STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055608	A. Building B. Wing	05/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Primrose Post-Acute	515 Centinela Ave. Inglewood, CA 90302

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46832 Based on observation, interview, and record review, the facility failed to ensure adequate space to access the room's restroom for two out of 7 sampled residents (Resident 28 and Resident 39). This deficient practice resulted in psychological harm from the shame of possibly soiling themselves while sitting in their wheelchairs. Findings: a. A review of Resident 28's admission record indicated Resident 28 was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included falls, dementia (a group of thinking and social symptoms that interferes with daily functioning), polyneuropathy (damage to multiple brain and spinal cord nerves), and gait/mobility abnormalities (an unusual walking pattern). A review of Resident 28's Minimum Data Set (MDS- an assessment and care screening tool) assessment, dated 4/4/2024, indicated Resident 28's cognitive patterns were moderately impaired and was dependent on staff members with toileting, showering and upper/lower body dressing. b. A review of Resident 39's admission record indicated Resident 39 was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included hemiplegia of the left side (muscle weakness or paralysis on one side of the body), gait/mobility abnormalities (an unusual walking pattern), depression (a low mood or loss of pleasure or interest in activities), and asthma (a lung disease where the airways become narrowed and swollen, making it difficult to breathe). A review of Resident 39's Minimum Data Set (MDS- an assessment and care screening tool) assessment, dated 4/25/2024, indicated Resident 39's cognitive patterns were severely impaired and was dependent on staff members with toileting, showering and upper/lower body dressing. During a concurrent observation and interview, on 5/7/2024 at 1:33 p.m., with Resident 28, Resident 28 was observed sitting in her wheelchair near her bed. Observation showed there was inadequate space to access the restroom due to roommate's bed blocking the restroom door. Resident 28 stated she was unable to walk. Resident 28 stated to use the restroom, she had to call a staff member for assistance. Resident 28 stated staff would park her wheelchair at the foot of her roommate's bed. Resident 28 stated when she receives assistance, a staff member would walk into the adjacent room next door through their shared restroom and transfer her into the restroom. Resident 28 stated this made her feel rushed to use the restroom and afraid of soiling herself. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview, on 5/7/2024 at 1:44 p.m., with Resident 39, Resident 39 was also observed sitting in her wheelchair near her bed. Resident 39 stated she couldn't walk and required assistance to use the restroom. Resident 39 stated staff would also park her wheelchair at the end of their roommate's bed and transfer her to the restroom. Resident 39 stated staff would also take her to other residents' rooms to use the restroom. Resident 39 stated this made her feel frustrated and afraid that she would not make it to the restroom in a timely matter. During an interview, on 5/10/2024 at 11:52 a.m., with CNA 3, CNA 3 stated Resident 28 and Resident 39 did not use the restroom on their own and required assistance to the restroom. CNA 3 stated to get Resident 28 and Resident 39 to the restroom, a roommate's bed that is blocking the residents was moved. CNA 3 stated if roommate was asleep and Resident 28 or Resident 39 had to use the restroom, the bed would be moved. CNA 3 stated Oh, that resident doesn't mind, she is comfortable and sleeps through it. During an interview, on 5/10/24 at 12:00 p.m., with LVN 3, LVN 3 stated all residents in room [ROOM NUMBER] (Resident 28 and Resident 39's room) were total care (dependent on staff for assistance) residents. LVN 3 stated the room was rearranged once all resident in the room were total care residents. LVN 3 stated beds should not had been moved to access the restroom. LVN 3 stated We don't move the bed. I don't usually work at this station. I don't know how the staff at this station transfer the residents to the restroom. During an interview, on 5/10/24 at 4:03 p.m., with the DON, DON stated it had been noticed staff members were having a hard time opening the door fully to the restroom. DON stated she was informed when Resident 28 and Resident 39 need to go the restroom, staff must go through the other room and bathroom to assist the resident. DON stated it would be hard on the staff and residents to be assisted to the restroom without disturbing the roommate. DON stated the risks of having inadequate space for residents to use the restroom could result in limiting resident's ability to freely go to restroom, increase the risk of falling and residents may not be able to wait to use the restroom. During an interview, on 5/10/24 at 4:15 p.m., with the Administrator, Administrator stated he did not believe the inadequate space reduced the quality of care being given. Administrator stated inadequate space could result in challenges for nurses to provide care for the residents, perform their job effectively, and create a barrier to care. Administrator stated for residents, it could challenge residents to get to restroom freely. Administrator stated the risk of having inadequate space to the restroom could result in residents feeling more cumbersome and enclosed in small areas. Administrator stated, We are cognizant of room assignments and size of room, we work with residents to ensure comfort and needs are met. A review of the facility's policy and procedures, titled Accommodations of Needs, dated 3/2021, indicated In order to accommodate individual needs and preferences, adaptions may be made to the physical environment, including the resident's bedroom and bathroom, as well as the common areas in the facility. Examples of adaptions may include: f. moving furniture or large items in rooms and common areas that may obstruct the path of a resident.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47042 Based on interview and record review the facility failed to: 1. Ensure a change of condition was formulated and responsible party notified for one of 18 sampled residents (Residents 55). This deficient practice violated the responsible party's right to be informed of the care services provided, violated the resident's rights of notification to the resident's representative (family member) and hand the potential to result in lack of proper care and treatment. Findings: A review of Resident 55's Admission Record indicated, Resident 55 was initially admitted to the facility on [DATE]. Resident 55's diagnoses included acute kidney failure (sudden loss of the ability of the kidneys to function), cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area), dementia (loss of the ability to think, remember, and reason to levels that affect daily life and activities), and hypertension (when the pressure in your blood vessels is too high). A review of Resident 55's History and Physical (H&P), dated 1/27/2024, indicated Resident 55 had the capacity to understand and make decisions. A review of Resident 55's Minimum Data Set ([MDS], a standardized assessment and care planning tool), dated 4/18/2024, the MDS indicated Resident 55 had clear cognition (ability to think and reason). The MDS indicated Resident 8 required dependent assistance from staff for activities of daily living (ADLs) such as toileting, showering, and dressing. During a concurrent interview and record review on 5/10/2024 at 4:20 p.m., with Licensed Vocational Nurse (LVN) 6, Resident 55's electronic medical record (eMAR) was reviewed, no change of condition was documented for the transfer to hospital on 2/19/2024. LVN 6 state there was no change of condition record documented for 2/19/2024. LVN 6 stated there should always be a change of condition document when there is change in the resident's condition. LVN 6 stated if a change of condition was not done it could be potentially harmful to the resident, due to the physician or responsible party not aware and nothing would be done for them. During an interview on 5/10/2024 at 4:30 p.m., with the Director of Nursing (DON), the DON stated if a change of condition regarding the resident was not documented there would be no way to know if physician was notified. The DON stated if change of condition was not reported the residents change would not be addressed. The DON stated the resident would potentially get worse. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the policy and procedure (P&P) titled, Change in a Resident's Condition or Status, dated 2001, the P&P indicated, prior to notifying the physician, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the SBAR communication form. Nurse will notify the resident's representative when: there is a significant change in the resident's physical, mental, or psychosocial status and or it is necessary to transfer the resident to a hospital/treatment center. Except in medical emergencies, notifications will be made within twenty-four hours of a change occurring in the resident's medical/mental conditions or status. Regardless of the resident's current mental or physical condition, a nurse will inform the resident of any changes in his/her medical care or nursing treatments.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47923 Based on interview and record review, the facility failed to ensure an accurate Minimum Data Set ([MDS] assessment and care screening tool), regarding functional limitation in range of motion, was conducted for one of 18 sampled residents (Resident 47). This deficient practice had the potential to result inaccurate care and services for Resident 47 due to inappropriate MDS care screening and tool assessment practices. Findings: A review of Resident 47's Admission Record Resident 47 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 47's diagnosis included osteoarthritis (a degenerative joint disease in which the tissues in the joint break down over time) and contractures (chronic loss of joint mobility) on right elbow, right knee, and left knee. A review of Resident 47's History and Physical (H&P), dated 8/7/2023, the H&P indicated Resident 47 had the capacity to understand and make decisions. A review of Resident 47's Rehab Joint Mobility Screen Assessment (a form used to assess the ability of the joints to move without any restrictions), dated 3/18/20224, indicated Resident 47 had severe impairment in range of motion on left and right hip, left and right knee, and left and right ankle. During a concurrent interview and record review on 5/10/2024 at 12:15 p.m., with the MDS Nurse, Resident 47's MDS assessment, dated 3/22/2024 was reviewed. The MDS assessment under section GG (Functional Limitation in Range of Motion) indicated Resident 47's had no impairment in functional limitation (inability to perform an activity or task) on lower extremity and coded as ([0] no impairment). The MDS nurse stated the assessment was not accurate. The MDS nurse stated the MDS assessment should had been coded as 2 (impairment on both sides of lower extremity). The MDS nurse stated it was very important to have an accuracy of assessment for residents to have proper interventions and facility reimbursement. During an interview on 5/10/2024 at 12:33 p.m., with the Director of Nursing (DON), the DON stated the standard of practice was to provide accurate MDS assessment to all residents so they could have adequate and quality of care. A review of the facility's Policy and Procedure (P&P), titled, Certifying Accuracy of the Resident Assessment, dated 2019, indicated any person completing a portion of the MDS must sign and certify the accuracy of that portion of the assessment.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 46832 Based on interview and record review the facility failed to develop a care plan (the process of identifying a patient's needs and facilitating care and ensures collaboration among nurses, patients, and other healthcare providers) for three of 18 sampled residents (Residents 44, 16, and 53). This deficient practice had the potential for Resident 44, Resident 16, and Resident 53 to not receive the care and services needed. Findings: a. A review of Resident 44's Admission Record indicated, Resident 44 was initially admitted to the facility on [DATE] and last readmitted on [DATE]. Resident 44's diagnoses included multiple sclerosis (a potentially disabling disease of the brain and spinal cord), Huntington's disease (a condition that damages nerve cells in the brain causing them to stop working properly), and insomnia (inability to fall asleep). A review of Resident 44's Minimum Data Set ([MDS], a standardized assessment and care planning tool), dated 2/21/2024, indicated the resident was assessed to have no cognitive impairment in daily decision making (ability to think and reason). The MDS indicated Resident 44 was dependent on staff for activities of daily living (ADLs, self-care activities performed daily such as toileting, showering, and dressing). During a concurrent interview and record review on 5/10/2024 at 3:10 p.m., with Registered Nurse (RN) 1, Resident 44's care plan was reviewed. RN 1 stated there was no care plan for Resident 44's fall on 3/22/2024. RN 1 stated there should have been a care plan. RN 1 stated a care plan was the plan of care for the resident, which included goals and interventions. RN 1 stated if there was no care plan created the resident could potentially decline and would not get the best care they should have received. During an interview on 5/10/2024 at 4:30 p.m., with the Director of Nursing (DON), the DON stated a care plan was for the specific plan of care regarding the resident. The DON stated care plans were very important to help the staff to care for the resident. The DON stated if a care plan was not created the staff would not know what interventions the residents would need for specific conditions. b. A review of Resident 16's admission record indicated Resident 16 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 16's diagnoses included epilepsy (a chronic disorder of the brain characterized by recurrent brief episodes of involuntary movement that may involve a part of the body or the entire body), dyspnea (difficult, painful breathing or shortness of breath), hemiplegia (paralysis [inability to move] of one side of the body), and encephalopathy (damage or disease that affects the brain). A review of Resident 16's History and Physical (H&P), dated 12/15/2023, indicated Resident 16 did not have the capacity to understand and make decisions. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 16's MDS, dated [DATE], indicated Resident 16's was dependent on staff with toileting, showering and upper/lower body dressing. During a concurrent interview and record review, on 5/9/2024 at 1:05 p.m., with Licensed Vocational Nurse (LVN) 7, Resident 16's care plans was reviewed. LVN 7 stated care plans were initiated upon admission and with any residents' change of condition. LVN 7 stated care plans were extremely important in guiding a resident's care. LVN 7 performed a search of Resident 16 and Resident 53's care plans. LVN 7 stated there was no care plan nor a physician's order for Resident 16 regarding oxygen administratio n. LVN 7 stated the risk of not having a care plan resulted in giving improper care to a resident. c. A review of Resident 53's admission record indicated Resident 53 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 53's diagnoses included Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), asthma (a chronic disease making it difficult to breathe), congestive heart failure (chronic condition where the heart does not pump blood effectively), and adult failure to thrive (loss of appetite, eats and drinks less than usual, loses weight, and is less active than normal). A review of Resident 53's H&P, dated 4/25/2024, indicated Resident 53 did not have the capacity to understand and make decisions. A review of Resident 53's MDS, dated [DATE], indicated Resident 53 was dependent on staff with toileting, showering and upper/lower body dressing. A review of Resident 53's physician orders, dated 4/25/2024, indicated Resident 53 had a gastrostomy tube (a flexible plastic tube placed into the stomach to help provide nutrition when someone is unable to eat). Resident 53's physician's order indicated Enteral Feed Order one time a day GT feeding. During a concurrent interview and record review, on 5/9/2024 at 1:10 p.m., with Licensed Vocational Nurse (LVN) 7, Resident 53 care plan was reviewed. LVN 7 stated care plans were initiated upon admission and with any residents' change of condition. LVN 7 stated care plans were extremely important in guiding a resident's care. LVN 7 performed a search of Resident 53's care plan. LVN 7 stated there was no care plan for Resident 53 regarding a gastrostomy tube. LVN 7 stated the risk of not having a care plan resulted in giving improper care to a resident. During an interview on 5/10/2024 at 11:46 a.m., with the DON, the DON stated licensed staff were responsible for initiating and revising care plans. The DON stated the importance of care plans were to guide the licensed staff on caring for residents. The DON stated, the risk of not having a care plan, shows that we don't have a plan in place for the resident. The care plan shows how we are supposed to take care of them. A review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, dated March 2022, indicated, a comprehensive person-centered care plan should be developed and include measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs. The interdisciplinary team should review and update the care plan when there has been a significant change in the resident's condition.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47042 Based on interview and record review the facility failed to: 1. Ensure g-tube residuals were checked for one of one sampled residents (Resident 8). 2. Ensure a clean stirring utensil was used when diluting the medications for one of one sampled residents (Resident 8). 3. Ensure physician orders were followed to place floor mats for one of 18 sampled residents (Residents 44). This deficient practice had the potential for the affected resident not to receive the care and services needed and the provision of a poor-quality care. Findings: a. A review of Resident 44's Admission Record indicated, Resident 44 was initially admitted to the facility on [DATE] and last readmitted on [DATE]. Resident 44's diagnoses included multiple sclerosis (a potentially disabling disease of the brain and spinal cord), Huntington's disease (a condition that damages nerve cells in the brain causing them to stop working properly. The damage can affect movement, cognition (perception, awareness, thinking, judgement) and mental health.), and insomnia (inability to fall asleep). A review of Resident 44's Minimum Data Set ([MDS], a standardized assessment and care planning tool), dated 2/21/2024, the MDS indicated the resident was assessed to have a clear cognition in daily decision making. The MDS indicated Resident 44 required dependent assistance from staff for activities of daily living (ADLs) such as toileting, showering, and dressing. During a concurrent observation and interview on 5/9/2024 at 4:10 p.m., with Certified Nursing Attendant (CNA) 2 in resident's room, Resident 44 had no floor mats placed next to bed. CNA 2 stated there are no floor mats on the ground. CNA 2 stated when a resident is on fall precautions floor mats should be placed on both sides of the bed. CNA 2 stated that the floor mats are placed for the resident's protection to add cushion if they should fall. CNA 2 stated the resident could potentially get hurt. During a concurrent interview and record review on 5/9/2024 at 4:13 p.m., with Director of Staff Development (DSD), Resident 44's physician orders, dated 3/29/24 were reviewed. The physician orders indicated low bed with floor mats at bedside. The DSD stated if physician orders are not followed it could affect the resident in so many ways, for fall precautions that are not put in place there was potential for falls with injuries. During an interview on 5/10/2024 at 4:30 p.m., with the Director of Nursing (DON), the DON stated when staff receives a physician order it was followed and carried out. If physician orders are not followed it could affect the resident and delay care that is needed. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the policy and procedure (P&P) titled, Medication and Treatment Orders, dated 2001, the P&P indicated, orders for medications and treatments will be consistent with principles of safe and effective order writing. b. During an observation on 5/10/2024 at 9:00 a.m. in Resident 8 room during medication administration, LVN 3 was observed checking placement of g-tube and did not check the residuals. LVN 3 then proceeded to prepare the residents' medication by adding 30ml water into each crushed medication cup, LVN 3 proceeded to use the same syringe to stir all the medication cups. LVN 3 then proceeded to administer the medication to Resident 8. A review of Resident 8 Admission Record indicated, Resident 8 was initially admitted to the facility on [DATE] and last readmitted on [DATE]. Resident 8's diagnoses included acute kidney failure (sudden loss of the ability of the kidneys to function), type 2 diabetes mellitus (abnormal blood sugar), hypertension (when the pressure in your blood vessels is too high), and dementia (loss of the ability to think, remember, and reason to levels that affect daily life and activities). A review of Resident 8 History and Physical (H&P), dated 7/15/2023, indicated Resident 8 did not have the capacity to understand and make decisions. A review of Resident 8's Minimum Data Set ([MDS], a standardized assessment and care planning tool), dated 3/6/2024, the MDS indicated the resident was assessed to comprehend most conversations. The MDS indicated Resident 8 required dependent assistance from staff for activities of daily living (ADLs) such as toileting, showering, positioning, and dressing. During an interview on 5/10/2024 at 4:30 p.m., with the Director of Nursing (DON), the DON stated residents on g-tubes, residuals and placement should be checked before giving medications. The DON stated it is important to check residuals to make sure the resident is absorbing food. The DON stated the resident could be potentially getting overfed and vomit. The DON stated this is a safety issue for the resident. The DON stated when you reconstitute the medication with water you need to stir each cup with a different spoon/stir stick. The DON stated if you stir with the same spoon, and the resident had a reaction there is no way to know which mediation gave the reaction. A review of the policy and procedure (P&P) titled, Administering Medications through and Enteral Tube, dated November 2018, the P&P indicated dilute crushed (powdered) medication with purified water. Administer each medication separately.

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46832 Based on interview and record review, the facility failed to implement its policy and procedures (P/P) titled Emergency Procedures for Cardiopulmonary Resuscitation ([CPR] an emergency procedure to restart a person's heart and breathing after one or both suddenly stop) by not calling 911 (an emergency alert system) when one of one sampled resident (Resident 65), who had full code status (when a medical personal does everything possible to save a person's life in a medical emergency), was observed unresponsive in bed, on [DATE]. This deficient practice resulted in Resident 65's death and placed 54 other residents, who had Full Code statuses, at risk of not receiving timely life saving measures. Findings: On [DATE] at 2:28 p.m., the Administrator (ADM), and Director of Nursing (DON) were notified of an Immediate Jeopardy (IJ- a situation on which the facility's noncompliance with on or more requirements of participation has caused, or is likely to cause serious injury, harm impairment, or death to a resident) was called for the facility's failure to call 911 during a medical emergency for Resident 65. The facility's staff did not call 911 after initiating CPR for Resident 65. The facility's Administrator and DON were notified of the seriousness of all resident's health and safety were at risk due to staff's failure to call 911 after initiating CPR. An IJ removal plan (am intervention to immediately correct the deficient practices) was requested. On [DATE] at 2:20 p.m., the facility submitted an acceptable IJ removal plan. After onsite verification if the IJ Removal Plan was implemented through interviews, and record reviews, the IJ was removed on [DATE] at 2:44 p.m., in the presence of the ADM, DON and Assistant Administrator (AADM). The IJ Removal Plan included the following: a. On [DATE], Cardio-Pulmonary Emergencies/CPR in-services were initiated for all licensed staff and certified nurse assistants (CNAs) and expected to be completed by [DATE]. b. On [DATE], Physician Orders for Life-Sustaining Treatment ([POLST] a written medical order from a physician, nurse practitioner or physician assistant that helps give people with serious illnesses more control over their own care by specifying the types of medical treatment they want to receive during serious illness) in-services was initiated by the DSD to licensed nurses. Training referred to the section titled Directions for Healthcare Provider was expected to be completed by [DATE]. c. On [DATE], the Director of Staff Development (DSD) conducted a review of the employee files pertaining to the nursing dept, specially checking for CPR certifications. The DSD did not find any expired CPR certificates. d. On [DATE], the DON conducted an in-service informing licensed nurses about the notification procedures following a death in the facility which included prompt notification to the DON and Administrator. The training was expected to be completed by [DATE]. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	e. An annotated provider was invited to provide the nursing staff an in-service regarding emergency response during CPR on [DATE]. f. During daily clinical meetings from Monday to Friday, the DON will review all reported changes in condition to ensure comprehensive assessment of changes, evaluation of initial interventions, identification of additional needs, implementation of adjustments, follow-up, and thorough documentation. g. On the weekends, the Registered Nurse Supervisor will review admissions with a particular focus on POLST and their accurate completion. Any review findings will be completed by the RN, and a summary will be submitted to the DON by the next business day. h. On weekends, the RN Supervisor will review any changes of a resident's condition and report any concerns to the DON by the next business day to ensure adequate interventions were provided. i. The DSD will provide weekly reports on the emergency response CPR review for newly hired staff, if applicable. For employees who undergo annual reviews, the DSD will report monthly to the DON. j. The emergency response system will be reviewed during the annual competency evaluation by the DSD and reported to the DON for acknowledgement. k. The Administrator will update the Quality Assessment & Assurance (QA&A) committee during next Quality Assurance (QA) meetings for progress of action plan or if revisions are necessary. Findings: A review of Resident 65's closed record (face sheet), indicated Resident 65 was initially admitted to the facility on [DATE], and readmitted on [DATE]. Resident 65's diagnoses included encephalopathy (brain disease that causes confusion and memory loss), sepsis (a life-threatening condition in which the body responds improperly to an infection), acute respiratory failure (occurs when the lungs cannot release enough oxygen into a person's blood), and pneumonia (an infection that affects one or both lungs). A review of Resident 65's Minimum Data Set ([MDS] an assessment and care screening tool) dated [DATE], indicated Resident 65's cognitive patterns (the process of thinking) were severely impaired. The MDS indicated Resident 65's required extensive assistance from staff for activities of daily living ([ADLs]- an individual's daily self-care activities such as toileting, showering, dressing oneself). The MDS indicated Resident 65's was dependent on staff for toileting, showering and upper/lower body dressing. A record review of Resident 65's Change of Condition document, dated [DATE], indicated Resident 65's code status was Full Code. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of Resident 65's progress notes, dated [DATE] at 4:30 a.m., indicated on [DATE], at 4:00 a.m., Certified Nurse Assistant (CNA 1) observed Resident 65 in bed, flaccid (loose or floppy limbs), cool to touch with no rise and fall of the chest and nonresponsive to tactile (touch) and verbal stimuli. The progress notes indicated CNA 1 notified Licensed Vocational Nurse (LVN 1) of Resident 65's change of condition at 4:00 a. m. Code Blue (a medical emergency code used to describe a resident who is in cardiac or respiratory arrest) was called, and LVN 1 and LVN 2 performed CPR on Resident 65 for 20 minutes. The progress notes indicated at 4:20 a.m., LVN 1 notified Resident 65's primary physician (Physician 1) via telephone, and the physician pronounced Resident 65 deceased (dead). A review of Resident 65's Death Certificate, dated [DATE], indicated Resident 65's cause of death was respiratory failure. During a telephone interview, on [DATE] at 4:10 p.m., with LVN 1, LVN 1 stated on [DATE] around 4:00 a.m., CNA 1 went to Resident 65's room to reposition him. LVN 1 stated CNA 1 ran back out of the room informing her that Resident 65 did not look good. LVN 1 stated she went into Resident 65's room, assessed the resident's pulses and announced a code blue. LVN 1 stated she initiated CPR on Resident 65 at 4:02 a.m. LVN 1 stated LVN 2 came to assist with CPR for 20 minutes. LVN 1 stated 911 was not called because she called to notify the resident's physician (MD 1) of Resident 65's situation at 4:20 a.m. LVN 1 stated the physician pronounced Resident 65 dead over the telephone at 4:20 a.m., during the phone call. LVN 1 stated the physician did not assess the resident prior to pronouncing the resident dead. During an interview, on [DATE] at 3:25 p.m., with Registered Nurse (RN 1), RN 1 stated during a code blue, a resident's airway, breathing, and circulation should always be checked, followed by the resident's POLST. RN 1 stated if a resident had no vital signs and was a full code, staff start CPR immediately. RN 1 stated another staff should be asked to call 911 right away, and another staff should notify the resident's physician on the resident's condition immediately. RN 1 stated paramedics (healthcare professional trained to respond to emergency calls for medical help outside of a hospital) had the capacity to handle life threatening situations and provide advanced cardiac life support. RN 1 stated 911 was not called on [DATE], after CNA 1 observed Resident 65 unresponsive. During an interview, on [DATE] at 11:46 a.m., with the DON, the DON stated CPR should be initiated if a resident was found unresponsive without a pulse and not breathing. The DON stated during a code blue, staff were supposed to call for assistance, take a crash cart to the resident's room and call 911 immediately. The DON stated 911 was not called on [DATE], when CNA 1 observed Resident 65 unresponsive in bed. The DON stated if 911 was called as soon as a Code Blue was called, Resident 65 might have received prompt lifesaving care. During an interview, on [DATE] at 3:05 p.m., with Resident 65's the physician, the physician stated she could not recall the details but remembered she received an early morning phone call on [DATE], regarding Resident 65. The physician stated LVN 1 informed her Resident 65 was found unresponsive around 4:00 a. m., and staff-initiated CPR for 20 minutes. The physician stated the standard of practice was to initiate CPR and call 911. Physician 1 stated she did not have any notes or documentation from the call received from the facility on [DATE] regarding Resident 65. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A record review of the facility's policy and procedure (P/P), titled Emergency Procedures- Cardiopulmonary Resuscitation, dated February 2018, indicated if an individual was found unresponsive, staff would briefly assess for abnormal or absence of breathing and if a sudden cardiac arrest was likely, staff should begin CPR, instruct another staff member to activate the emergency response system (code) and call 911. The P/P indicated staff should continue with CPR until an emergency medical personnel arrived.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46832 Based on observation, interview, and record review, the facility failed to: 1. Ensure respiratory care was consistent with professional standards of practice when there was no physician order to administer oxygen for one of 7 sampled residents (Resident 16). This deficient practice had the potential to result in unsafe use of oxygen equipment, respiratory infection, unable to breathe comfortably, and/or hospitalization for Resident 16. Findings: A review of Resident 16's admission record indicated Resident 16 was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included epilepsy (seizures), dyspnea (difficulty breathing), hemiplegia (muscle weakness or paralysis on one side of the body), and encephalopathy (a brain disease in which the brain is affected by an infection or toxins). A review of Resident 16's Minimum Data Set (MDS- an assessment and care screening tool) assessment, dated 3/20/2024, indicated Resident 16's was dependent on staff members with toileting, showering and upper/lower body dressing. A review of Resident 16's history and physical (H&P), dated 12/15/2023, indicated Resident 16 was alert and oriented to her name and did not have the capacity to understand and make decisions. During an observation, on 05/07/24 at 11:36 a.m., Resident 16 observed receiving 3 liters of oxygen by a nasal canula. A record review of Resident 16's physician orders, on 05/07/24 at 12:08 PM, indicated there was no order for oxygen administration. During an observation, on 05/09/24 at 11:52 a.m., Resident 16 was observed receiving 2 liters of oxygen by nasal cannula. During a concurrent interview and record review, on 5/09/2024 at 12:40 p.m., with LVN 7, LVN 7 stated a physician order was required to administer oxygen. LVN 7 stated Resident 16 was on oxygen and had a physician order. Resident 16's physician orders were reviewed. LVN 7 stated there was no order to administer oxygen to Resident 16. LVN 7 stated the risk of administering oxygen without an order can cause the resident to receive too much oxygen. During an interview, on 5/10/2024 at 11:46 a.m., with the DON, DON stated a resident must have a physician order to receive oxygen. DON stated oxygen was also a medication and without an order the staff would not know how much oxygen to administer to the resident. DON stated the risk of administering oxygen without a physician order was a medication error. DON stated administering too little or too much oxygen could result in, affecting a resident's respiratory system. A resident can also become confused as well. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure, titled, Oxygen Administration, dated 10/2010, indicated to Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47923 Based on interview and record review, the facility failed to ensure a resident who received hemodialysis ([HD]) process of removing waste products and excess fluids from the body) received treatments in accordance with standards of practice for one of three sampled residents (Resident 216) by failing to communicate to physician and implement the fluid restrictions (certain amount of liquid each day) as recommended by hemodialysis. This deficient practice placed Resident 216 at risk for fluid overload, swelling, shortness of breath and discomfort. Findings: A review of Resident 216's Admission Record, indicated, Resident 216 was admitted to the facility on [DATE] with diagnoses including end stage renal disease (a life-threatening condition when the kidneys fail to filter the blood) and hyperkalemia (too much potassium in the blood). A review of Resident 216's History and Physical (H&P), dated 4/30/2024, indicated, Resident 216 had the capacity for medical decision making. A review of Resident 216's Minimum Data Set ([MDS] resident assessment and care screening tool), dated 5/3/2024, the MDS indicated Resident 216 needed moderate assistance (Helper does less than half the effort) in oral hygiene and upper body dressing. A review of Resident 216's Order Summary Report, dated 5/10/2024, indicated Resident 216 had a physician order for HD treatment every Tuesday, Thursday and Saturday. During a concurrent interview and record review on 5/8/2024 at 10:29 a.m., with Licensed Vocational Nurse 3 (LVN 3), Resident 216's Daily Skilled Charting Note dated 4/27/2024 was reviewed. LVN 3 stated the Daily Skilled Charting Note, indicated Resident 216 was on fluid restriction of 1200 cubic centimeter ([cc] unit of measurement) per day. LVN 3 stated the fluid restriction was not communicated to the physician of Resident 216 and the facility did not monitor Resident 216's for signs and symptoms of fluid overload (your body has too much water). During an interview on 5/8/2024 at 11:03 a.m. with the Director of Nursing (DON), the DON stated the facility failed to collaborate the plan of care to the hemodialysis center by not communicating Resident 216's physician regarding the fluid restriction. The DON stated the facility did not follow the standard of practice in managing a hemodialysis resident. During an interview on 5/9/2024 at 3:30 p.m. with Registered Nurse 1 (RN 1), RN 1 stated there was an order for Resident 216 to have 1200 cc fluid restriction per day from the hemodialysis center when Resident 216 was admitted to the facility on [DATE]. RN 1 stated she did not inform Resident 216's physician regarding the fluid restriction. RN 1 stated it was essential to placed Resident 216 for fluid restriction since he is receiving dialysis treatment. RN 1 stated too much fluid would cause shortness of breath, swelling and other cardiac (heart) complications. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of facility's policy and procedure (P&P) titled, End-Stage Renal Disease, Care of a Resident with, undated, the P&P indicated, Residents with end-stage renal disease will be cared for according to currently recognized standards of care.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46832 Based on interview and record review, the facility failed to ensure that licensed nurses have the specific competencies and skill sets necessary to provide emergency care for one of 8 sampled residents (Resident 65) by: 1. Failing to call 911 after initiating CPR. This deficient practice resulted in Resident 65's death. Findings A review of Resident 65's closed record (face sheet), indicated Resident 65 was initially admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses that included encephalopathy (a broad term for any brain disease that alters brain function or structure), sepsis (a serious condition resulting from the presence of harmful microorganisms in the blood or other tissues and the body's response to their presence, potentially leading to the malfunctioning of various organs, shock, and death), acute respiratory failure (the inability of the respiratory system to meet the oxygenation, ventilation, or metabolic requirements needed of the body), and pneumonia (an infection that inflames air sacs in one or both lungs, which may fill with fluid). A review of Resident 65's Minimum Data Set (MDS- an assessment and care screening tool) assessment, dated [DATE], indicated Resident 65's cognitive patterns were severely impaired and needed extensive assistance from staff members for activities of daily living and was dependent with toileting, showering and upper/lower body dressing. A review of Resident 65's progress notes, dated [DATE], indicated Resident 65 was found by Certified Nurse Assistant 1 (CNA 1). CNA 1 noted Resident 65 was flaccid, cool to touch with no rise and fall of the chest wall and nonresponsive to tactile and verbal stimuli. CNA 1 notified Licensed Vocational Nurse (LVN 1) of Resident 65's change of condition at 4:00 a.m. Code Blue (a medical emergency code used to describe a resident who is in cardiac or respiratory arrest) was called, and CPR was initiated by LVN 1. LVN 1 and LVN 2 performed CPR for 20 minutes. At 4:20 a.m., Resident 65's primary physician (MD) was notified by LVN 1 via telephone, who pronounced Resident 65 deceased . A review of the facility's licensed staff CPR certificates indicated all certifications were current. During an interview, on [DATE] at 3:15 p.m., with Certified Nurse Assistant 2 (CNA 2), CNA 2 stated if a Code Blue was called for a resident, 911 was to be called immediately. CNA 2 stated 911 is called if a resident is found without a pulse and not breathing. CNA 2 stated when 911 is called, the paramedics arrive to the facility within 2 minutes. CNA 2 stated the risk of not calling 911 during a Code Blue could result in the patient dying. CNA 2 stated We cannot wait to call 911, we have to call right away whether a resident is full code or a do not resuscitate (DNR) resident. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on [DATE] at 3:33 p.m., with Licensed Vocational Nurse 4 (LVN 4), LVN 4 stated CPR is performed if a resident is a full code. LVN 4 stated while CPR is performed, another staff member should call 911. LVN 4 stated the importance of calling 911 was provide advanced CPR techniques such as using a defibrillator, IV medications and advanced cardiac life support. LVN 4 stated the facility did not have an AED. LVN 4 stated the risk of not calling 911 would result in a resident dying. During a telephone interview, on [DATE] at 4:10 p.m., with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated on [DATE] at 4: 00 a.m., CNA 1 informed her of Resident 65 not looking good. LVN 1 stated she went into the room, assessed Resident 65's pulses and initiated CPR. LVN 1 stated LVN 2 came to assist with Resident 65's CPR for 20 minutes. LVN 1 stated 911 was not called because she called to notify the MD of Resident 65's situation at 4:20 a.m. LVN 1 stated MD pronounced Resident 65's death overt the telephone. LVN 1 stated the importance of calling 911 is so the paramedics can assist with intubation, setting up any IVs, and do things that we can't do when giving CPR. LVN 1 stated the risk of not calling 911 during a Code Blue could result in a resident's death. During an interview, on [DATE] at 3:25 p.m., with Registered Nurse 1 (RN 1), RN 1 stated during a Code Blue, a resident's airway, breathing, circulation should always be checked, followed by the resident's POLST. RN 1 stated if a resident has no vitals and is a full code, CPR is to be initiated and other staff members are asked to call 911 immediately then the resident's doctor is called. RN 1 stated paramedics have the capacity to handle life threatening situations and can provide advanced cardiac life support. RN 1 stated 911 was not called for Resident 65. RN 1 stated the risk of not calling 911 during a Code Blue could resident in a resident's death. During an interview, on [DATE] at 11:46 a.m., with the Director of Nursing (DON), the DON stated CPR should be initiated if a resident is found unresponsive without a pulse and is not breathing. DON stated during a Code Blue, staff members should call for assistance, bring a crash cart to the resident's room and call 911 immediately. DON stated 911 was not called for Resident 65 and should have been. DON stated the risk of not calling 911 during a Code Blue could result in a resident's death. A review of the facility's policy and procedure, titled Emergency Procedures- Cardiopulmonary Resuscitation, dated February 2018, indicated If an individual is found unresponsive, briefly assess for abnormal or absence of breathing. If sudden cardiac arrest is likely, begin CPR: a. Instruct a staff member to activate the emergency response system (code) and call 911. and Continue with CPR/BLS until emergency medical personnel arrive.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 50379 Based on observation, interviews, and record review, the facility failed to document quality control checks for two of two medication carts in Nursing Station 1. This deficient practice had the potential to result in inaccurate blood sugar measurements for residents requiring blood sugar checks and can lead to uncontrolled blood sugar. Findings: During concurrent observation and interview on 5/10/2024 at 3:15 p.m. with Licensed Vocational Nurse (LVN) 5, at Medication Carts 1 and 2 in Nursing Station 1, the glucometer (a hand-held device that measures blood sugar) test solutions were not found in two of two medication carts. LVN 5 was unable to find the test solutions. LVN 5 stated the glucometer's results could be inaccurate if the glucometer was not calibrated at least once per day. LVN 5 stated the calibration was done by the night shift. During concurrent interview and record review on 5/10/2024 at 3:18 p.m. with LVN 5, the Quality Control Record, dated May 2024, in Cart 1 and Cart 2 for Station 1 were reviewed. The records indicated there was no documentation for blood sugar calibration quality control indices such as: the test strip lot number, test strip expiration date, normal control lot number, normal control expiration date, normal control range, high control lot number, high control expiration date and high control range instead of entries. LVN 5 stated she did not know why there were blank spaces in the record. During concurrent interview and record review on 5/10/2024 at 3:25 p.m. with the Director of Nursing (DON), the Quality Control Record (QCR), dated May 2024, in Cart 1 and Cart 2 at Nursing Station 1 were reviewed. The DON stated there was no documentation on the QCR that calibration was performed on 5/1/2024. The DON stated that glucometers should be calibrated and recorded at least once per day to ensure resident's blood sugar results are accurate. During review of the facility's policy titled Obtaining a Fingerstick Glucose Level, dated 10/2011, indicated that the facility must ensure the equipment and devices are working properly by preforming any calibrations or checks as instructed by the manufacturer or this facility. During review of the manufacturer's insert titled Assure Platinum QAQC Manual, dated 12/2014, the insert indicated, On each day, two controls (high & normal) should be performed per instrument. During review of the manufacturer's insert titled Assure Dose Control Solution, dated 5/2022, the insert indicated that Healthcare Professionals: Record result in the quality logbook.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50379 Based on observation, staff interviews, and record review, the facility failed to ensure expired and discontinued medications were discarded and disposed in accordance with the regulatory requirement: 1. The facility failed to label medications in accordance with the facility's medication disposition policy for one of three residents (Resident 53) who was discharged from the facility 2. The facility failed to label multi-dose medications with an open date for two of two residents (Residents 1 and 17). This failure had the potential to result in the loss of medication potency and for residents to receive ineffective medication dosages. Findings: A. During review of Resident 53's Admission Record (facesheet), the record indicated the resident was initially admitted to the facility on [DATE], and the most recent re-admission was on [DATE]. Resident 53's diagnoses included hypertension (high blood pressure), hyperlipidemia (high cholesterol), malnutrition, venous thrombosis and embolism (blood clots in veins), and Parkinson's disease (nervous system disease). During concurrent observation and interview on [DATE] at 11:10 a.m. with Registered Nurse (RN) 1 inside the Medication Storage closet in Nursing Station 1, an unlabeled clear bag containing nine medications for Resident 53 were stored in the closet. The following medications were observed unlabeled in the Medication Storage closet at Nursing Station 1: a. Mirtazapine (used to treat depression) b. Metoprolol (used to treat high blood pressure) c. Atorvastatin (used to treat high cholesterol) d. Famotidine (used to prevent stomach ulcers) e. Eliquis (used to reduce the risk of blood clots) f. Carbidopa-Levodopa (used to treat Parkinson's disease) (continued on next page)

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Primrose Post-Acute	515 Centinela Ave. Inglewood, CA 90302

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RN 1 stated registered nurses collect and label medications when residents are transferred to the hospital with the resident's name, discharge location, and the date the resident was transferred to hospital prior to locking the bag in the medication storage closet. RN 1 stated there was no resident name or date of discharge labeled on or in the bag containing the medications for Resident 53. RN 1 was unable to tell when the resident discharged and when the medication bag was placed into storage. During an interview on [DATE] at 11:41 a.m. with the Director of Staff Development (DSD), in the Medication Storage closet at Nursing Station 1, the DSD stated the bag of medications was missing a label and stated that nurses should write the resident's name and date of transfer on a piece of paper and place in the bag with the medications. The DSD stated that nurses should review the stored bags every shift because medication bags could go missing if they are not properly labeled. During an interview on [DATE] at 11:25 a.m. with the Director of Nursing (DON), the DON stated that an RN should collect non-narcotic medications and place the medication packs in a bag in the Medication Storage closet with a paper indicating the resident's name, room number, and date of transfer to the hospital. The DON stated the facility stores the medication for up to 30 days before destruction. The DON stated that storing unlabeled medications can cause a medication error. During a record review of the facility's policy and procedure titled, Storage of Medication, dated ,d+[DATE], indicated The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner and Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed. During a record review of the facility's policy and procedure titled, Disposal of Medications and Medication-Related Supplies [undated], indicated When medications are discontinued by a prescriber, a resident is transferred or discharged and does not take medications with him/her, or in the event of a resident's death, the medications are marked as discontinued and destroyed, or, if the packages are unopened, returned to the issuing pharmacy. B. During a review of Resident 1's Admission Record (facesheet), the record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including constipation (difficulty passing stool) and a history of bowel blockage. During a review of Resident 1's physician orders, an order placed on [DATE] indicated Resident 1 was receiving lactulose (a medication to help pass stool), 30 milliliters four times daily. During a review of Resident 17's Admission Record (facesheet), the record indicated Resident 17 was admitted to the facility on [DATE] with diagnoses including diabetes mellitus type 2 (disease that effects blood sugar control). During a review of Resident 17's physician orders, an order placed on [DATE] indicated Resident 17 received insulin lispro (a medication to control blood sugar) before meals and at bedtime. During a concurrent observation and interview on [DATE] at 12:06 p.m. with Licensed Vocational Nurse (LVN) 6 at Medication Cart 1, two medications did not have open dates indicated on the packaging or vial. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. One multi-dose vial of insulin lispro (a medication to control blood sugar) 100 units per 1 milliliter for Resident 17 was opened with no open date. b. One multi-dose container of lactulose (a medication to treat constipation) solution 10 grams per 15 milliliters for Resident 1 was opened with no open date. LVN 6 stated the open date indicates how long the medication has been opened so others know when it expires because expired medication may not be effective. LVN 6 stated whoever opened the vial, should have placed an open date on the vial. During an interview on [DATE] at 11:32 a.m., the DON stated that nurses can cause an error and will not be able to verify expiration dates if the medication is not labeled with an open date. During review of the manufacturer's recommendations, Insulin Lispro, the recommendations indicate After opening, store at room temperature. Throw away any part not used after 28 days. During review of the facility's policy titled Administering Medication, dated ,d+[DATE], the policy indicated When opening a multi-dose container, the date opened is recorded on the container.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47923 Based on interview and record review, the facility failed to ensure laboratory test of Comprehensive Metabolic Panel ([CMP] a test that measures different substances in the blood and provides important information of the body's chemical balance and how it uses food and energy) results for one of 18 sampled residents (Resident 216) was reported to the physician in a timely manner. This deficient practice had the potential to result in Resident 216 experiencing preventable complications from abnormal lab values and possibly leading to medical complications requiring hospitalization . Findings: A review of Resident 216's Admission Record, indicated, Resident 216 was admitted to the facility on [DATE] with diagnoses including end stage renal disease (a life-threatening condition when the kidneys fail to filter the blood) and hyperkalemia (too much potassium in the blood). A review of Resident 216's History and Physical (H&P), dated 4/30/2024, indicated Resident 47 had the capacity for medical decision making. A review of Resident 216's Minimum Data Set ([MDS] resident assessment and care screening tool), dated 5/3/2024, the MDS indicated Resident 216 needs moderate assistance (Helper does less than half the effort) in oral hygiene and upper body dressing. A review of Resident 216's Order Summary Report, dated 5/10/2024, indicated Resident 216 had a physician order to check CMP on 4/29/2024. The Order Summary Report also indicated Resident 216 was taking lokelma (a medication that is used to treat high level of potassium in the blood) every Monday. During a concurrent interview and record review on 5/8/2024 at 11:15 a.m., with the Director of Nursing (DON), Resident 216's clinical records were reviewed. The DON stated Resident 216's laboratory test results were available in the chart. The DON stated there was no documentation indicating the facility communicated Resident 216's laboratory test results to the physician. The DON stated Resident 216's lokelma should had been discontinued since his potassium level in the blood was 3.9. The DON stated the normal range (set of values that a doctor uses to interpret a patient's test results) of potassium level in the body was 3.5 to 5.1. The DON stated low potassium level in the body could cause fatigue, muscle cramps, and abnormal heart rhythms. The DON stated CMP blood test were important to monitor resident health condition and to prescribe medication if needed. A review of the facility's policy and procedure (P&P) titled, Lab and Diagnostic Test Results-Clinical Protocol, undated ,the P&P indicated, A physician can be notified by phone, fax or voicemail. The P&P indicated facility staff should document information about when, how, and to whom the information was provided and the response. The P&P indicated this should be done in the Progress Notes section of the medical record.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47923 Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices in the kitchen when: 1. Several food items were not dated and labeled in the dry storage area, reach in Refrigerator 1, Freezer 1, Freezer 2, and Freezer 3. 2. Dietary Aide 1 (DA 1) did not perform handwashing or wear gloves when cleaning the stainless-steel table. 3. [NAME] 1 did not perform handwashing or wear gloves when handling the scooper. 4. DA 2 did not perform handwashing after picking up a dirty towel on the kitchen floor. These failures had the potential to result in harmful bacterial growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness in 59 out of 64 residents who received food from the kitchen. Findings: 1. During a concurrent observation and interview on [DATE] at 8:45 a.m., with the Dietary Service Supervisor (DSS), in the dry storage area, four cans of evaporated milk were not labeled. The DSS stated all the food items in the dry storage should be labeled. During an observation on [DATE] at 8:50 a.m., in Refrigerator 1, two plastic containers of strawberries and one plastic bag of mushrooms were not dated and labeled. During an observation on [DATE] at 9:00 a.m., in Freezer 1, eight unopened frozen plastic bags of corn, eight unopened frozen plastic bags of chopped spinach, eight unopened frozen plastic bags of mixed vegetables, and five unopened frozen plastic bags of green beans were not dated and labeled. During an observation on [DATE] at 9:05 a.m., in Freezer 2, one unopened plastic bag of tater tots and three unopened plastic bags of hash browns were not dated and labeled. During an observation on [DATE] at 9:07 a.m., in Freezer 3, three unopened packs of hotdogs were not dated and labeled. During an interview on [DATE] at 9:10 a.m., with the DSS, the DSS stated the risk of not having items labeled could cause confusion on knowing when the food items were opened or whether the contents were expired or not. The DSS stated that staff who received the food items were responsible for labelling and dating the food items. A review of the facility's policy and procedure (P&P) titled, General Receiving of Delivery of Food and Supplies, dated 2018, indicated label all items with the delivery date or use-by date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's P&P titled, Procedure for Freezer Storage, dated 2018, indicated all frozen food should be labeled and dated. A review of the facility's P&P titled, Procedure for Refrigerated Storage, dated 2018, indicated food items should be arranged so that older items will be used first. The P&P indicated dating the package or containers will facilitate this practice. The P&P indicated individual packages of refrigerated or frozen food taken from the original packing box need to be labeled and dated. 2. During a concurrent observation and interview on [DATE] at 11:25 a.m. in the kitchen, observed DA 1 cleaning the stainless-steel table with no gloves. DA 1 stated she did not wash her hands or put the gloves on before touching and cleaning the stainless-steel table. DA 1 stated handwashing and putting on gloves were important to prevent cross contamination in the kitchen which could lead to residents developing food borne illness. 3. During a concurrent observation and interview on [DATE] at 11:43 a.m., in the kitchen, observed [NAME] 1 walking with a scooper with bare hands. [NAME] 1 handed the scooper to [NAME] 2. Cook1 stated she forgot to perform handwashing and wear new clean gloves. 4. During a concurrent observation and interview on [DATE] at 12:43 p.m., in the kitchen, observed DA 2 pick up a dirty towel on the floor then threw the dirty towel outside the kitchen by the dumpster area. DA 2 then walked directly to the dry storage area without washing her hands. DA 2 stated she forgot to wash her hands. During an interview on [DATE] at 12:50 p.m., with the DSS, the DSS stated all dietary staff were expected to practice good hand hygiene by washing their hands in between tasks. The DSS stated the dietary staff were aware of the facility's policy to wear gloves when working in the kitchen area. A review of the 2022 U.S. Food and Drug Administration Food Code, code number ,d+[DATE].14 (F) and (H) When to Wash Hands, indicated during food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks and before donning gloves to initiate a task that involves working with food. A review of the facility's P&P titled Handwashing/Hand Hygiene, dated 2001, indicated the facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. 47923 Based on observation, interview, and record review, the facility failed to ensure the trash stored in the dumpster area was maintained in a sanitary manner when one out of one garbage bin was overfilled with the lid open. This deficient practice had the potential for harboring mice and other pest. Findings: During a concurrent observation and interview on 5/9/2024 at 1:00 p.m., with the Dietary Service Supervisor (DSS), in the outside kitchen area, found one garbage dumpster overfilled with the lid open. The DSS stated the lid was unable to close due to overfilling trash. The DSS stated trash bins that were open attracted unwanted pests to the area. A review of the 2022 U.S. Food and Drug Administration Food Code, code number 5-501.116 Cleaning Receptacles indicated, Outside receptacles must be constructed with tight-fitting lids or covers to prevent the scattering of the garbage or refuse by birds, the breeding of flies, or the entry of rodents. A review of the facility's policy and procedure (P&P) titled, Food-Related Garbage and Refuse Disposal, revised 2017, the P&P indicate, Outside dumpsters provided by garbage pickup services will be kept closed and free of surrounding litter.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 46832 Based on interview and record review, the facility failed to revise and provide an updated accurate resident census in the Facility's Assessment. This deficient practice had the potential to place residents at risk for lack or delay of care and treatment services. Findings: A review of the facility census for 5/7/2024, indicated 64 residents were in the facility. A review of the Facility's Assessment on 5/10/2024 at 2:10 p.m., indicated the Facility Assessment was last revised for the period of 1/1/2024. The assessment provided was for a census of 52-53 residents. A record review of the Facility Assessment, on 5/10/24 at 02:12 PM, the Facility Assessment did not match the census number for provision of Activities of Daily Living (ADL). During a concurrent interview and record review, on 5/10/2024 at 2:47 p.m., with the DON, the DON stated the census recorded on the facility assessment did not match with the current census. DON stated there were residents who were not accounted for on the Facility Assessment. DON stated the residents who weren't accounted for on the facility assessment were receiving care in the facility. DON stated I am responsible for providing an accurate census of the residents on the facility assessment. I don't know what happened. DON stated the risk of not having an accurate census on the facility assessment could result in appearing as if the unaccounted residents were not being taken care of. During a concurrent interview and record review, on 5/10/2024 at 2:50 p.m., with the Administrator, the Admin stated the facility assessment contains data of all the metrics of the care provided to the facility's residents. Admin stated the risk of incorrect documentation of the resident census could result in, appearing as if we are taking care of some residents and not the others. According to Centers for Medicare and Medicaid Services (CMS) the intent of the facility assessment was for the facility to evaluate its resident population and identify the resources needed to provide the necessary person-centered care and services the residents require. Specifically, under Acuity Section 1.5. the facility was to describe the residents' acuity levels to help them understand the potential implications regarding the intensity of care and services needed. The intent of this was to give an overall picture of acuity data obtain from data sources such as RUGs (Resource Utilization Groups are significant because they are the core of the nursing home payment system), MDS data, and resident/patient acuity tools to plan for staffing across the different shifts in the facility. https://www.cms.gov/Outreach-and-Education/Outreach/NPC/National-Provider-Calls-and-Events-Items/2017-09-07-Dementia-Care-in-Nursing-Homes-Call.html

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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** 46832 Based on observation and record review, the facility failed to meet the required 80 square feet for each resident in rooms 1, 2, 3, 5, 22, and 31. This deficient practice had the potential to result in inadequate space to provide safe nursing care and privacy for residents in room [ROOM NUMBER], 2, 3, 5, 22 and 31 and resulted in psychosocial harm for two out of 21 residents. Findings: A review of the Request for waiver variation letter completed by the facility, on 5/8/2024 at 11:30 a.m., dated on 1/25/2024, indicated room [ROOM NUMBER], 2, 3, 5, 22 and 31 did not meet the requirement of 80 square feet (sq ft) per resident as follows: a. room [ROOM NUMBER] had three resident beds, which measured 212 square feet, b. room [ROOM NUMBER] had three resident beds, which measured 227 square feet. c. room [ROOM NUMBER] had four resident beds, which measured 280 square feet. d. room [ROOM NUMBER] had four resident beds, which measured 286 square feet. e. room [ROOM NUMBER] had three resident beds, which measured 181 square feet. f. room [ROOM NUMBER] had four resident beds, which measured 269 square feet. During a concurrent observation and interview, on 5/7/2024 at 1:33 p.m., with Resident 28, Resident 28 was observed sitting in her wheelchair near her bed. Observation showed there was inadequate space to access the restroom due to roommate's bed blocking the restroom door. Resident 28 stated she was unable to walk. Resident 28 stated to use the restroom, she had to call a staff member for assistance. Resident 28 stated staff would park her wheelchair at the foot of her roommate's bed. Resident 28 stated when she receives assistance, a staff member would walk into the adjacent room next door through their shared restroom and transfer her into the restroom. Resident 28 stated this made her feel rushed to use the restroom and afraid of soiling herself. During a concurrent observation and interview, on 5/7/2024 at 1:44 p.m., with Resident 39, Resident 39 was also observed sitting in her wheelchair near her bed. Resident 39 stated she couldn't walk and required assistance to use the restroom. Resident 39 stated staff would also park her wheelchair at the end of their roommate's bed and transfer her to the restroom. Resident 39 stated staff would also take her to other residents' rooms to use the restroom. Resident 39 stated this made her feel frustrated and afraid that she would not make it to the restroom in a timely matter. (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	During observations of the care being provided to residents in room [ROOM NUMBER] and 4 by staff from 5/7/2024 to 5/10/2022, the square footage of the resident rooms did not interfere with the care and services provided by the staff but did cause psychosocial harm for Resident 28 and Resident 39. There were no negative observations related to the adequacy of space for nursing care, the resident's privacy, and visitors. A review of the facility's policy and procedure (P&P) titled, Bedrooms, dated May 2018, the P&P indicated, all residents are provided with clean, comfortable, and safe bedrooms.