STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055617	A. Building B. Wing	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pasadena Grove Health Center	1470 N Fair Oaks Ave Pasadena, CA 91103

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44636 Based on interview and record review, the facility failed to ensure resident received reasonable accommodation of needs for two (2) of 18 sampled residents (Residents 17 and 28) by failing to ensure Residents 17 and 28's call lights were within reach. This deficient practice had the potential to result in the inability for Residents 17 and 28 to obtain necessary care and services. Findings: 1. During a review of the Resident 17's Admission Record, the Admission Record indicated Resident 17 was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses of dementia (progressive brain disorder that slowly destroys memory and thinking skills), depression (severe feelings on sadness and hopelessness), and hypothyroidism (condition in which the thyroid gland does not produce enough thyroid hormone). During a record review of Resident 17's Minimum Data Set (MDS, a resident assessment and tool), dated 2/7/2025, the MDS indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making was moderately impaired. The MDS indicated Resident 17 was dependent (helper does all the effort, resident does none of the effort to complete the activity) for toileting hygiene, shower/bathing self, and chair/bed-to-chair transfer. The MDS indicated Resident 17 required substantial/maximal assistance (helper does more than half the effort) for personal hygiene, rolling left to right, sit to lying, and lying to sitting on side of bed. During a record review of Resident 17's care plan, dated 5/21/2024, the care plan indicated Resident 17 was at moderate risk for falls related to poor balance and unsteady gait (a manner of walking or moving on foot). The care plan interventions for staff were to ensure Resident 17's call light was within reach and encourage the resident to use it for assistance as needed. During an observation on 2/25/2025 at 9:05 AM in Resident 17's room, Resident 17's call light was observed on the floor. During a concurrent interview with Resident 17, Resident 17 stated, I don't know where my call button is at. Resident 17 stated she wanted to call the nurse to ask for help to change the channel on the tv. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055617	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/28/2025
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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 - Few	During a concurrent observation and interview on 2/25/2025 at 9:25 AM in Resident 17's room with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated Resident 17's call light was on the floor. CNA 1 stated Resident 17's call light was not supposed to be on the floor. CNA 1 stated Resident 17's call light was supposed to be near the resident and was not within Resident 17's reach. During an interview on 2/28/2025 at 2:13 PM with the Director of Nursing (DON), the DON stated residents' call light should be within reach of the residents. The DON stated call lights served as a way to contact the staff in case of an emergency and for residents to get help. 47362 2. A review of Resident 28's Admission Record indicated the facility admitted Resident 28 on 1/29/2025 with the diagnoses that included dysphagia (difficulty swallowing), depression (mood disorder that causes a persistent feeling of sadness and loss of interest), Diabetes mellitus (disorder in which the body does not produce enough or respond normally to insulin, causing blood sugar (glucose) levels to be abnormally high) A review of Resident 28's MDS, dated [DATE], indicated Resident 28 cognition was moderately impaired skills for daily decision making. The MDS indicated Resident 28 required substantial /maximal assistance on eating. The MDS also indicated the resident is dependent on oral hygiene, toilet hygiene, shower/ bathe self, lower body dressing and putting on/ taking off footwear. During a review of Resident 28's care plan,initiated 9/4/2020, revised on 12/10/2023 indicated moderate risk for fall/ injuries. Interventions/ task indicated to place call light and frequently use items within easily reach. During observation 2/25/2025 at 9:20 AM on Resident 28's room, call light was in-between the right upper side rails and the mattress. During interview on 2/25/2025 at 9:21 AM with Resident 28, resident stated does not know where the call light was. Resident 28 also stated she would yell out when she wants to call the nurse. During concurrent observation and interview on 2/27/2025 at 10:59 AM with the license vocational nurse (LVN 1), LVN 1 stated the call light for Resident 28 was out of reach. It was in-between the side rails and mattress. LVN 1 also stated call light was residents' way of communication it should be within reach. During an interview on 2/28/2025 at 10:52 AM with the director of nursing (DON) , the DON stated call lights were important for residents to access easily and readily so they can use it to call for help. The DON further stated, this may cause possible delay of care if not within the resident's reach and/ or places resident at risk for injury like falling when they get up or tried to reach for the call light. During a record review of the facility's policy and procedure titled, Communication - Call System, revised 11/1/2017, the policy indicated the call system provided a mechanism for residents to promptly communicate with nursing staff. Call cords will be placed within the resident's reach in the resident's room.

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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 0645

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

PASARR screening for Mental disorders or Intellectual Disabilities

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 44636

Based on interview and record review, the facility failed to ensure the preadmission screening and resident review assessment (PASRR, preventing individuals with mental illness, developmental disability, intellectual disability, or related conditions from being inappropriately placed in nursing homes for long term care) form was accurately completed for a resident who had a mental illness for one (1) of three (3) sampled residents (Resident 2).

This deficient practice had the potential for Resident 2 to not receive the necessary and appropriate psychiatric (of or relating to the study of mental illness) treatment and evaluation.

Findings:

During a review of the Resident 2's Admission Record, the Admission Record indicated Resident 2 was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses of schizophrenia (a chronic and severe mental disorder that affects how a person thinks, feels, and behaves), depression (severe feelings on sadness and hopelessness), and dementia (progressive brain disorder that slowly destroys memory and thinking skills) with behavioral disturbance.

During a record review of Resident 2's Minimum Data Set (MDS, a resident assessment and tool), dated 2/14/2025, the MDS indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making was moderately impaired. The MDS indicated Resident 2 had a psychiatric (relating to mental illness or its treatment)/mood disorder and was taking antipsychotic (drugs that work by altering brain chemistry to help reduce psychotic symptoms like hallucinations, delusions, and disordered thinking) and antidepressant (drugs used to treat depression) medications. The MDS also indicated Resident 2 did not have any mood and behaviors.

During a review of Resident 2's Physician Order Summary Report, dated 5/28/2024 and 6/11/2024, the Physician Order Summary Report indicated the following order:

- 6/11/2024: Invega Sustenna (antipsychotic medication) Intramuscular Suspension prefilled Syringe 156 mg/ml - Inject 1 ml intramuscularly every 30 days for schizophrenia manifested by agitation as evidenced by fighting with other residents.

During a review of Resident 2's PASRR Level I Screening, dated 5/4/2024, the record indicated the PASRR Level I was negative (there was no suspected mental illness or intellectual/developmental disability or related condition). The PASRR Level I Screening also indicated under Section three Resident 2 did not have a serious diagnosis of mental disorder such as depressive disorder (depressed mood or loss of pleasure or interest in activities for long periods of time), anxiety disorder (persistent and excessive worry that interferes with daily activities), panic disorder (an anxiety disorder with sudden attacks of panic or fear), schizophrenia/schizoaffective disorder (a mental illness that causes loss of contact with reality), or symptoms of psychosis, delusions (believed to be true or real but is actually false or unreal), and/or mood disturbance.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/27/2025 at 11:44 AM with the Director of Nursing (DON), the DON stated the Registered Nurse Supervisor 3 (RNS 3) was responsible in completing or ensuring residents' PASRR was accurate. During an interview and review on 2/27/2025 at 11:45 AM of Resident 2's PASRR with RNS 3, RNS 3 stated Resident 2's PASRR Level I Screening indicated that Resident 2 did not have a serious mental illness but Resident 2 had a diagnosis of schizophrenia, dementia with behavioral disturbance, and depression upon admission which were not reflected on the PASRR. RNS 3 stated the MDS Nurse (MDSN) was responsible to ensuring accuracy of the residents' PASRR. RNS 3 stated the PASRR screening should be accurately completed to ensure correct placement of the residents in the facility. During an interview on 2/27/2025 at 3:37 PM with MDSN, MDSN stated MDSN was not responsible for reviewing Resident 2's PASRR. MDSN stated the Admissions Coordinator (AC) was responsible for Resident 2's PASRR. During a record review of the facility's policy and procedure titled, Pre-Admission Screening and Resident Review (PASRR), revised 7/1/2023, the policy indicated all facility applicants are screened for mental illness and/or intellectual disability and ensure coordination with the appropriate state agencies. The facility ensures that PASRR Level I is completed either by the transferring general acute care hospital (GACH) or by the facility for applicants prior to admission to determine if they have a serious mental illness (SMI) and/or intellectual disability, developmental disability or related conditions(s).

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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 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** 44636 Based on observation, interview, and record review, the facility failed to update and revise the fall care plan for one (1) of 18 sampled residents (Resident 2) in accordance with the facility policy. This failure had the potential to place Resident 2 at risk for further falls, which could result in harm/injury to the resident. Findings: During a review of the Resident 2's Admission Record, the Admission Record indicated Resident 2 was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses of schizophrenia (a chronic and severe mental disorder that affects how a person thinks, feels, and behaves), dementia (progressive brain disorder that slowly destroys memory and thinking skills) with behavioral disturbance, Parkinsonism (progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movement), and difficulty in walking. During a record review of Resident 2's Minimum Data Set (MDS, a resident assessment and tool), dated 2/14/2025, the MDS indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making was moderately impaired. The MDS indicated Resident 2 required substantial/maximal assistance (helper does more than half the effort) for rolling left and right, sit to lying, lying to sitting on side of bed, sit to standing, and walking ten (10) feet. During a record review of Resident 2's Fall Risk Assessment, dated 8/2/2024, the assessment indicated Resident 2 was at moderate risk for falls. During a record review of Resident 2's Fall Risk Assessment, dated 10/6/2024, the assessment indicated Resident 2 was at high risk for falls. During a record review of Resident 2's SBAR (an acronym for Situation-Background-Assessment-Recommendation is a technique used to provide a framework for communication between members of the health care team), dated 10/6/2024, the record indicated Resident 2 had a fall. During a record review of Resident 2's Nursing Notes, dated 10/6/2024, the record indicated at 7:10 AM Resident 2 was seen sitting on the floor in between two wheelchairs facing the exit door. The nursing notes indicated Resident 2 stated, I have trouble seeing but I was trying to transfer from this chair to this chair, stood up and felt weak and I sat down on the floor. During a record review of Resident 2's Physician Order Summary Report, dated 10/7/2024, the order indicated Resident 2 was transferred to the hospital for further evaluation and treatment of status post (s/p, a term used in medicine to refer to a treatment, diagnosis or just an event, that a resident had experienced) fall and confusion. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of Resident 2's fall care plan, revised 7/17/2024, the care plan indicated staff interventions were to encourage resident to call for assistance before attempting to transfer or ambulate, siderails up while in bed, and call light within reach and answered promptly. During a concurrent interview and review of Resident 2's care plans on 2/27/2025 at 3:39 PM with the Minimum Data Set Nurse (MDSN), MDSN stated another fall care plan needed to be done for Resident 2's unwitnessed fall. MDSN stated the care plans needed to be updated to carry out plans for interventions based on physician orders and nursing interventions. MDSN stated Resident 2's fall care plan was not revised after Resident 2's fall on 10/6/2024. MDSN stated a care plan was not and should have been revised after Resident 2's unwitnessed fall to address the underlying cause of fall. MDSN stated specific individualized care plans outlined what interventions should be done to prevent reoccurrence of having another fall. During an interview on 2/28/2025 at 1:53 PM with the Director of Nursing (DON), the DON stated residents care plans needed to be updated after a fall. The DON stated updated care plans were done since other interventions were no longer applicable. The DON stated staff needed to create new interventions to the resident's plan of care to ensure the resident's safety. During a record review of the facility's policy and procedure (P&P) titled, Fall Management Program, revised 11/1/2017, the P&P indicated the Licensed Nurse will review the circumstances of the fall, review the plan of care, implement new interventions as appropriate and revise the plan as indicated. During a review of the facility's P&P titled, Care Planning, revised 10/24/2022, the P&P indicated the Interdisciplinary Team (IDT, group of healthcare professionals from diverse fields who work in a coordinated manner toward a common goal for the resident) will revise the comprehensive care plan as needed as dictated by changes in the resident's condition, to address changes in care and other times as appropriate or necessary.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47362 Based on observation, interview, and record review, the facility failed to provide the necessary services to maintain good grooming and personal hygiene for three (3) of 3 sampled residents (Resident 27, 28, 38) who was dependent with activities of daily living (ADLs- are activities related to personal care that include bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating), by failing to ensure the residents' nail were kept trimmed and clean in accordance with the facility's policy. This deficient practice resulted in Resident 27, 28, and 38 having dirty, long and jagged (having rough, sharp points protruding) fingernails, potentially leading to skin injury, infection, and scarring. Findings: 1. A review of Resident 28's Admission Record indicated the facility admitted Resident 28 on 1/29/2025 with the diagnoses that included dysphagia (difficulty swallowing), depression (mood disorder that causes a persistent feeling of sadness and loss of interest), diabetes mellitus (disorder in which the body does not produce enough or respond normally to insulin, causing blood sugar [glucose] levels to be abnormally high) A review of Resident 28's Minimum Data Set (MDS, resident assessment tool), dated 2/4/2025, indicated Resident 28 cognition was moderately impaired (processes of thinking and reasoning) skills for daily decision making. The MDS indicated Resident 28 required substantial /maximal assistance (helper does more than half of the effort) on eating. The MDS also indicated the resident is dependent (helper does all the effort. Resident does none of the effort to complete the activity) on oral hygiene, toilet hygiene, shower/ bathe self, lower body dressing and putting on/ taking off footwear. During a review of Resident 28's care plan date initiated 9/11/2020, revised on 9/25/2020 indicated problem: selfcare deficit: inability to participate in any independent Activities of Daily Living (ADLs), activities related to personal care. They include bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating) requires extensive assist with bed mobility , locomotion(movement or the ability to move from one place to another), personal hygiene (regularly washing parts of the body and hair with soap and water (including washing your hands and feet), grooming nails, facial cleanliness, covering coughs and sneezes, and menstrual hygiene). The care plan goal indicated resident will have bathing and grooming needs met as evidence by lack of unpleasant odors and a neat and clean appearance on daily basis. The care plan intervention indicated keep nails clean and trimmed. During observation on 2/25/2025 at 9:20 AM at Resident 28's room, Resident 28's nails on both hands were dirty with color black to yellowish stuff under the long-jagged nails. During a concurrent observation and interview on 2/26/2025 at 3:44 PM with the Director of Nursing (DON) at Resident 28's room, DON stated resident's nail was long and dirty. The nails should be clean and smooth all the time. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 2/26/2025 at 3:56 PM with the registered nurse supervisor (RNS 4), Resident 28's care plan for self- care deficit revised 9/25/2020 was reviewed. Resident's care plan indicated keep nails trim and clean. RNS 4 stated Resident 28 was dependent on ADL's, and it was important to provide proper hygiene to the resident because long and dirty nails can harbor bacteria and germs that can cause sickness and skin abrasion. During concurrent interview and record review on 2/28/2025 at 9:10 AM of Resident 28's medical records (chart) dated from 1/29/2025 to 2/282/2025 with minimum data set nurse (MDSN), MDSN stated no documentation on resident refusing nail care found on the chart. MDSN also stated Resident 28's nails were supposed to be kept clean, trimmed and smooth all the time to prevent possible skin tear, infection or sickness like stomachache or diarrhea. 2. A review of Resident 27's Admission Record indicated the facility admitted Resident 27 on 11/14/2024 with the diagnoses that included dysphagia, diabetes mellitus, hemiplegia and hemiparesis (loss of strength in the arm, leg, and sometimes face on one side of the body) A review of Resident 27's MDS, dated [DATE], indicated Resident 27 cognition was moderately impaired skills for daily decision making. The MDS indicated Resident 27 required substantial /maximal assistance (helper does more than half of the effort) oral hygiene and personal hygiene. During a review of Resident 27's care plan date initiated 2/15/2024 indicated Problem: selfcare deficit: inability to participate in any ADLs. The care plan indicated the resident requires extensive assist with bed mobility, eating, transfer, locomotion, dressing, toilet use, personal hygiene. The care plan goal indicated resident will have bathing and grooming needs met as evidence by lack of unpleasant odors and a neat and clean appearance on daily basis. The care plan intervention indicated keep nails clean and trimmed. During an observation on 2/25/2025 at 3:46 PM at the activity room, Resident 27 was on a Geri chair (a large, padded chair that is designed to help seniors with limited mobility) scratching self with dirty, and jagged nails. Observed a [NAME] pillow with a smear of tiny amount of blood beside the resident and the Resident 27 with small amount of blood smear and Resident 27's head with multiple skin tear. During interview on 2/27/2025 at 11:20 AM with the License Vocational Nurse (LVN 1), LVN 1 stated Resident 27 always scratches self, it was possible to harm self from scratching, resident nails are jagged and dirty. During observation and interview on 2/27/2025 at 12:15 PM with the infection preventionist nurse (IP), IP stated Resident 27 nails were dirty, jagged/ not smooth. IP stated, Resident 27's nails were supposed to be clean and smooth to prevent scratches or skin tear. During concurrent interview with MDSN and record review on 2/28/2025 at 9:18 AM of Resident 27's medical records (chart) dated from 11/14/2024 to 2/28/2025 was reviewed. MDSN stated no documentation on Resident 27 was refusing nail care found on the resident's chart. MDSN also stated the residents' nails were supposed to be clean and smooth all the time to prevent possible skin tear, infection or sickness like stomachache or diarrhea. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review of the facility's Policy and Procedure (P&P) titled Grooming Care of the Fingernails and Toenails date revised 11/1/2027 indicated, purpose nail care is given to clean and keep the nails trimmed. 44636 3. During a review of the Resident 38's Admission Record, the Admission Record indicated Resident 38 was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses of encephalopathy (brain disease, damage, or malfunction that results in an altered mental state), dementia (progressive brain disorder that slowly destroys memory and thinking skills) with other behavioral disturbance, contracture (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) of the right and left knee, and muscle weakness. During a record review of Resident 38's MDS, dated [DATE], the MDS indicated the resident's cognitive (skills for daily decision making was moderately impaired. The MDS indicated Resident 38 had impairment to both sides of the upper extremities (shoulders, elbows, wrists, and hands) and lower extremities (hips, knees, ankles, feet). The MDS indicated Resident 38 was dependent (helper does all the effort and resident does none of the effort to complete the activity) for eating, shower/bathing self, lower body dressing, rolling left and right, lying to sitting on side of bed, and chair/bed-to-chair transferring. During a record review of Resident 38's care plan, revised 6/12/2024, the care plan indicated Resident 38 had self-care deficit and was unable to participate in any independent ADLs. The care plan interventions for staff were to inspect skin daily of skin breakdown, change gowns and clothing daily and as needed, and keep nails clean and trimmed. During an observation on 2/25/2025 at 3:57 PM in Resident 38's room, Resident 38 was lying in bed scratching his head with his left hand. Resident 38's left thumbnail was thick, yellowish in color, and partially detached from the nail bed. Resident 38's left thumbnail was angled at 45 degrees from nail bed. Resident 38's right hand was under the blanket and was not observed. During an interview on 2/28/2025 at 8:10 AM with Certified Nursing Assistant 3 (CNA 3), CNA 3 stated residents' nails were checked daily and clipped weekly and as needed. CNA 3 stated anything abnormal with nails needed to be reported right away to the charge nurse or treatment nurse. During a concurrent interview and observation on 2/28/2025 at 8:16 AM with CNA 3 in Resident 38's room, CNA 3 stated Resident 38's right hand fingernails were long, yellowish in color, and looked like there was fungus (common infection of the nail causing nail to discolor, thicken, and crumble at the edge) with thickened and discolored. CNA 3 stated Resident 38's left thumbnail looked yellowish on top and blackish in color at the bottom of the nail and was falling off. CNA 3 stated the thumbnail was pointing 90 degrees up from the nail base. CNA 3 stated the condition of Resident 38's nail needed to be reported to the charge nurse. CNA 3 stated Resident 38 was not able to verbalize his needs, and Resident 38 was dependent on staff for his care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation of Resident 38's nail and interview on 2/28/2025 at 1:55 PM with the Director of Nursing (DON), the DON stated staff needed to do daily morning care which included checking on the residents' nails. During an observation of Resident 38's nail, Resident 38's right hand fingernails were long, yellowish in color, and looked like there was fungus with thickened and blackish discoloration on the left thumbnail. In addition, the left thumbnail looked black and was falling off from the nail bed. The DON stated licensed nurses needed to call the physician and the podiatrist (a specialist who treats nail issues). During a concurrent interview and review on 2/28/2025 at 2:11 PM of Resident 38's SBAR and care plans with the DON, the DON stated Resident 38's care plan indicated staff were to keep Resident 38's nails trimmed and cleaned. The DON stated there was no notification to the physician regarding Resident 38's left thumbnail. The DON stated the licensed nurses needed to report Resident 38's thumbnail to the physician. The DON stated Resident 38's nail could become infected. During a record review of the facility's policy and procedure titled, Grooming Care of the Fingernails and Toenails, revised 11/1/2017, the policy indicated nail care is given to clean and keep the nails trimmed. Residents with hypertrophic (abnormally thickened nails), mycotic (nail infected by a fungus) and keratotic (nails that have thickened from keratin buildup) nails will be referred to podiatrist.

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NAME OF PROVIDER OR SUPPLIER: Pasadena Grove Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1470 N Fair Oaks Ave, Pasadena, CA 91103	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44636 Based on observation, interview, and record review, the facility failed to provide Restorative Nursing Services (a program available in nursing homes to help residents maintain progress made during therapy treatments, enabling them to achieve their highest practicable level of functioning) as ordered by the physician to increase, prevent, or maintain range of motion (ROM, full movement potential of a joint) for one of three sampled residents (Resident 36). This deficient practice placed Resident 36 at risk for decline in physical functions and developing contractures (condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) in the extremities (a limb of the body, such as the arm or leg) for not receiving the ordered exercises. Findings: During a review of Resident 36's Admission Record, the record indicated Resident 36 was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses of right hand contracture, hemiplegia (a condition caused by brain damage or spinal cord injury that leads to paralysis [loss of motor function in one or more muscles] on one side of the body) and hemiparesis (weakness on one side of the body) following cerebrovascular (condition affecting the brain's blood flow and blood vessels) disease affecting right dominant side, and chronic respiratory failure (a long-term condition in which the respiratory system is unable to adequately exchange oxygen and carbon dioxide in the body). During a review of Resident 36's Minimum Data Set (MDS, a resident assessment and tool), dated 1/3/2025, the record indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making was severely impaired. The MDS indicated Resident 36 had an impairment to one side of the upper extremity (shoulder, elbow, wrist, hand) and lower extremity (hip, knee, ankle, foot). The MDS indicated Resident 36 was dependent (helper does all of the effort) for toileting hygiene, shower/bathing self, lower body dressing, chair/bed-to-chair transferring. The MDS indicated Resident 36 required substantial/maximal assistance (helper does more than half the effort) for eating, oral hygiene, personal hygiene, rolling left and right, sit to lying, and lying to sitting on side of bed. The MDS also indicated Resident 36 had five (5) days of splint or brace assistance. During a review of Resident 36's Physician Order Summary, dated 12/28/2023, 9/6/2024, and 2/7/2025, the orders indicated as follows: - 12/28/2023: Restorative Nursing Assistant (RNA) for passive range of motion (PROM, the range that can be achieved by external means such as another person or a device) to right upper extremity (RUE) 10 repetitions for two (2) sets five (5) times a week every day or as tolerated. - 9/6/2024: RNA to apply Carrot hand splint (an orthotic device designed to position the finger away from the palm, protecting the skin from moisture, pressure, and potential nail punctures) on right hand for three to four hours after care daily. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 2/4/2025: RNA for PROM exercises on bilateral lower extremity (BLE) 10 repetitions for 2 sets every day 5 times per week or as tolerated. During a review of Resident 36's care plan, revised 9/25/2023, the care plan indicated Resident 36 had impaired physical mobility related to stiffness of right hand muscles secondary to contracture. The care plan interventions were for RNA to provide PROM to RUE 10 repetitions for 2 sets 5 times a week every day or as tolerated and RNA order to apply Carrot hand splint on right hand after care daily. There was no revised care plan for Resident 36's BLE RNA services. During a review of Resident 36's Restorative Nursing charting, the charting indicated Resident 36 received RNA for Carrot hand splint as follows for the month of February 2025: - Week 1: 2/6/2025, 2/7/2025 (missing 5 days) - Week 2: 2/10/2025, 2/11/2025, 2/12/2025, 2/13/2025, 2/14/2025 (missing 2 days) - Week 3: 2/17/2025, 2/19/2025, 2/20/2025, 2/21/2025 (missing 3 days) - Week 4: 2/24/2025, 2/25/2025, 2/26/2025 (missing 4 days) During a review of Resident 36's Restorative Nursing charting, the charting indicated Resident 36 received RNA for PROM to RUE 10 repetitions for 2 sets 5 times a week as follows for the month of February 2025: - Week 1: 2/6/2025, 2/7/2025 (missing 3 days) - Week 3: 2/17/2025, 2/19/2025, 2/20/2025, 2/21/2025 (missing 1 day) - Week 4: 2/24/2025, 2/25/2025, 2/26/2025 (missing 2 days) During a review of Resident 36's Restorative Nursing charting, the charting d indicated Resident 36 received RNA for PROM exercises to BLE 10 repetitions for 2 sets 5 times a week or as tolerated as follows for the month of February 2025: - Week 3: 2/17/2025, 2/21/2025 (missing 3 days) - Week 4: 2/24/2025 (missing 5 days) During an observation on 2/26/2025 at 8:51 AM in Resident 36's room, Resident 36's right hand was closed in a fist. During an interview on 2/28/2025 at 9:48 AM with RNA 1, RNA 1 stated he was in charge of RNA exercises for resident on the south station. RNA 1 stated Resident 36 had a hand splint and RNA exercises. RNA 1 stated Resident 36 never refused any RNA services provided to her. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and review on 2/28/2025 at 9:52 AM with RNA 1 of Resident 36's Restorative Nursing charting, RNA 1 stated the physician's order for RNA services were not being done as ordered. RNA 1 stated the hand splints were supposed to be done daily, RNA for the RUE and BLE were supposed to be done 5 times per week and were not being done per order. RNA 1 stated Resident 36 was weak on the right side so the splint was to help loosen the right hand. RNA 1 stated Resident 36 was not able to walk, and her legs were stiff, therefore the PROM of the BLE would help loosen the lower extremities. RNA stated the RNA exercises and splint were needed for Resident 36 to prevent her from being contracted and prevent the areas from getting stiff. During a concurrent interview and review on 2/28/2025 at 11:04 AM with the MDS Nurse (MDSN) of Resident 36's care plan, MDSN stated Resident 36's care plan needed to be updated when there are new orders for RNA services for resident's BLE. MDSN stated once the orders for RNA services for the BLE were received, the licensed nurse should have also updated the care plan. MDSN stated there was no care plan revision for Resident 36's BLE RNA services. MDSN stated the care plan ensures that Resident 36's plan was executed, and the interventions done would prevent atrophy (decrease in size due to disuse) and improve Resident 36's range of motion for the exercises done. During an interview on 2/28/2025 at 2:17 PM with the Director of Nursing (DON), the DON stated RNA services were performed for the resident's mobility and to prevent contractures. The DON stated an order for RNA services also requires the care plan to be updated. The DON stated the plan of care would need to be monitored to see if the residents were getting better, getting worse, or getting contracted. The DON stated RNAs needed to make sure the doctor's orders were being followed to know if the resident's mobility and contractures were progressing or not. The DON stated by not following the physician's orders there could be a decrease in mobility and an increase in contractures for residents. During a review of the facility's policy and procedure titled, Restorative Nursing Program Guidelines, revised 11/1/2017, the policy indicated in conjunction with the Attending Physician and staff, therapists will propose a rehabilitation or restorative care plan that provides an appropriate intensity, frequency and duration of interventions to help achieve anticipated goals and expected outcomes. The Restorative Nurse's Aide carries out the restorative program according to the care plan and documents daily.

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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 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** 47362 Based on observation, interview and record review, the facility failed to ensure one (1) of 1 sampled resident (Resident 16) receiving 5 liters of oxygen therapy (the odorless gas that is present in the air and necessary to maintain life) had a physician's order. This deficient practice had the potential to result in negative outcome of Resident 16's breathing pattern. Findings: During a review of Resident 16's Admission Record, the Admission Record indicated Resident 16 was initially admitted to the facility on [DATE] with diagnosis which dysphagia (swallowing difficulties), pneumonia (an infection that affects one or both lungs), pleural effusion (occurs when fluid builds up in the space between the lung and the chest wall) During a review of Resident 16's Minimum Data Set (MDS, a resident assessment tool), dated 2/1/2025, the MDS indicated Resident 16's cognitive skills (processes of thinking and reasoning) for daily decision making was intact. The MDS also indicated Resident 16 was on oxygen therapy while a resident (performed while a resident of this facility and within the last 14 days). During observation on 2/25/2025 at 9:34 AM at Resident 16's room Resident 16 was observed in bed with the oxygen on via nasal canula (flexible tube that goes around your head and into your nose) at 5 LPM. During observation on 2/25/2025 at 9:41 AM at Resident 16's room Resident 16 was observed in bed with the oxygen on via nasal canula at 5 LPM. During observation on 2/25/2025 at 12:58 PM at Resident 16's room Resident 16 was observed in bed with the oxygen on via nasal canula at 5 LPM. During observation on 2/25/2025 at 3:42 PM at Resident 16's room Resident 16 was observed in bed with the oxygen on via nasal canula at 5 LPM. During concurrent observation and interview on 2/26/2025 at 11:14 AM in Resident 16's room with the Director of Nursing (DON), the DON stated the resident was able to place the nasal cannula connected to oxygen concentrator with setting of 5LM. During a concurrent interview and record review of Resident 16's medical records on 2/26/2025 at 3:15 PM with Minimum Data Set Nurse (MDSN), MDSN stated there was no order for oxygen on Resident 16's Order Summary Report, no order for 2LPM no order for 5LPM. During a concurrent interview and record review on 2/27/2025 at 11:07 AM with the license vocational nurse (LVN 1), LVN 1 stated there was no order for oxygen for Resident 16 found on Order Summary Report. LVN 1 also stated all medication, and treatment should have physicians order, to know the proper dosage and route (the location at which the drug/ treatment is administered). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/28/2025 at 10:59 AM with the Director of Nursing (DON), the DON stated upon admission all orders should be check and verified. During a record review of the facility's Policy and Procedure (P&P) titled Oxygen administration revised date 11/1/2017 indicated the physicians order is required to initiate oxygen therapy, except in an emergency. The order shall include: i. Oxygen flow rate ii. Method of administration iii. Usage of therapy (continuous or PRN (as needed) iv. Titration instructions v. Indication for use. The P&P also indicated under the Procedure: i. Explain the procedure to the resident ii. Check the physician's order. iii. Wash hands iv. Assist resident to semi- or high fowler's position (the head of the bed needs to be elevated as high as possible) , if tolerated.

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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** 44636 Based on interview and record review, the facility failed to provide one of one sampled resident (Resident 30) safe and appropriate care for the provision of dialysis (a lifesaving treatment for residents with kidney failure) consistent with professional standards and in accordance with the facility's policy by failing to: 1. Ensure Resident 30 received 1800 milliliters (ml, unit of volume) of fluids per day as indicated on the care plan. 2. Monitor Resident 30's fistula (an abnormal opening or passage between two body structures that do not normally connect) for dialysis access. These deficient practices resulted in underloading Resident 30 with fluid and had the potential for dehydration ((harmful reduction in the amount of water in the body) and placed Resident 30 at risk for a delay in detecting a non-functioning arteriovenous shunt (AV, a connection or passageway between an artery and vein used for hemodialysis [(medical procedure that filters the blood of waste products when the kidneys are not able to)]) and complications such as infections and bleeding. Findings: During a review of the Resident 30's Admission Record, the Admission Record indicated Resident 30 was admitted to the facility on [DATE], with diagnoses of end stage renal disease (ESRD, advanced stage kidney failure), dependence on renal dialysis (a lifesaving treatment for residents with kidney failure or end stage renal disease), and arteriovenous fistula (AVF, an abnormal connection between an artery and a vein). During a record review of Resident 30's Minimum Data Set (MDS, a resident assessment and tool), dated 2/10/2025, the MDS indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making was moderately impaired. The MDS indicated Resident 30 was dependent (helper does all of the effort and resident does none of the effort to complete the activity) for sit to standing, chair/bed-to-bed transferring, and toilet transferring. The MDs indicated Resident 30 required substantial/maximal assistance (helper does more than half the effort) for toileting hygiene, shower/bathing self, sit to lying, and lying to sitting on side of bed. The MDS also indicated Resident 30 received hemodialysis. During a record review of Resident 30's Physician Order Summary, dated 2/5/2025, the order indicated as follows: - Fluid restriction 1800 ml per day Dietary 1200 ml: breakfast: 480 ml, lunch: 360 ml, dinner =360 ml, Nursing 600 ml: 11 pm to 7 am = 120 ml, 7 am to 3 pm = 240 ml, 3 pm to 11 pm = 240 ml. - Monitor intake and output every shift for 30 days intake: dietary: breakfast = 480 ml, lunch: 360 ml, dinner =360 ml, Nursing 600 ml: 11 pm to 7 am = 120 ml, 7 am to 3 pm = 240 ml, 3 pm to 11 pm = 240 ml. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of Resident 30's care plan, revised 2/7/2025, the care plan indicated Resident 30 needed fluid restriction of 1800 ml/day secondary to diagnosis of ESRD. The care plan interventions for staff were to provide 1800 ml of fluids per day, record intake and output, monitor weights and report any loss or gain of five percent to the physician. During a record review of Resident 30's care plan, revised 2/7/2025, the care plan indicated Resident 30 was at risk for infection in shunt site. The care plan interventions for staff were to monitor shunt site for symptoms of infection, shunt care per order, monitor intake and output, and monitor access area for redness, swelling or pain, and report to physician promptly. During a record review of Resident 30's Medication Administration Record (MAR, a medical record used by healthcare providers to document the administration of a medication or treatment) for the month of February, the MAR indicated from 2/6/2025 to 2/27/2025 Resident 30's intake ranged from 240 ml to 960 ml per day, except on days 2/22/2025 and 2/23/2025 which were 1200 ml and 1680 ml, consecutively. During a record review of Resident 30's Medical Records for the month of February, the records did not indicate staff were monitoring Resident 30's shunt site every shift. During a concurrent interview and record review on 2/28/2025 at 8:24 AM with Registered Nurse 3 (RN 3) of Resident 30's physician orders and MAR, RN 3 stated monitoring for Resident 30's fistula was not and should have been completed to ensure it was functioning and there was no infection or deterioration such as failure or worsening of the fistula. During the same interview on 2/28/2028 at 8:24 AM with RN 3, RN 3 stated dehydration could occur if Resident 30 received too little fluids. RN 3 stated symptoms such as headache, confusion, and electrolyte (minerals in water or body fluids that support body functions) imbalance resulting in the body to start shutting down. RN 3 stated since the physician had an order for fluid restriction of 1800 ml, fluids below 1500 ml per day could be enough to affect Resident 30 and cause dehydration side effects. During a concurrent record review of Resident 30's MAR with RN 3, RN 3 stated Resident 30 had received less than 1500 ml per day for this month except for 1 day. During an interview on 2/28/2025 at 1:44 PM with the Director of Nursing (DON), the DON stated intake and output monitoring was done to monitor for dehydration or fluid overload. The DON stated an intake of less fluids could also result in weight loss. The DON stated the fistula should be monitored by staff to ensure that it was working by checking on the bruit (an audible swishing or whooshing sound associated with turbulent blood flow) and thrill (palpable vibration felt over a vessel where a bruit is heard) and to physically inspect the site for possible infection. The DON stated after monitoring the fistula, the licensed nurses would need to document the monitoring on the resident's Medication Administration Record (MAR, a medical record used by healthcare providers to document the administration of a medication or treatment). During a record review of the facility's policy and procedure (P&P) titled, Dialysis Care, revised 11/1/2017, the policy indicated staff were to inspect shunt site area for color, warmth, redness, tenderness, pain, edema, drainage, and bruit once per shift. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of the facility's P&P titled, Intake and Output Recording, revised 11/1/2017, the policy indicated intake and output (I&O) of fluids is documented when indicated by an Attending physician order. Nursing staff will be responsible for completing the I&O record at the end of each shift. Information obtained from the I&O will be totaled daily and reviewed to ensure that resident's intake and output are sufficient to meet the resident's needs.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. 47362 Based on observation, interview, and record review, the facility failed to post the accurate and complete Census and Direct Care Service Hours Per Patient Day (DHPPD, refers to the actual hours of work performed per patient day by a direct caregiver) in accordance with the facility's policy and procedure by failing to ensure the Postage Nursing Hours for Direct Care Staff (nurse staffing information) posted on 2/25/2025 was accurate to reflect the correct date and total number of projected hours and the actual hours of licensed and unlicensed nursing staff directly responsible for resident care per shift. This deficient practice had the potential for residents and visitors not to be informed of the facility census and staffing. Findings: During observation on 2/25/2025 at 7:46 AM at the facility entrance lobby, a facility form titled, Posted Nursing Hours for Direct Care Staff, indicated the following: Census at beginning of today: 54 Todays average census: 54 Direct nursing hours/ day 219.50 (C.N.A.137.50) The Nursing Hours for Direct Care Staff also indicated a date of 2/24/2025 therefore the Posted Nursing Hours for Direct Care Staffing was inaccurate for the day. During a concurrent observation and interview on 2/27/2025 at 12:12 PM with the Infection Preventionist Nurse (IPN), IPN stated the posted nursing hours for direct care staff was not accurate on 2/25/2025 at 7:46 AM, it was dated 2/24/2025. During concurrent interview and record review of facility's Policy and Procedure (P&P) on 2/28/2025 at 10:43 AM with the Director of Nursing (DON), the DON stated the P&P titled, Nursing Department Staffing , Scheduling and Posting revised 10/24/2022 indicated its purpose was to ensure an adequate number of nursing personnel are available to meet resident needs. The P&P also indicated the facility will post the following information daily: i. facility name. ii. the current date, iii. the total number and actual hours worked by the following categories of licensed and unlicensed nursing staffing directly responsible for resident care per shift. The P&P, under Posting Requirements, also indicated: (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	i. The facility will post the nurses staffing data specified above, daily at the beginning of each shift. ii. Data must be posted in a clear and readable format in a prominent place readily accessible to residents and visitors. The DON stated the facility did not comply with the P&P because the Nursing Hours for Direct Care Staffing posted on 2/25/2025 at 7:46 AM was dated 2/24/2025, making the information inaccurate.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44636 Based on observation, interview, and record review, the facility failed to ensure a medication was administered per physician's order for one of four sampled residents (Resident 21). This deficient practice had the potential for delayed absorption and decrease effectiveness of the medication, which could affect Resident 21's wellbeing. Findings: During a review of the Resident 21's Admission Record, the Admission Record indicated Resident 21 was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses of dementia (progressive brain disorder that slowly destroys memory and thinking skills) with agitation, metabolic encephalopathy (abnormalities of water, electrolytes, vitamins, and other chemicals that adversely affect the brain function), and hypertension (high blood pressure). During a record review of Resident 21's Minimum Data Set (MDS, a resident assessment and tool), dated 1/8/2025, the MDS indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making was moderately impaired. The MDS indicated Resident 21 was dependent (helper does all the effort, resident does none of the effort to complete the activity) for toileting hygiene, shower/bathing self, and chair/bed-to-chair transfer. The MDS indicated Resident 21 required substantial/maximal assistance (helper does more than half the effort) for personal hygiene, rolling left to right, sit to lying, and lying to sitting on side of bed. During a record review of Resident 21's Physician Order Summary Report, dated 1/31/2025, the order indicated Aspirin (drug used to treat or prevent heart attacks, strokes, and chest pain) tablet chewable 81 milligram (mg, unit of measurement) - Give one tablet by mouth one time a day for cerebrovascular accident (CVA - stroke; damage to the brain from interruption of its blood supply) prophylaxis (measures to preserve health and prevent the spread of disease). During a record review of Resident 21's care plan, dated 5/3/2021, the care plan indicated Resident 21 was at risk for bleeding related the use of anticoagulant medication. The care plan interventions for staff were to administer the medication as ordered and monitor for side effects of anticoagulant. During an observation on 2/27/2025 at 9:04 AM in Resident 21's room with Licensed Vocational Nurse 2 (LVN 2), LVN 2 gave Resident 21's eight medications in a medication cup. Resident 21 took the cup and swallowed all the medications. During an interview on 2/27/2025 at 9:06 AM with LVN 2, LVN 2 stated Resident 21 drank all her medications at the same time. LVN 2 stated Resident 21 had Aspirin 81 mg which was a chewable tablet, but Resident 21 swallowed the tablet instead of chewing the tablet. LVN 2 stated the Aspirin was supposed to be chewed and not swallowed. LVN 2 stated the purpose of chewing the Aspirin was for better absorption of the medication. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pasadena Grove Health Center	1470 N Fair Oaks Ave Pasadena, CA 91103

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/28/2025 at 2:20 PM with the Director of Nursing (DON), the DON stated when the physician placed the order for Aspirin chewable, then the Aspirin should be separated from the rest of the medications to ensure the Resident chewed the Aspirin when taking. The DON stated the Aspirin needed to be crushed, then swallowed for the absorption of the medication. During a record review of the facility's policy and procedure titled, Medication Administration, revised 11/1/2017, the policy indicated medication will be administered by a Licensed Nurse per the order of an Attending Physician.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48143 Based on interview and record review, the facility failed to act upon the facility's Pharmacy Consultant's recommendations during the Medication Regimen Review (MRR, a monthly thorough evaluation by the consulting pharmacist of a resident's medication regimen, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication) to address the recommendation/ irregularities for the month of January 2025's MRR for one (1) of five (5) sampled residents (Resident 4). This deficient practice had the potential to result in adverse medication outcome for potential unnecessary medications to Resident 4. Findings: During a review of Resident 4's Admission Record, the Admission record indicated Resident 4 was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included quadriplegia, (a condition characterized by the complete or partial loss of motor and sensory function in all four limbs, arms and legs), seizures (a sudden, uncontrolled burst of electrical activity in the brain that can cause temporary changes in behavior, movement, sensation, or consciousness), and encephalopathy (a group of conditions that cause brain dysfunction). During a review of the Minimum Data Set (MDS- resident assessment tool) dated 2/12/2025, indicated Resident 4 had severely impaired (never/ rarely made decisions) cognitive skills (the mental processes that allow people to think, learn, and solve problems) for daily decision making. Resident 4 was dependent and required helper does all the effort, (the assistance of 2 or more helpers is required for the resident to complete the activity) with the toilet, personal hygiene, change of position, and transfer. During a review of Consultant Pharmacist's Medication Regimen Review (MRR), dated 1/31/2025, the MRR indicated Resident 4's current order of Aspirin oral table 325 milligrams (mg, unit of measure) give 1 tablet by mouth one time a day for CVA (cerebrovascular accident, blood flow to the brain is interrupted, causing brain cells to die) prophylaxis (to prevent). The MRR indicated that aspirin 81 to 162 mg daily is the recommended dose; 325 mg is used for pain and using a higher daily dose of aspirin could lead to GI (gastrointestinal, the organs and system involved in digestion) side effects. MRR indicated MD clarification for the dose. During a review of Resident 4's February 2025's Medication Administration Record (MAR), indicated Aspirin 325 mg was given from 2/1/2025 to 2/28/2025. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 2/28/2025 at 9:24 AM, with the Registered Nurse Supervisor (RNS 1), RNS 1 stated the Director of Nurses (DON) give assignments to all the licensed staff to review the January 2025 and February 2025 monthly MRR. RNS 1 stated the doctor was not made aware of the MRR which indicated the irregular and/ or recommendations by the pharmacist for Resident 4's January 2025 MRR. RNS 1 stated Resident 4's January 2025 MRR was not reviewed and followed up. RNS 1 stated not notifying the physician to follow up on the pharmacist recommendation can cause medication side effects to Resident' 4 digestive system, which can lead to resident harm, serious illness, and/ or worsening of condition. During an interview on 2/28/2025 at 3:27 PM, with the facility's pharmacist (PHAR), the PHAR stated pharmacist strongly recommended the facility to review the monthly MRR report and notify individual resident's physician for any irregularities and recommendations as indicated on the monthly MRR report. During an interview on 2/28/2025 at 4 PM with the Director of Nurses (DON), the DON stated the Quality Assurance (QA), and the nurses should have reviewed Resident 4's January 2025 MRR report. The DON stated review and follow up for the MRR can prevent medication overdose or misuse and it can prevent harm to the residents. During a review of the facility Policy and Procedure (P&P) titled, Drug Regimen Review, revised 11/1/2017, the P&P indicated: 1. The intent is that the facility maintains the resident's highest practicable level of physical, mental and psychosocial well-being and prevents or minimizes adverse consequences related to medication therapy to the extent possible, by providing oversight by a licensed pharmacist, attending physician, medical director, and the director of nursing. 2. The pharmacist will report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. 3. The consulting Pharmacist will report any irregularities such as unnecessary drugs (which include but are not limited to excessive dosage, excessive duration, inadequate monitoring, inadequate indications for use or adverse consequences of use) to the Facility's Medical Director, Director of Nursing, and the Attending Physician. 4. The Attending physician will respond to any irregularities reported by the pharmacist by reviewing the irregularities and documenting in the resident's medical record that the irregularity has been reviewed, and what, if any, action has been taken to address it. a. If no action has been taken, the attending physician must document his/her rationale. b. Documentation by the Attending Physician must occur within 30 days of issuance of the pharmacist's report, unless the irregularity is an emergent issue requiring immediate action. 5. The Medical Director and DON will also review the pharmacist's report if any irregularities are identified. The DON is responsible for following up with the Attending Physician, as indicated.

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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** 48143 Based on observation, interview, and record review, the facility failed to follow proper food storage handling practices in accordance with its policy and procedure by failing to label and discard expired food items stored in the facility's kitchen refrigerators, freezers, and dry storage. This deficient practice had the potential to result in food borne illness (any sickness that is caused by the consumption of foods or beverages that are contaminated with certain infectious or noninfectious agents) in a population of 50 residents consuming food by mouth. Findings: During a concurrent observation and interview on [DATE] at 7:59 AM in the facility kitchen with the Dietary Aide (DA) and Kitchen Aide (KA), the following food items were observed: a. One cube of opened butter in the refrigerator with no open date and use by date b. One carton of Smithfield Pork sausage skinless links in the freezer without a label indicating received date and use by date. c. One Frozen bag of chopped spinach without a label indicating received date and use by date. d. 16 boxes of [NAME] Raisins with a label indicating received date of [DATE] and a best before date of [DATE]. e. Four cans of Ready Care Instant Food thickener with a label indicating delivery date of [DATE] and use by date of [DATE]. f. Unopened box of Golden Tip tea bags box with a label indicating received date of [DATE]. There were no other labels to indicate use by date or expiration date. g. one opened box of [NAME] tea bags box with a label indicating delivery date of [DATE] and use by date of [DATE]. h. one bag of opened chicken gravy mix inside a zip log bag with a label indicating open date on [DATE]. There were no other labels to indicate use by date or expiration date. During an interview on [DATE] at 3:48 PM with DSS, DSS stated per facility policy, all food items received should be labeled with a received date and a use by date once opened. DSS stated the use by date is the last day the item can be used and must be discarded after that date. DSS also stated it was important to label, store, and discard food items per policy to ensure that the food items were safe to eat for the residents. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's Policy and Procedure (P&P) titled, Food Storage and Handling, revised [DATE], the P&P indicated to label and date all food items and storage products. Cans should be stored with labels exposed for easy identification. Dry Storage Guidelines, any opened products should be placed in storage containers with tight fitting lids, label, and date storage products.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 48143 Based on observation, interview, and record review, the facility failed to ensure the lids of one garbage container (dumpster) remained closed as indicated in the facility policy titled, Garbage and Trash Can Use and Cleaning. This failure had the potential to result in the attraction and spread of vermin (animals that are believed to be harmful, or that carry diseases, such as rodent's parasitic worms or insects) that could potentially enter the facility and spread diseases to the residents. Findings: During an observation on 2/25/2025 at 12:08 PM in the facility's parking lot dumpster area, there was one dumpster with two (2) lids which were both left opened. The gate of the dumpster area was not closed. During an observation on 2/26/2025 at 2:50 PM in the facility's parking lot dumpster area, the dumpster was observed with one lid closed and one lid open exposing the contents inside the dumpster. The gate of the dumpster area was not closed. During an interview on 2/27/2025 at 3:32 PM with the Maintenance Supervisor (MS) and Dietary Supervisor (DSS), MS and DSS both stated per facility policy, the outside dumpster lids were supposed to be kept closed at all times and kept clean to keep out flies and rodents and to prevent transfer of disease. During a review of the facility's Policy and Procedure (P&P) titled, Garbage and Trash Can Use and Cleaning, revised 11/1/2017, the P&P indicated food waste will be placed in covered garbage and trash cans.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44636 Based on interview and record review, the facility failed to ensure provision of hospice (specialized care providing physical comfort and emotional, social and spiritual support for people nearing the end of life) services for one of two sampled residents (Resident 36) by failing to ensure: 1. Hospice nurses (Skilled Nurses [licensed nurses] and Certified Home Health Aide [CHHA]) conducted a visit according to the hospice care summary order. 2. Hospice calendar for 2/2025 was completed to reflect frequency of hospice SN and CHHA visits according to the care summary order. These deficient practices had the potential to result in a delay or a lack of necessary care and services which could negatively affect Resident 36s' physical comfort, psychosocial well-being. Findings: During a record review of the Resident 36's Admission Record, the Admission Record indicated Resident 36 was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses of hemiplegia (a condition caused by brain damage or spinal cord injury that leads to paralysis [loss of motor function in one or more muscles] on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (a stroke, damage to tissue in the brain due to loss of oxygen to the area) affecting right dominant side, sequelae of cerebral infarction (a stroke, damage to tissue in the brain due to loss of oxygen to the area), and chronic kidney disease (gradual loss of kidney damage where kidneys cannot filter the blood the way they should). During a record review of Resident 36's care plan, revised 1/20/2023, the care plan indicated Resident 36 was under hospice care related to terminal prognosis of end stage of cardiovascular accident (CVA, stroke - blood flow to part of the brain is blocked or a bleed in the brain). The care plan intervention for staff was to work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs are met. During a record review of Resident 36's Physician Order Summary Report, dated 12/21/2023, indicated admit to hospice care with diagnosis of end stage CVA. During a record review of Resident 36's Minimum Data Set (MDS, a resident assessment and tool), dated 1/3/2025, the MDS indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making was severely impaired. The MDS indicated Resident 36 was dependent (helper does all the effort, resident does none of the effort to complete the activity) for shower/bathing self, lower body dressing, and chair/bed-to-chair transferring, and toilet transferring. The MDS indicated Resident 36 required substantial/maximal assistance (helper does more than half the effort) for oral hygiene, personal hygiene, rolling left to right, and sit to lying. The MDS also indicated Resident 36 was on hospice care. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of Resident 36's hospice plan of care summary orders, dated 12/11/2023, the record indicated as follows: - Certified Home Health Aide (CHHA) services two times a week. - Skilled Nurse (SN) visits one time a week to promote comfort and symptom management. During a record review of Resident 36's hospice monthly calendar for February 2025, indicated as follows: - Weeks 1 to 3: SN did not have weekly scheduled visits. - Week 4: CHHA was missing one scheduled visit. - Week 5: CHHA did not have two scheduled visits; Skilled Nurse did not have a weekly scheduled visit. During a record review of Resident 36's hospice flow sheet for January and February 2025, the record indicated date, time in, time out, and signature/title. There was no documentation that CHHA came to see Resident 36 for the month of January and February 2025. During a concurrent interview and review on 2/27/2025 at 4:06 PM with Registered Nurse 3 (RN 3) of Resident 36's hospice plan of care summary orders, RN 3 stated CHHAs were supposed to visit twice weekly, and SNs were supposed to visit once weekly. During a concurrent interview and review on 2/27/2025 at 4:19 PM with RN 3 of Resident 36's hospice monthly calendar for February 2025, RN 3 stated there was no schedule on the calendar for CHHA and SN visits after 2/19/2025. RN 3 stated there was no SN scheduled visits for weeks 1, 2, and 3. RN 3 stated hospice nurses signed in the flow sheet when they visited Resident 36. RN 3 stated there was no sign in or documentation that CHHA came to the facility to provide care for Resident 36. RN 3 also stated hospice calendars provided a schedule to ensure coordination of care between hospice and facility staff. RN 3 stated hospice staff did not and were supposed to sign in the flow sheet sign in sheet to indicate that they conducted a visit to Resident 36. During an interview on 2/28/2025 at 2:15 PM with the Director of Nursing (DON), the DON stated hospice calendars needed to be completed so the facility staff were aware of who (hospice staff) visited for the day. The DON stated if hospice staff did not come during the scheduled visits, then the facility staff could provide the needed care to Resident 36. The DON stated hospice staff had a binder which had sign in sheets for the hospice staff to sign in when they conduct their visit. During an interview on 2/28/2025 at 3:46 PM with Hospice Performance Improvement Coordinator (HPIC), HPIC stated all hospice staff who visited the hospice resident should sign in using the hospice binder. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of the Contract Agreement Between Hospice and Provider, dated 10/25/2023, the contract indicated hospice retrains professional management responsibility of the hospice services provided to the resident in accordance with the hospice plan of care and makes any arrangements necessary for hospice-related inpatient care. Hospice furnishes the provider a copy of the resident's plan of care and specifies the inpatient services to be furnished. During a record review of the facility's policy and procedure titled, End of Life Care, revised 6/1/2021, the policy indicated the resident's Care Plan will reflect hospice interventions as ordered by the Attending Physician and elected by the resident or his/her representative.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44636 Based on interview and record review, the facility failed to implement its protocol for Antibiotic Stewardship to reduce inappropriate antibiotic (medication used to kill bacteria and to treat infections) use by not administering antibiotic drug if the antibiotic drug use criteria (Loeb's, an Infection Screening Evaluation in facility's medical record, surveillance definitions of infections in Long-Term Care Facilities) was not met for one (1) of two (1) sampled residents (Resident 206). This deficient practice had the potential for Resident 206 to develop antibiotic resistance (when bacteria, viruses, fungi, and parasites no longer respond to antimicrobial medicine and become ineffective making infections difficult or impossible to treat increasing the risk of disease spread, severe illness, disability, and death) and suffer adverse side effects from unnecessary or inappropriate antibiotic use. Findings: During a review of the Resident 206's Admission Record, the Admission Record indicated Resident 17 was admitted to the facility on [DATE], with diagnoses of sepsis (a serious condition resulting from the presence of harmful microorganisms in the blood), urinary tract infection (UTI, an infection in any part of the urinary system, the kidneys, bladder [organ that stores urine] or urethra [the tube through which urine leave the body]), and extended spectrum beta lactamase (ESBL, bacteria) resistance (when bacteria produce enzymes that make antibiotics unable to treat infections). During a record review of Resident 206's Minimum Data Set (MDS, a resident assessment and tool), dated 2/23/2025, the MDS indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making was moderately impaired. The MDS indicated Resident 206 required substantial/maximal assistance (helper does more than half the effort) for sit to standing, chair/bed-to-chair transferring, and toilet transferring. The MDS also indicated Resident 206 was taking an antibiotic. During a record review of Resident 206's Physician Order Summary Report, dated 2/10/2025, the order indicated Invanz (type of antibiotic used to treat severe infections) Injection Solution Reconstituted 1 gram (gm, unit of measurement) - Use 1 gm intravenously (IV, administered into a vein) one time a day for septicemia (an infection that occurs when bacteria enter the bloodstream and spread) for six (6) days in 0.9 % sodium chloride (NaCl, salt) 50 milliliter (ml, unit of volume). During a record review of Resident 206's Medication Administration Record (MAR, a medical record used by healthcare providers to document the administration of a medication or treatment) for the month of February 2025, the MAR indicated Resident 206 received Invanz on the following days: 2/11/2025, 2/12/2025, 2/13/2025, 2/14/2025, 2/15/2025, and 2/16/2025. During a record review of Resident 206's Surveillance Data Collection Form, dated 2/10/2025, the record indicated the following Loeb's Minimum Criteria for initiating antibiotics needed to be met: - Temperature of greater 100 Fahrenheit (?) or 2.4 ? above baseline and (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- At least one of the following criteria: rigors (a sudden feeling of cold with shivering accompanied by a rise in temperature) or delirium (an altered state of consciousness). During a concurrent interview and review on 2/26/2025 at 4:07 PM of Resident 206's Surveillance Data Collection Form with the Infection Prevention Nurse (IPN), IPN stated Resident 206 was on Invanz for community acquired septicemia and status post (s/p, a term used in medicine to refer to a surgical procedure, diagnosis or just an event) surgery. IPN stated based on Loeb's Criteria Resident 206 did not have a temperature greater than 100 ?, temperature 2.4 ? above baseline, rigors, or delirium when admitted to the facility with the antibiotic. IPN stated Resident 206 did not meet the Loeb's criteria for antibiotic use. IPN stated Resident 206 completed the full 6 days of IV antibiotics. IPN stated the physician should have been notified when Resident 206 did not meet the Loeb's criteria which indicated Resident 206 was receiving an IV antibiotic that was not needed. IPN stated the purpose of the Antibiotic Stewardship Program was to monitor the usage of antibiotic and to avoid any resistance to antibiotics. During an interview on 2/28/2025 at 2:22 PM with the Director of Nursing (DON), the DON stated after three days, a time out (an active reassessment of an antibiotic prescription to offer the opportunity to modify therapy) for antibiotic use was done. The DON stated if the resident did not have any signs or symptoms of an infection, the licensed nurse would need to contact the physician and inform the physician the resident did not meet the criteria for antibiotic usage. The DON stated an antibiotic time was done to prevent residents from getting used to taking antibiotics and the continued usage of unnecessary antibiotics would create resistance. The DON stated the next time the resident was prescribed the antibiotic, the antibiotic would no longer be effective in treating the infection. During a record review of the facility's policy and procedure titled, Antibiotic Stewardship Program, revised 12/1/2021, the policy indicated the Antibiotic Stewardship Program (ASP) was designed to promote appropriate use of antibiotics while optimizing the treatment of infections, and simultaneously reducing the possible adverse events associated with antibiotic use. The IP will collect and analyze infection surveillance data and monitor the adherence to the ASP.

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44636 Based on interview and record review, the facility failed to administer pneumococcal vaccination (vaccine that protect against bacteria that cause illnesses such as pneumonia [infection of the lungs], ear infections, sinus infections, meningitis [infection of the tissue covering the brain and spinal cord], and bacteremia [infection of the blood]) for one of five sampled residents (Resident 30) after obtaining a consent on 2/7/2025. This deficient practice placed Residents 30 at higher risk of acquiring and transmitting complications from the pneumococcal disease. Findings: During a review of the Resident 30's Admission Record, the Admission Record indicated Resident 30 was admitted to the facility on [DATE], with diagnoses of end stage renal disease (advanced stage kidney failure), type 2 diabetes mellitus (a disease that occurs when there is a problem in the way the body regulates and uses sugar as fuel), and myocardial infarction (heart attack). During a record review of Resident 30's Physician Order Summary, dated 2/5/2025, the order indicated Pneumococcal Polysaccharide Vaccine (PPV, vaccination that protects against pneumococcal infections [an infection that causes inflammation and fluid in the lungs]) 0.5 milliliters (ml, unit of volume) intramuscular (administered into the muscle) and every five years. Informed consent obtained from the resident/responsible party after explanation of risks and benefits. During a record review of Resident 30's Pneumonia Vaccine Consent, dated 2/7/2025, the consent indicated Resident 30 requested for the pneumonia vaccine be administered. During a record review of Resident 30's Minimum Data Set (MDS, a resident assessment and tool), dated 2/10/2025, the MDS indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making was moderately impaired. The MDS indicated Resident 30 was dependent (helper does all of the effort and resident does none of the effort to complete the activity) for sit to standing, chair/bed-to-bed transferring, and toilet transferring. The MDs indicated Resident 30 required substantial/maximal assistance (helper does more than half the effort) for toileting hygiene, shower/bathing self, sit to lying, and lying to sitting on side of bed. The MDS also indicated Resident 30's Pneumococcal Vaccine was not up to date. During a record review of Resident 30's Resident undated Immunization Record History, the record indicated there was no pneumococcal vaccine administered to Resident 30. During a record review of Resident 30's undated CAIR2 (a secure, statewide computerized system used to tract immunization), the record indicated Resident 30 was past due for the PneumoConjugate vaccine (vaccine that protects against pneumococcal disease). (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 2/26/2025 at 3:18 PM with the Infection Prevention Nurse (IPN) of Resident 30's consent, Immunization Record, and CAIR2, IPN stated Resident 30 requested to receive the pneumococcal vaccine on 2/7/2025. IPN stated the supervisor informed IPN Resident 30 had consented to receive the pneumococcal vaccination. IPN stated IPN was supposed to but did not review Resident 30's medical records for vaccinations. IPN stated IPN should have but did not administer the pneumococcal vaccine to Resident 30. IPN stated Resident 30 was due to receive the pneumococcal vaccine. IPN stated it was important for Resident 30 to receive the pneumococcal vaccination since Resident 30 was immunocompromised which placed Resident 30 at risk for respiratory complications and pneumonia. During an interview on 2/28/2025 at 2:25 PM with the Director of Nursing (DON), the DON stated all residents were offered and educated about the immunizations. The DON stated when residents consent to the immunization, the immunization should be administered to the residents. During a record review of the facility's policy and procedure titled, Pneumococcal Disease Prevention, 10/1/2024, the policy indicated the facility will provide education and offer the pneumococcal vaccine to residents to prevent and control the spread of pneumococcal disease in the facility. The resident's medical record includes documentation that the resident either received the pneumococcal vaccine or did not receive the vaccination due to medical contraindications or refusal.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44636 Based on interview and record review, the facility failed to follow its policy on Covid-19 (Coronavirus Disease 19, a respiratory viral infection that affects primarily the lungs and result in cough and difficulty breathing) by failing to: 1. Provide education, offer, and document the 2024-2025 Covid-19 vaccinations for two of five sampled residents (Residents 2 and 17). 2. Provide education, offer, and/or document the 2024-2025 Covid-19 vaccination for staff. This deficient practice place residents and staff at risk for possible Covid-19 infection due to missed vaccination dosage. Findings: 1. During a review of the Resident 2's Admission Record, the Admission Record indicated Resident 2 was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses of schizophrenia (a chronic and severe mental disorder that affects how a person thinks, feels, and behaves), dementia (progressive brain disorder that slowly destroys memory and thinking skills) with behavioral disturbance, Parkinsonism (progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movement), and difficulty in walking. During a record review of Resident 2's Minimum Data Set (MDS, a resident assessment and tool), dated 2/14/2025, the MDS indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making was moderately impaired. The MDS indicated Resident 2 required substantial/maximal assistance (helper does more than half the effort) for rolling left and right, sit to lying, lying to sitting on side of bed, sit to standing, and walking ten (10) feet. The MDS also indicated Resident 2's Covid-19 vaccination was not up to date. During a review of Resident 2's undated Immunization Record History, the report indicated there was no record to indicate a consent, refusal, or administration for the 2024-2025 Covid-19 vaccination. During a concurrent interview and record review on 2/26/2025 at 3:33 PM with the Infection Prevention Nurse (IPN) of Resident 2's immunization record, IPN stated the staff did not and should have obtained a consent from Resident 2 for the 2024-2025 Covid-19 vaccination. IPN stated Resident 2 had not received the 2024-2025 Covid-19 vaccination. 2. During a review of the Resident 17's Admission Record, the Admission Record indicated Resident 17 was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses of dementia (progressive brain disorder that slowly destroys memory and thinking skills), depression (severe feelings on sadness and hopelessness), and hypothyroidism (condition in which the thyroid gland does not produce enough thyroid hormone). (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review of Resident 17's MDS, dated [DATE], the MDS indicated the resident's cognitive skills for daily decision making was moderately impaired. The MDS indicated Resident 17 was dependent (helper does all the effort, resident does none of the effort to complete the activity) for toileting hygiene, shower/bathing self, and chair/bed-to-chair transfer. The MDS indicated Resident 17 required substantial/maximal assistance for personal hygiene, rolling left to right, sit to lying, and lying to sitting on side of bed. The MDS also indicated Resident 17's Covid-19 vaccination was not up to date. During a review of Resident 17's Immunization Report, dated 2/28/2025, the report indicated there was no record to indicate a consent, refusal, or administration for the 2024-2025 Covid-19 vaccination. During a concurrent interview and record review on 2/26/2025 at 3:51 PM with the IPN of Resident 17's immunization record, IPN stated Resident 17 did not have a consent form or declination form. IPN stated Resident 17 had not received the 2024-2025 Covid-19 vaccine. 3. During a record review of the employees' vaccination, there was no record to indicate which employees were offered, received, and/or declined the 2024-2025 Covid-19 vaccine. During an interview on 2/26/2025 at 3:56 PM with the IPN, IPN stated the previous Director of Staff Development (DSD) was in charge of the employee vaccinations. IPN stated the DSD left during the end of December 2024 and IPN was responsible for the employee immunizations. During a follow up interview on 2/27/2025 at 10:19 AM with the IPN, IPN stated IPN was able to locate DSD files for employee immunizations. During a concurrent record review of 78 staff members consents, declinations, and immunizations forms with IPN, IPN stated there were no employee documentation for the 2024-2025 Covid-19 vaccination. IPN stated the facility did not offer the 2024-2025 Covid-19 vaccination at the facility. IPN stated if staff were offered the 2024-2025 Covid-19 vaccination, staff needed to sign a consent or a declination form. IPN stated the 2024-2025 Covid-19 vaccine should have been offered and a consent should have been obtained from the staff starting October 2024. IPN stated covid vaccinations were supposed to help and minimize covid symptoms. IPN stated if one resident or staff were to get infected with covid, then the covid disease could spread to the rest of the residents and staff. During a record review of the facility's policy and procedure titled, COVID-19 Vaccination, dated 6/5/2023, the policy indicated the facility will educate and offer Covid-19 vaccinations to residents, facility staff, and consultants to reduce transmission of Covid-19 and may administer such vaccine upon consent. IV. Documentation A. The Infection Preventionist, or designee, will maintain documentation in the personnel file that each facility staff member was educated on the benefits and potential side effects of the Covid-19 vaccine and offered vaccination unless medically contraindicated or the facility staff member has already been immunized. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	i. If a facility staff member is not eligible for Covid-19 vaccination because of previous immunization at another location or outside of the facility, the facility should request vaccination documentation from the facility staff member to confirm vaccination status. B. The Infection Preventionist, or designee, will ensure that the resident's medical record includes documentation that, at a minimum, the resident and/or resident representative was provided education regarding the vaccine they were offered, if they accepted and received the vaccine or refused, and each dose of the Covid-19 vaccine if administered. i. Such documentation should include the date the education was offered; and ii. The name of the representative, if applicable. iii. If there is a contraindication to the resident having the vaccination, the appropriate documentation must be made in the resident's medical record.

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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** 48143 Based on observation, interview, and record review, the facility failed to ensure 31 of 31 Resident rooms (Rooms 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31 and 32) met the 80 square feet (sq. ft.) per Resident in multiple resident rooms. This deficient practice had the potential to affect the residents' personal space, decrease freedom of mobility and could compromise the provision of care. Findings: During the initial tour observation of the facility on 2/25/2025 at 10:28 AM, Rooms 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, and 32 did not meet the minimum requirement of 80 sq. ft. per resident in multiple residents' rooms. During an interview with Resident 45 on 2/25/2025, at 12:46 PM, Resident 45 stated was comfortable in his room and had enough space for his belongings and wheelchair. During an observation on 2/26/2025 at 10:48 AM in room [ROOM NUMBER], Resident 15 was observed assisted by Certified Nurse Assistant 2 (CNA 2) to the bed safely. CNA2 stated he has enough room to move residents around inside the room without any space concern. During an interview with the Licensed Vocational Nurse 3 (LVN 3), on 2/28/2025 at 11:12 AM, LVN 3 stated, There were no complaints from the staff regarding the room sizes. The staff were able to perform the task required for the residents. During a review of the facility's Client Accommodation Analysis Form, dated 2/25/2025, the form indicated there were resident rooms that did not meet the 80 square footage requirements. These rooms were 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 14, 15, 16, 17,18, 19, 20,21, 22,23,24,25, 26,27,28,29,30, 31 and 32. During a review of the facility's room waiver request, dated 2/25/2025, the waiver indicated the rooms measuring less than 80 sq. ft. per Resident were as follows: 1. room [ROOM NUMBER] has four beds and measured 300 sq. ft, to equal 75 sq. ft. per resident. 2. Rooms 2, 9, 11, 12, have two beds and measured 153 sq. ft., to equal 76.5 sq. ft. per resident. 3. Rooms 3, 4, 5, 6, 7, have two beds and measured 144 sq. ft, to equal 72 sq. ft per resident. 4. room [ROOM NUMBER], 10, 21 have two beds and measured 147 sq. ft, to equal 73.5 sq. ft per resident. 5. room [ROOM NUMBER] has two beds and measured 154 sq. ft., to equal 77 sq. ft per resident. (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	6. room [ROOM NUMBER] has four beds and measured 298 sq. ft., to equal 74.5 sq. ft per resident. 7. room [ROOM NUMBER] has two beds and measured 150 sq. ft., to equal 75 sq. ft. per resident. 8. Rooms 17, 19, 20 have two beds and measured 148 sq. ft, to equal 74 sq. ft. per resident. 9. room [ROOM NUMBER] has four beds and measured 296 sq. ft., to equal 74 sq. ft. per resident. 10. Rooms 22, 23, 24, 25, 26, 27, 28, 30 have two beds and measured 144 sq. ft., to equal 72 sq. ft. per resident. 11. room [ROOM NUMBER] has two beds and measured 143.9 sq. ft., to equal 71.9 sq. ft. per resident. 12. room [ROOM NUMBER] has four beds and measured 291.9 sq. ft., to equal 72.9 sq. ft per resident. 13. room [ROOM NUMBER] has three beds and measured 208 sq. ft., to equal 69.3 sq. ft per resident. The facility's room waiver request indicated there was sufficient room nursing care, comfort and privacy of the residents. The Department is recommending approval of the room waiver request for 31 of 31 rooms.