's lunch tray. RD stated the kitchen staff are responsible to follow the meal ticket and place the appropriate adaptive equipment on the Resident's meal tray. During a concurrent interview and record review on 2/26/25 at 4:15 p.m. with Certified Dietary Manager (CDM), Resident 72's Adaptive Equipment Tally Report (AETR), dated 2/24/25 was reviewed. The AETR indicted, Resident 72 should have had adaptive Equipment which included 2-Handle sip cup, coated Spoon, and [NAME] grip spoon. CDM stated the kitchen staff should have provided Resident 72 with the appropriate adaptive devices for meals. During a review of Resident 72's Occupational Therapy Treatment Encounter Notes ([NAME]), dated 10/23/24, the [NAME] indicated, Date of service 10/23/24: skilled interventions to facilitate Independence with Self Feeding abilities included compensatory training to increase independence in self-feeding, adaptive equipment instruction to facilitate safety, analysis of performance with adaptive equipment and self-feeding techniques. Pt [Patient-Resident 72] attempted use of built-up handle and ucuff [universal cuff - a leather cuff that fits around the palm of the user's hand and is secured with an elastic strap for better control with utensils] for self-feeding. Pt was able to use both successfully with dycem [a non-slip surface] required to keep plate from sliding. Spoke with OT [occupational therapist] and did right (sic) orders for kitchen to have Pt with built up utensil, maroon spoon, dycem and plate guard as needed for each meal. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 72's Order Listing Report (OLR), dated 2/27/25, the OLR indicted, Resident 72 will use Universal Cuff, built up utensil (plastic, maroon spoon), dycem, and plate guard during all mealtimes as needed to facilitate independence during feeding. During a review of the facility's policy and procedure (P&P) titled, Assistive Devices and Equipment, [undated], the P&P indicated, Policy Statement. Our facility maintains and supervises the use of assistive devices and equipment for residents. Policy Interpretation and Implementation 1. Certain devices and equipment that assist with resident mobility, safety and independence are provided for residents. These may include (but are not limited to): a. specialized eating utensils and equipment.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48901 Based on interview and record review, the facility failed to ensure the binding Arbitration Agreement (a contract that requires parties to resolve disputes outside of court) was written in a form and manner resident could understand for three of three sampled residents (Resident 44, Resident 70, and Resident 329). This failure had the potential for Resident 44, Resident 70, and Resident 329 to sign the Arbitration Agreement without understanding the implications. Findings: During a review of the facility's ARBITRATION AGREEMENT (AA), 1/20/22, the AA indicated, The Resident and/or Resident's agent certifies that he/she has read this Agreement and has been given a copy of this Agreement, and affirmatively represents that he/she is duly authorized by virtue of the Resident's consent, instruction, and/or durable power of attorney, to execute this Agreement and accept its terms. During a review of Resident 44's ADMISSION RECORD (AR), dated 2/26/25, the AR indicated, Primary [NAME]. [language] Spanish. During a review of Resident 44's AA, dated 5/31/24, the AA (printed in English) indicated the AA was signed by Resident 44 on 5/31/24. During an interview on 2/26/25 at 2:58 p.m. with Resident 44, Resident 44 stated she does not read, speak, or understand English. Resident 44 stated she did not know what an arbitration agreement was and did not remember signing the AA printed in English. Resident 44 stated she would have preferred to have the AA written in Spanish. During a review of Resident 70's AR, dated 2/26/25, the AR indicated, Primary [NAME]. Spanish. During a review of Resident 70's AA, dated 11/24/23, the AA (printed in English) indicated the AA was signed by Resident 70 on 11/24/23. During an interview on 2/26/25 at 2:51 p.m. with Resident 70, Resident 70 stated he did not read English and understood very little spoken English. Resident 70 stated he did not know what an AA was and did not remember signing an AA. During a review of Resident 329's AR, dated 2/26/25, the AR indicated, Primary [NAME]. Spanish. During a review of Resident 329's signed AA, dated 2/6/25, the AA (printed in English) indicated the AA was signed by Resident 329 on 2/6/25. During an interview on 2/26/25 at 2:41 p.m. with Resident 329, Resident 329 stated she did not understand, speak or read English. Resident 329 stated she spoke only Spanish and she did not understand the AA she signed. (continued on next page)

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	055568	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sierra Valley Rehab Center	301 West Putnam Porterville, CA 93257

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/26/25 at 3:22 p.m. with Admission Coordinator (AC), AC stated she tells residents that the AA can be rescinded/canceled within 30 days after signing the legal document. AC stated the AA was written in English which would prevent the Spanish speaking residents from reviewing the AA to see if they would like to rescind the AA. During an interview on 2/27/25 at 2:19 p.m. with Administrator, Administrator stated the facility has a Spanish speaking population which is greater than 5% and stated the importance of having vital information like the AA written in the residents' preferred language. During a review of the facility's policy and procedures (P&P) titled, Translation and/or Interpretation of Facility Services, dated November 2020, the P&P indicated, Policy Statement. This facility's language access program will ensure that individuals with limited English proficiency (LEP) shall have meaningful access to information and services provided by the facility. Policy Interpretation and Implementation. 6. This facility shall provide written translation of vital information pertaining to health services, resident rights and facility policy if the limited English proficiency (LEP) population represents at least five (5) percent of the population of 1000 people eligible to be served by the facility (whichever is fewer). During a review of the facility's P&P titled, Binding Arbitration Agreements, dated November 2023, the P&P indicated, Policy Statement. Residents (or representatives) are informed of the nature and implications of any proposed binding arbitration agreements so as to make informed decisions on whether to enter into such agreements. Policy Interpretation and Implementation. 1. Residents (or representatives) have the right to make informed decisions about important aspects of their health, welfare and safety. 6. The terms and conditions of a binding arbitration agreement are explained to the resident (or representative) in a form and manner that he or she understands, taking in to consideration the resident's (or representation) language, literacy and stated preference for learning.8. Residents (or representatives) are provided 30 days after signing to fully review and rescind any agreement not understood at the time of admission.

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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. 42148 Based on observation, interview, and record review, the facility failed to follow standards of practice for infection control when: 1. One of one sampled resident (Resident 42) presented with signs and symptoms of a cough and treated with Influenza (flu-a contagious respiratory virus) medication was not put in Droplet Isolation Precautions (Isolation for residents with contagious respiratory symptoms requiring resident to be isolated and staff/visitors to wear a gown, gloves, and a mask. 2. Two of two sample residents (Resident 4 and Resident 42) requiring oxygen, did not have the tubing on their oxygen and nebulizer machine dated and timed and oxygen tubing found on the floor uncovered. 3. One of one resident (Resident 229) requiring portable suction machine [used to clear secretions from resident mouth and throat], did not having the tubing and canister dated or timed and the suction tip of the machine was left at bedside uncovered. 4. One of one sampled resident (Resident 86) was provided hand hygiene before being served lunch. These failures had the potential to result in infections or viruses for Resident 4, Resident 42, Resident 229, Resident 86 and staff/visitors. Findings: 1. During a concurrent observation and interview on 2/24/25 at 10:38 a.m. with Resident 42, in Resident 42's room, Resident 42 had a wet cough and stated it started last Friday and his roommate and family was concerned about him being contagious. During a concurrent interview and record review on 2/27/25 at 11:08 a.m. with Director of Nursing (DON), Resident 42's, Clinical Record (CR), multiple dates, were reviewed. The CR indicated, on 2/15/25 Resident 42's physician was notified Resident 42 was not feeling well and had a cough. On 2/15/25 Nursing Note indicated, MD [Medical Doctor] made aware received new order to start Xofluza [medication used to treat the flu] 80 mg [milligram] 1 tab[tablet] for one time, Tamiflu [medication used to treat the flu] 75 mg bid [twice a day] for 5 days and prednisone [medication used to treat inflammation] 10mg daily for 10 days r/t [related to] flu. Interdisciplinary team (a group of department leaders that meet to discuss resident needs) note dated 2/17/25 at 9:22 a.m. indicated, Change of condition- Flu like symptoms with Interventions: Medications as ordered. Respiratory assessments - ongoing, O2 as ordered. Physician and Responsible Party notified. DON stated there is no documentation supporting or showing that Resident 42 was put on Droplet Isolation Precautions and stated if a resident is on Tamiflu and Xofluza they should be on isolation precautions to protect staff and visitors. During an interview on 2/27/25 at 11:14 a.m. with Infection Preventionist (IP). IP stated, The medications were given because [Resident 42] had a cough and was refusing to go to the ER, so MD put him on Tamiflu just in case it was the flu. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/27/25 at 11:32 a.m. with Registered Nurse Consultant (RNC) 2, RNC 2 stated if a resident is being treated with virus medication and symptomatic with respiratory sign and symptoms, the resident should be placed in Droplet Precautions. RNC 2 stated there is no evidence that Resident 42 was placed in Droplet Precautions. During a review of the facility's policy and procedure (P&P) titled, Isolation- Categories of Transmission-Based Precautions, dated September 2022, the P&P indicated, Transmission-based precautions are initiated when a resident develops signs and symptom of a transmissible infection, arrives for admission with symptoms of an infection.and is at risk of transmitting the infection to other residents. 2. Transmission-based precautions are additional measures that protect staff, visitors, and other residents from becoming infected. These measures are determined by the specific pathogen and how it is spread from person to person.Droplet Precautions 1. Droplet precautions are implemented for an individual documented or suspected to be infected with microorganisms transmitted by droplets . that can be generated by the individual coughing, sneezing, talking.2. Residents on droplet precautions are placed in a private room if possible. 3. Masks are worn when entering the room. 4. Gloves, gown, and goggles are worn if there is risk of spraying respiratory secretions. 2. During a concurrent observation and interview on 2/24/25 at 10:33 a.m. with Licensed Vocational Nurse (LVN) 4, in Resident 42's Room, Resident 42 was wearing oxygen tubing that was connected to a oxygen machine next to his bed. There was no date or time on the tubing. There was also a Nebulizer Machine at the bedside with tubing and a mask without date or time. LVN 4 stated the tubing on both machines were supposed to be changed every Sunday and should have had a label on them and stated neither of them were labeled. During a record review of Resident 42's, Order Summary (OS), dated February 2025, the OS indicated, CHANGE O2 [Oxygen] TUBING EVERY WEEK every Sat [Saturday]. O2 AT 2 LITERS/MINUTE VIA NASAL CANULA [oxygen tubing] PRN [as needed] FOR SOB [Shortness of Breath]. During a concurrent observation and interview on 2/24/25 at 10:50 a.m. with LVN 4, in Resident 4's room, there was an oxygen machine by the bed with oxygen tubing that connects to the resident on the ground. No date on the oxygen tubing. There was a nebulizer machine also at bedside. Facemask and tubing not dated. The pouch holding the mask was dated 1/9/25. LVN 4 stated the oxygen tubing should not be on the floor and should have a date on it. LVN 4 stated the nebulizer mask and tubing should have a date on it. During a review of Resident 4's, OS, dated February 2025, the OS indicated, Oxygen at 2 liters per minute via nasal cannula as needed. CHANGE O2 TUBING every night shift every Sat. [Saturday] 3. During an observation on 2/24/25 at 11:45 a.m. in Resident 229's room, there was a suction canister noted at bedside. The suction tip was sitting on bedside table, not covered or in a package. The suction canister contained liquid that was not labeled or dated. During a concurrent observation and interview on 2/25/25 at 10:20 a.m. with LVN 3, in Resident 229's room, the suction canister was still at the bedside with the suction tip on the bedside table uncovered. The suction canister still had the same liquid as the day before without a date or label. LVN 3 stated the suction canister should have a date and time on it and the suction tip should not be uncovered. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/27/25 at 11:43 a.m. with DON, DON stated the suction machine canister should have a date and time and the suction tip should be covered in a package or a bag. During a review of Resident 229's, OS, dated February 2025, the OS indicated, CHANGE SUCTION CANISTERS 2X/WEEK [two times a week] ON WEDNESDAY & SATURDAY & PRN [as needed] every night shift every Wed [Wednesday], Sat [Saturday] AND as needed. During a review of the facility's P&P titled, Suctioning, dated August 2014, the P&P indicated, The purpose of this procedure is to help prevent infections associated with suctioning and to prevent transmission of such infections to residents and staff. General guidelines: 12. The suction collection canister should be emptied and cleaned daily and changed or decontaminated as necessary. 4. During a concurrent observation and interview on 2/24/25 at 1:07 p.m. with Licensed Vocational Nurse (LVN) 10 in Resident 86's room, LVN 10 delivered Resident 86's lunch tray. LVN 10 was asked if she had provided hand hygiene to Resident 86 prior to her giving him his lunch tray. LVN 10 stated she had not provided hand hygiene to Resident 86 and stated she should have. During a review of the facility P&P titled, Hand Hygiene Policy for Patients before and after Meals, [undated]. The P&P indicated, Hand Hygiene Before Meals.Nursing staff must assist resident who are unable to wash their hands by: providing hand wipes or sanitizer or assisting with handwashing at a sink if needed. 41035

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44134 Based on observation and interview, the facility failed to provide the minimum square footage as required by regulation in 20 of 48 facility bedrooms. This failure had the potential to affect the care and safety of residents. Findings: During a concurrent observation and interview on 2/27/25 at 10:13 a.m. with Environmental Services Director (ESD), in the facility's multiple occupancy rooms, the multiple occupancy rooms were measured. ESD stated the following rooms did not provide the minimum square footage (sq. ft.) as required by regulation (80 sq. ft. per resident for multi-occupation rooms): room [ROOM NUMBER] measured 239 inches (in.) x (by) 132 in. (219 sq. ft.) and had three resident beds; room [ROOM NUMBER] measured 239 in. x 132 in. (219 sq. ft.) and had three resident beds; room [ROOM NUMBER] measured 238 in. x 130 in. (215 sq. ft.) and had three resident beds; room [ROOM NUMBER] measured 238 in. x 129 in. (213 sq. ft.) and had three resident beds; room [ROOM NUMBER] measured 238 in. x 130 in. (215 sq. ft.) and had three resident beds; room [ROOM NUMBER] measured 238 in. x 128 in. (211 sq. ft.) and had three resident beds; room [ROOM NUMBER] measured 238 in. x 130 in. (215 sq. ft.) and had three resident beds; room [ROOM NUMBER] measured 238 in. x 132 in. (218 sq. ft.) and had three resident beds; room [ROOM NUMBER] measured 240 in. x 126 in. (210 sq. ft.) and had three resident beds; room [ROOM NUMBER] measured 240 in. x 130 in. (217 sq. ft.) and had three resident beds; room [ROOM NUMBER] measured 239 in. x 129 in. (214 sq. ft.) and had three resident beds; room [ROOM NUMBER] measured 239 in. x 130 in. (216 sq. ft.) and had three resident beds; room [ROOM NUMBER] measured 240 in. x 130 in. (217 sq. ft.) and had three resident beds; room [ROOM NUMBER] measured 297 in. x 128 in. (264 sq. ft.) and had four resident beds; room [ROOM NUMBER] measured 238 in. x 129 in. (213 sq. ft.) and had three resident beds; room [ROOM NUMBER] measured 238 in. x 129 in. (213 sq. ft.) and had three resident beds; (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	room [ROOM NUMBER] measured 238 in. x 126 in. (208 sq. ft.) and had three resident beds; room [ROOM NUMBER] measured 238 in. x 132 in. (218 sq. ft.) and had three resident beds; room [ROOM NUMBER] measured 238 in. x 130 in. (215 sq. ft.) and had three resident beds; room [ROOM NUMBER] measured 238 in. x 130 in. (215 sq. ft.) and had three resident beds. ESD stated there had not been any adjustments to room sizes or the facility floor plan since the previous survey. During an interview on 2/27/25 at 11:17 a.m. with Administrator, Administrator stated there had been no changes to resident room sizes. Administrator stated although 20 of the resident rooms did not provide the minimum sq. ft. as required by regulation, residents had reasonable amount of privacy, closets, adequate storage, bedside tables, and there was sufficient space to ambulate and/or use their wheelchair. Requested a copy of previous room waiver, unable to provide.

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F 0920 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide at least one room set aside to use as a resident dining room and for activities, that is a good size, with good lighting, air flow and furniture. 42148 Based on observation and interview, the facility failed to ensure the dining room was accessible and had space to accommodate the 132 Residents who reside at the facility. This failure had the potential to negatively affect the resident's social interaction, physical, mental, and psychosocial well-being. Findings: During a concurrent observation and interview on 2/24/25 at 12:13 p.m. with Assistant Director of Nursing (ADON) in the dining room, the dining room door was closed and had a coded lock. There were seven round tables. There was a seating chart on the wall that listed where 15 residents would sit. Eight residents were waiting for lunch to be served. ADON stated they usually have around eight residents in the dining room at one time. ADON stated the facility does not have the space for more than eight reisents at one time in the dining room. ADON stated the residents wait in the hallway until the other residents finish their meal and leave the dining room before they enter the dining room for their meal. ADON stated the coded lock on the door is to ensure only staff can open the dining room door. During a concurrent observation and interview at 2/26/25 at 11:27 a.m. with ADON in the dining room, there were six residents sitting at the tables waiting for lunch to be served. DON stated there were 10 residents in the hallway waiting to enter the dining room. Door was closed. ADON stated the10 residents in the hallway were waiting for the other six residents to finish eating before they entered the dining room. During a concurrent observation and interview on 2/26/25 at 11:50 a.m. with Certified Dietary Manager (CDM) outside the locked and closed dining room door. Ten residents were waiting for lunch outside of dining room. CDM stated the dining room door was always closed and locked as not to be accessible to residents. CDM stated I am not sure why that is. CDM stated the dining room is not big enough to accommodate the 10 residents waiting in the hall in addition to the six residents that were already in the dining room. During an interview on 2/27/25 at 11:31 a.m. with Administrator, Administrator stated the dining room will accommodate no more than 15 residents. The dining room should not have a closed locked door. Administrator stated the dining room should be a common space area allowing Residents to come and go. A Policy and Procedure addressing dining room space was requested and not provided.

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have policies on smoking. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42148 Based on observation, interview, and record review, the facility failed implement its Policy and Procedure (P&P) titled, Smoking, for one of 21 Residents (Resident 4) when tobacco was at the bedside, a smoking care plan and smoking assessment were not completed. These failures had the potential to place residents, visitors, and staff at risk for injury/harm due to potential unsafe smoking practices and access to tobacco. Findings: During a concurrent observation and interview on 2/25/25 at 11:31 a.m. with Licensed Vocational Nurse (LVN) 4 in Resident 4's room, Resident 4 had a can of tobacco at the bedside. LVN 4 stated the tobacco should be locked up and not left at the bedside. During an interview on 2/26/25 at 11:18 a.m. with Activities Assistant (AA), AA stated, If [Resident 4] had full access to his chewing tobacco he will use too much .It is supposed to be locked up. During a concurrent interview and record review on 2/27/25 at 11:52 a.m. with Director of Nursing (DON), Resident 4's, clinical record was reviewed. DON was stated there was no tobacco use care plan or safe smoking evaluation for Resident 4. DON stated Resident 4 should not have tobacco products at the bedside and there should be a tobacco use evaluation and tobacco care plan in place before he is able to use the tobacco. During an interview on 2/27/25 at 2:34 p.m. with Family Member (FM) 1, FM 1 stated, His [Resident 4] tobacco pouches have always been at the bedside but I noticed today they aren't, he needs that, he has been using tobacco for over [AGE] years. During a review of the facility's P&P titled, Smoking, dated 2001, the P&P indicated, This facility has established and maintains safe resident smoking practices. 6. Resident smoking status is evaluated upon admission. If a smoker, the evaluation includes a. current level of tobacco consumption; b. method of tobacco consumption (traditional cigarettes, electronic cigarettes; pipe, etc.); c. desire to quit smoking; and d. ability to smoke safely with or without supervision (per a completed safe smoking evaluation). 7. The staff consults with the attending physician and the director of nursing services (DNS) to determine if safety restrictions need to be placed on a resident's smoking privileges based on the safe smoking evaluation. 8. A resident's ability to smoke safely is reevaluated quarterly, upon a significant change (physical or cognitive) and as determined by the staff. 9. Any smoking-related privileges, restrictions, and concerns (for example, need for close monitoring) are noted on the care plan, and all personnel caring for the resident shall be alerted to these issues. 13. Residents with smoking privileges may not have or keep any smoking items, including cigarettes, tobacco, etc., except under direct supervision.