STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055664	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
York Healthcare & Wellness Centre	6071 York Blvd. Los Angeles, CA 90042

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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	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46779 Based on observation, interview and record review, the facility failed to accommodate the needs for one of one sampled resident (Resident 288) in accordance with the facility's policy and procedure by failing to ensure the call light (a device used by residents to signal his or her needs for assistance) was within reach. This deficient practice had the potential for Resident 288 not able to call the facility staff to ask for help or assistance specially during emergency. Findings: During a review of Resident 288's Admission Record indicated the facility originally admitted Resident 288 on 11/6/21 and readmitted on [DATE] with diagnoses that included encephalopathy (a disorder of brain function that often impairs consciousness) and history of fall. During a review of Resident 288's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 3/28/24, indicated Resident 288 had severely impaired memory and cognition (ability to think and reason). The MDS indicated Resident 288 required setup or clean-up assistance with eating and oral hygiene, partial/moderate assistance with toileting hygiene and personal hygiene, and substantial/maximal assistance with shower/bathe self, sit to lying, sit to stand, chair/bed-to-chair transfer, and toilet transfer. During a concurrent observation and interview on 5/6/24 at 3:06 PM with Resident 288, Resident 288 was lying in bed with head of bed elevated at 30 degrees angle. Resident 288 was receiving oxygen via nasal cannula (a flexible plastic tube placed at his nares to deliver oxygen). Resident 288 pointed to a yellow blanket at the foot of his bed and asked the surveyor to the yellow blanket .cover . There was no staff in the room or in the hallway at the moment. Resident 288 ' s call light was on the floor on the right side of the resident ' s bed. Resident 288 tried to turn his head and body to the right side, but he could not turn on his own. Resident 288 reached out with his right arm to locate the call light cord on the right side of the bed, but he could not reach the call light. Resident 288 panted and said he could not find his call light. During a concurrent observation and interview on 5/6/24 at 3:10 PM with the Case Manager (CM), Resident 288's call light was on the floor, and Resident 288 was unable to reach the call light. The CM stated the call light should be within residents' reach at all times for them to express their feelings and needs, so the staff would provide care right away and ensure the residents' safety. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During review of the facility's policy and procedure titled, Communication-Call System, dated on 1/1/12, indicated call cords will be placed within the resident's reach in the resident 's room.

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F 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident has the right to receive notices in a format and a language he or she understands. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44018 Based on interview and record review, the facility failed to promote the resident's rights of four (4) of eight (8) alert and oriented resident (23, 26, 31, and 58) who attended the Resident Council meeting (meeting held in the facility attended by the residents) reported they were not informed of the State Long Term Ombudsman program (a program consist of resident advocacy group that promotes resident's rights) and/or provided with the telephone numbers and/or email on how to contact the Ombudsman's office. This deficient practice had violated the resident's rights, and a potential not to receive residents' assistance from resident advocacy group should unresolved issues arise in the facility. Findings, On 5/8/24 at 11:43 AM, during the Resident Council meeting and resident group interview with eight alert and oriented residents that attended the meeting, four Residents (Residents 23, 26, 31, and 58) from the group stated they were not aware of what a State Long Term Ombudsman program does and how to contact the Ombudsman's office. All four residents stated it would be helpful to be aware of the role of the Ombudsman and how to contact the Ombudsman office for questions or unresolved issues in the facility. On 5/8/24 at 12:21 PM, during an interview, the Activity Director (AD) stated that residents were notified of the Ombudsman on admission to the facility and during the resident council meeting. The AD further stated the Ombudsman information were posted on the wall in the Activity Room and at the hallway. The AD further stated the facility will ensure the residents will be informed of the Ombudsman program especially for those who do not attend the Resident Council meeting. On 5/8/24 at 1:57 PM, during an interview, the Director of Nursing (DON) stated that it was important for the residents to know the role and the contact information of the ombudsman which was the spokesperson for the residents' concerns. 1. During a review of Resident 23's Record of Admission indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included hypertension (high blood pressure) and hyperlipidemia (a condition in which there are high levels of fat particles [lipids] in the blood). During a review of Resident 23's Minimum Data Set (MDS, a standardized assessment and care-screening tool) dated 3/2/24 indicated the resident usually understood or made self-understood to others and had moderate impairment in cognitive skills (mental action or process of acquiring knowledge and understanding). Resident 23 required substantial/maximal assistance (helper does more than half the effort) from staff for toileting hygiene and personal hygiene. A review of Resident 23's History and Physical dated 5/2/24 indicated the resident has the capacity to understand and make decisions. (continued on next page)

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F 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a review of Resident 26's Record of Admission indicated the resident was originally admitted to the facility on [DATE] with diagnoses that included depression (a common and serious medical illness that negatively affects how the person feels, the way they think and how they act) and hypertension. During a review of Resident 26's MDS, dated [DATE], indicated the resident usually understood or made self-understood to others and had moderate impairment in cognitive skills. Resident 26 required partial/moderate assistance (helper does less than half the effort) from staff for toileting hygiene, shower/bath self, and lower body dressing. A review of Resident 26's History and Physical dated 9/20/23 indicated the resident has the capacity to understand and make decisions. 3. During a review of Resident 31's Record of Admission indicated the resident originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe) and hyperlipidemia. During a review of Resident 31's MDS, dated [DATE], indicated the resident had severely impaired cognitive skills in decision making. Resident 31 required substantial/maximal assistance (helper does more than half the effort) from staff for shower/bathe self, and lower body dressing. A review of Resident 31's History and Physical dated 5/2/24 indicated the resident does not have the capacity to understand and make decisions. 4. During a review of Resident 58's Record of Admission indicated the resident admitted to the facility on [DATE] with diagnoses that heart failure (a chronic condition in which the heart does not pump and fill blood adequately) and adult failure to thrive (unintentional weight loss, a decline in functional abilities, and an overall decline in health status.) During a review of Resident 58's MDS, dated [DATE], indicated the resident usually understood or made self-understood to others and had moderate impairment in cognitive skills. Resident 58 required partial/moderate assistance (helper does less than half the effort) from staff for eating and personal hygiene. A review of Resident 58's History and Physical dated 2/22/24 indicated the resident has the capacity to understand and make decisions. A review of the undated facility's policy and procedure titled, Resident Council, indicated residents have the rights to invite facility staff, families, and the facility designated ombudsman to attend Resident Council meetings and providing feedback on resident grievance and complaint. A review of the undated facility's admission package included a form titled, Resident [NAME] of Rights, indicated a posting of names, addresses, and telephone numbers of all pertinent state client advocacy groups such as the State survey, and certification agency, the State licensure office, the State Ombudsman program, and the protection and advocacy network, and the Patients has the right to voice grievances to facility personnel free from reprisal and can submit complaints to the state (Department of Public Health) or its representative.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47467 Based on interview and record review, the facility failed to maintain a current copy of the resident's Advanced Healthcare Directive (AHCD, a legal document that provide instructions for medical care and only go into effect if you cannot communicate your own wishes) in the resident's medical record for one (1) of one (1) sampled residents (Resident 69). This deficient practice had the potential for Resident 69 to not have her wishes met regarding life-sustaining treatment (any treatment that serves to prolong life without reversing the underlying medical condition). Findings: A review of Resident 69's Admission Record indicated the facility admitted the resident on 5/14/23 with diagnoses that included end stage renal disease (ESRD-occurs when a gradual loss of kidney function reaches an advanced state in which kidneys no longer work as they should to meet the body's needs), type 2 diabetes mellitus (a disease that occurs when the body's blood sugar is too high), weakness, and depression (a constant feeling of sadness and loss of interest, which stops a person doing normal activities). A review of Resident 69's Minimum Data Sheet (MDS, a standard assessment tool that measures health status), dated 2/19/24, indicated Resident 69's cognitive level was cognitively intact (able to process information, remember and reason). The MDS indicated Resident 69 required setup or clean up assistance (helper sets up or cleans up, resident completes activity. Helper assists only prior to or following the activity) in eating, oral hygiene, and needed supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident competes activity. Assistance may be provided throughout the activity or intermittently) in toilet hygiene, upper body dressing and personal hygiene. During an interview on 5/7/24 at 2:37 PM, Resident 69 stated she created a written Advance Healthcare Directive (AHCD) a long time ago. During a concurrent record review and interview on 5/8/24 at 11:07 AM with the Social Service Worker (SSW), Resident 69's AHCD Acknowledgement Form dated 5/15/23 was reviewed. The SSW stated, Resident 69 had an AHCD, and the facility was aware of it since 5/15/23. The SSW stated, AHCD was a legal document which indicated the resident ' s wishes regarding their care so it was it's very important to make sure it was it ' s on file if the resident has an existing AHCD. During a concurrent interview and record review on 5/8/24 at 3 PM, with the SSW, Resident 69 's Social Services Progress notes from admitted [DATE] was reviewed. The SSW stated there was no documentation indicating SSW followed up with Resident 69's family member regarding Resident 69's AHCD. The SSW stated she was aware that Resident 69 had a AHCD since 5/15/23 (one year) (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/9/24 at 3:52 PM, with the Director of Nurses (DON), the DON stated, it is the facility's protocol to keep a copy of the resident's AHCD on file since the AHCD indicated the resident ' s wishes for medical emergencies toward the end of life in case the resident could no longer make medical decisions for themselves. The DON stated it was necessary to keep a copy of residents AHCD in their current medical records. A review of the facility's policy and procedure (P&P) titled, Advance Directives, revised July 2018, indicated the Facility would respect a resident's advance directive and would comply with the resident ' s wishes expressed in an advance directive. The P&P indicated upon admission, the admission staff or designee would obtain a copy of a resident ' s advance directive and a copy of the resident ' s advance directive would be included in the resident ' s medical record. The P&P indicated if the resident had an Advance Directive, the facility shall obtain a copy of the document and place it in the resident's medical record.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44018 Based on observation, interview, and record review, the facility failed to promote resident's rights by failing to maintain privacy for two of 2 sampled residents (Residents 67 and 66) by failing to: 1. During a medication pass observation, Licensed Vocational Nurse 4 (LVN 4) failed to pull the privacy curtain while administering medications to Resident 67. 2. During facility rounds, the privacy curtains were not drawn close, while Resident 66 was using the bedside commode (portable toilet) with her pants down, and Resident 66 could be seen from outside the room by anyone who passed by. This deficient practice had violated resident rights for personal privacy and had the potential to negatively affect the resident's quality of life. Findings: 1. During a review of Resident 67's Record of Admission indicated the resident admitted to the facility on [DATE] with diagnoses that included aphasia (is a disorder that affects how you communicate) and dysphagia (difficulty swallowing foods or liquid) following cerebral infarction (a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it.). During a review of Resident 67's Minimum Data Set (MDS, a standardized assessment and care-screening tool) dated 2/17/24 indicated the resident usually understood or made self-understood to others and had moderate impairment in cognitive skills. Resident 67 required partial/moderate assistance (helper does less than half the effort) from staff for toileting hygiene, shower/bath self, and personal hygiene. A review of Resident 67's History and Physical dated 6/23/23 indicated the resident has the capacity to understand and make decisions. During a review of Resident 67's Order Summery Report with the Report Date on 4/29/24, indicated the resident was ordered for the following medications: 1. Monitor temperature, pulse, respiration, blood pressure, and oxygen saturate and symptoms daily every shift. 2. Carvedilol (medication used to treat high blood pressure) 25 mg (milligrams - unit of measure) one tab, by mouth (PO) two times a day for hypertensive (high blood pressure, give with food. Hold SBP (Systolic blood pressure- the top number measures the pressure in the arteries when the heart beats) less than 110. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a Medication Pass observation on 5/8/24 at 10:38 AM, LVN 4 was observed performing a blood pressure measurement on Resident 67's left upper arm and prepared the Carvedilol 25 mg one tab for Resident 67. The door leading to the hallway was observed open and the curtain was not drawn closed between Resident 67's bed and his roommate. Resident 67's roommate was observed sitting in the wheelchair facing Resident 67. On 5/8/24 at 10:47 AM, during an interview, Resident 67 stated he didn't want other people to know what medications he was receiving. On 5/8/24 at 10:51 AM, during an interview, the LVN 4 stated she should have pulled the curtain to provide privacy to Resident 67. On 5/8/24 at 11:31 AM, during an interview, the Director of Nursing (DON) stated whenever a treatment or care was being done, LVN 4 should have pulled the curtain to provide privacy. LVN 4 violated the residents' rights to privacy. 47882 2. During a review of Resident 66's Record of Admission indicated the resident originally admitted to the facility on [DATE], and readmitted on [DATE] with diagnoses that included dementia (a group of related symptoms associated with an ongoing decline of the brain and its abilities), pulmonary fibrosis (lung tissue becomes damaged and scarred), and disorder of kidney and ureter (organs that collects and drains out urine from the body). During a review of Resident 66's Minimum Data Set (MDS, a standardized assessment and care-screening tool) dated 2/3/2024 indicated cognitive skills (ability to make daily decisions) was intact. Resident 66 required partial/moderate assistance (helper does less than half the effort) with sit to stand and walk 10 feet, supervision or touching assistance (helper provides verbal cues and/or touching/steadying and or contact guard assistance as resident completes activity) with persona hygiene and toileting hygiene. A review of Resident 66's History and Physical dated 5/2/2024 indicated the resident has the capacity to understand and make decisions. During a concurrent observation and interview on 5/6/2024 at 10:25 AM with Licensed Vocational Nurse (LVN) 1, nearby Resident 66's room, Resident 66 was using her bedside commode with her pants down, privacy curtains were not drawn, and Resident 66 could be seen from outside the room by anyone who passed by. LVN 1 stated, we should ensure residents privacy curtain is drawn when she is using her commode, it violates resident rights for privacy and dignity. During a concurrent observation and interview on 5/6/2024 at 10:35 AM with Resident 66 in Resident 66 ' s room, observed Resident 66 with frowned facial expression (the eyebrows are brought together, and the forehead is wrinkled, usually indicating displeasure, sadness or worry), stated, it is just hard for me to go around and draw the curtain when I used the bedside commode. A review of Resident 66's care plan (CP) titled bowel and bladder need assistance with toileting initiated on 5/9/2023, indicated to always treat resident with respect and dignity. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 66's care plan (CP) titled ADL self-care deficit related to impaired balance, limited mobility initiated 11/2/2023, the CP indicated to monitor/document/report as needed any changes, any potential for improvement, reasons for self-care deficit, expected course and decline for function, monitor ADL (activity of daily living) needs, and assist with ADL as needed. During an interview on 5/9/2024 at 7:28 AM with Director of Nurses (DON), stated, When a resident is using a bedside commode, I expect the facility nurse to ensure the privacy curtains are drawn, because the resident may feel embarrassed, as it violates resident rights for personal privacy and dignity. A review of the facility's policy and procedure (P&P) titled, Resident Rights - Quality of Life revised 3/2017, indicated, each resident shall be cared for in a manner that promotes and enhances the quality of life , dignity, respect, individuality and receives services in a person-centered manner, as well as those that support the resident in attaining or maintaining his/her highest practicable wellbeing. The P&P indicated, facility staffs promote, maintains, and protect resident privacy, when assisting with personal care and during treatment procedures.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47882 Based on observation, interview, and record review, the facility failed to develop a person-centered comprehensive care plan to address the resident's medical and physical needs for one of one sampled resident (Resident 28), had a physician order to receive Amoxicillin-Pot Clavulanate (a medication used to treat bacterial infections) tablet and Tylenol (medication used for aches and pains) tablet for tooth infection and tooth pain on 5/6/2024. This deficient practice had the potential to affect Resident 28's quality of care and quality of life by not receiving the appropiate interventions for the dental care. Findings: A review of Resident 28's Admission Record indicated the resident was admitted to the facility on [DATE], with diagnoses that included cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area) with hemiplegia (paralysis that affects one side of your body) and hemiparesis (weakness or the inability to move on one side of the body) affecting the right side, dysphagia (difficulty swallowing) and diabetes (lifelong condition that causes a person's blood sugar level to become too high). A review of the Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 4/17/2024, indicated Resident 28 ' s cognitive skills (ability to make daily decisions) was intact. The MDS indicated Resident 28 required set up or clean-up assistance (helper sets up or clean up resident; resident completes activity. Helper assists only prior to or following the activity) with eating and oral hygiene, substantial/maximal assist (helper does more than half the effort) with bathing and personal hygiene, and dependent (helper does all the effort) with toileting. A review of Resident 28's facility document titled Change of Condition Evaluation (COC) dated 5/6/2024, the COC indicated the resident complained of toothache and swollen gums (pink tissues in the upper and lower jaws that surround the base of your teeth). The COC indicated the PCP (Primary Care Physician) was made aware with an order for Amoxicillin-Pot Clavulanate twice a day for seven days and Tylenol every six hours for three days. A review of Resident 28's Physician Order dated 5/6/2024, indicated to give Amoxicillin-Pot Clavulanate tablet 875-125 mg (milligram) (unit of measurement) two times a day for toothache with swollen gums for 1 week, and Tylenol oral tablet 325 mg every six hours for tooth ache with swollen gums for three days. During a concurrent interview and record review, on 5/8/2024, at 9:45 AM, with the Director of Nurses (DON) and Minimum Data Set Nurse (MDSN), Resident 28's electronic medical record (EMR -a collection of medical information about a person that is stored on a computer) care plans was reviewed. The EMR did not indicate a plan of care was done for Resident 28's toothache, new order for Amoxicillin-Pot Clavulanate and the Tylenol. The DON stated, the care plan should have been initiated after the COC on 5/6/2024. MDSN stated, she did not know why the care plan was not initiated because a care plan should be initiated for any change of condition. (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 concurrent observation and interview on 5/8/2024 at 10:20 AM with Resident 28 in the hallway, the resident was observed with right upper and lower gums swollen. Resident 28 stated, the resident had trouble eating yesterday because of toothache. During a concurrent interview and record review, on 5/8/24, at 3:30 PM, Resident 28 facility document percentage of meal eaten (PME), dated 5/7/2024, was reviewed with the DON. The PME indicated, one entry for breakfast of 26% to 50% intake, no entry for lunch and dinner. The DON stated, Resident 28 possibly refused her lunch and dinner due to her toothache. During a review of Resident 28's care plan (CP), initiated 1/10/2022, the CP indicated risk for alteration in nutritional status due to dysphagia and diabetes, with a goal for resident to consume 80% to 100% of meals without any sign or symptoms of unplanned weight loss/gain in 3 months. The CP interventions included encourage food intake /diet as ordered. During an interview on 5/9/2024 at 7:57 AM with the DON, the DON stated, a person-centered care plan should be started immediately for residents who had a change of condition such as toothache and tooth infection to meet the health and safety of residents. The DON stated that residents who had toothaches had the potential to have difficulty taking oral diet and has potential for weight loss. A review of the facility's policy and procedure (P&P) titled, Comprehensive Person-Centered Care Planning, revised on 11/2018, indicated; a) facility is to provide person-centered, comprehensive and interdisciplinary care that reflects best practice standards for meeting health, safety, psychosocial, behavioral, and environmental needs of residents in order to obtain and maintain the highest physical, and mental, and psychosocial well-being, b)additional changes or updates the residents comprehensive care plan will be base on the assessed needs of the resident, and c) comprehensive care plan will be reviewed and revised at onset of new problems and change of condition.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47882 Based on observation, interview, and record review, the facility failed to implement a post fall intervention for one of two sampled residents (Resident 13) who was at high risk for fall, by not having a bed alarm (alarms to alert staff to respond quickly and intervene to assist the patient, thus preventing a fall) and bilateral floor mats (placed adjacent to the bed may prevent injury for those prone to rolling out of bed) placed as indicated in the resident's plan of care. This deficient practice had the potential for Resident 13 to have a recurrent fall that could cause serious injury and compromise the resident's well being. Findings: A review of Resident 13's admission record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included generalized muscle weakness, cervical disc disorder with radiculopathy (nerve compression in the neck, leading to pain, numbness, and weakness in specific areas), and anxiety disorder (feeling of unease, such as worry or fear, that can be mild or severe). A review of Resident 13's History and Physical Examination, dated 4/1/2024, indicated Resident 13 has the capacity to understand and make decisions. A review of Minimum Data Set (MDS, a standardized assessment and care screening tool), date 4/7/2024, indicated Resident 13 ' s cognitive skills (ability to make daily decisions) was mildly impaired. The MDS indicated Resident 13 required set up or clean-up assistance (helper sets up or clean up resident; resident completes activity. Helper assists only prior to or following the activity) with eating, partial/moderate assistance (helper does less than half the effort) with oral hygiene, and substantial/maximal assist (helper does more than half the effort) with upper body dressing. During a concurrent observation and interview on 5/8/2024 at 1:24 PM, Resident 13 lying in bed in his room and was able to move both upper extremities (arm, forearm, wrist, and hand) and turn left and right using bilateral bed grab bars (grab handles can be used by people who need help when getting in and out of bed). Resident 13 stated, I had a fall incident before, but I don ' t remember when. A review of Resident 13 titled Change of Condition Evaluation (COC), dated 3/8/2023, the COC indicated Resident 13 was heard calling for help and was found on the footrest of his wheelchair. The COC indicated, per Resident 13, he was trying to walk and slid out of the wheelchair. A review of Resident 13 facility document titled Fall Risk Evaluation (FRE) dated 3/29/2023 (Resident 13 readmitted), the FRE indicated Resident 13 was at risk for fall. A review of Resident 13 facility document titled Fall Risk Evaluation (FRE), dated 3/31/2024, the FRE indicated Resident 13 was at high risk for fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 13 care plan (CP), revised 1/17/2024, indicated Resident 13 ' s fall risk due to decreased functional mobility without physical therapy intervention, fall actual found on sitting position on the wheelchair footrest on 3/8/23, The CP revised on 4/1/2024, indicated the CP goal was to minimize incident of falls daily for 90 days. The CP interventions included to keep bed alarm to alert staff and bilateral floor mats. During a concurrent observation and interview on 5/8/2024 at 2:04 PM with Licensed Vocational Nurse (LVN) 5 in Resident 13's room, Resident 13 ' s bed did not have a bed alarm, and there were no bilateral floor mats on the side of the bed. LVN 5 stated, the care plan fall risk intervention was for Resident 13 to have bed alarm and bilateral floor mats, so Resident 13 should have it. LVN 5 stated, Resident 13 not having bed alarm and bilateral floor mats puts Resident 13 at risk for fall. Resident 13 stated, having a bed alarm and bilateral floor mats was ideal for his safety. During an interview on 5/9/2024 at 7:47 AM, the DON stated, the care plan for fall prevention for Resident 13 should have been implemented, especially Resident 13 who was high risk for fall. A review of the facility's policy and procedure (P&P) titled, Fall Management Program, 3/13/2021, indicated: a) The facility to provide residents a safe environment that minimizes complications associated with falls. b) Fall risk factor is identified, document interventions on the residents care plan. c) The Interdisciplinary team (IDT) and/or the licensed nurse will develop a care plan according to the identified risk factors and root cause(s) per care area assessment guidelines.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44018 Based on observation, interview and record review the facility failed to ensure the resident was free from significant medication error by not omitting Carvedilol (medication used to treat high blood pressure) during medication pass observation for one of five (Resident 67) sampled residents. This deficient practice had the potential to cause complications of hypertension hypertension (high blood pressure) and lead to heart attack (lack of blood flow to the heart), heart failure(failure of the heart to meet the body's demand) and stroke-poor blood flow to the brain results in cell death). Findings: On 5/8/24 at 9:01 AM, during a Medication Pass (Med Pass) observation, conducted with Licensed Vocational Nurse 4 (LVN 4) at Nursing Station 3, LVN 4 prepared and administered the following medications to Resident 67 orally (by mouth): 1. Colace 100 MG (milligrams - unit of measure) one capsule (for bowel management). 2. Lisinopril 40 MG one tablet (for hypertension). 3. Nifedipine ER Osmotic Release 30 MG one tablet (for hypertension) 4. Clonidine HCl 0.3 MG one tablet (for hypertension) During an interview after completing the Med Pass for Resident 67 on 5/8/24 at 9:18 AM, LVN 4 stated she had four medications in the medicine cup for Resident 67. During a review of Resident 67's Record of Admission indicated the resident admitted to the facility on [DATE] with diagnoses that included aphasia (is a language disorder that affects how you communicate) and dysphagia (difficulty swallowing foods or liquid) following cerebral infarction (a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it.). During a review of Resident 67's Minimum Data Set (MDS, a standardized assessment and care-screening tool) dated 2/17/24 indicated the resident usually understood or made self-understood to others and had moderate impairment in cognitive skills. Resident 67 required partial/moderate assistance (helper does less than half the effort) from staff for toileting hygiene, shower/bath self, and personal hygiene. During a review of Resident 67's History and Physical dated 6/23/23 indicated the resident has the capacity to understand and make decisions. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 67's May 2024 Order Summary (a physician's order) record and concurrent interview with LVN 4, on 5/8/24 at 10:24 a.m., the Order Summery Report indicated Resident 67 was ordered by the physician to administer Carvedilol 25 mg (a medication used to lower blood pressure) one tablet for hypertension (a condition of having high blood pressure). LVN 4 reviewed the Order Summary and stated Resident 67 was scheduled to have five medications administered at 9 a.m., LVN 4 stated that she omitted Carvedilol 25mg and was not given to Resident 67. LVN 4 stated it was important to administer antihypertensive medication as prescribed by the doctor to effectively managed Resident 67's high blood pressure. During an interview with the Director of Nursing (DON) on 5/8/24 at 11:31 AM, the DON stated it was important to take Carvedilol on time to help lower blood pressure and reduce the chances of having blood pressure related health problems such as heart disease or stroke (an interruption of blood flow to the brain). A review of the facility's policy and procedures titled, Monitoring of Medication Administration, date 5/2022, indicated, Medications are administered at the frequency and times indicated in the prescriber orders, verification of current orders for medication given, and identification of any orders omitted.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44018 Based on observation, interview, and record review the facility failed to ensure proper storage of medications and/or treatment supplies for one of one sampled residents (Resident 26) who was observed with opened tube of Fluocinonide (medication used to treat many skin disorders), opened tube of hydrocortisone (medication used to help relieve redness, itching, swelling, or other discomfort caused by skin condition), and unopened tube of Ketoconazole (used to treat fungal skin infection) in the wash basin on Resident 26's bedside table. These deficient practices had the potential for other residents to use medications that could cause cross contamination of infection and/ or consume by other residents with cognitive impairment that could be harmful to their wellbeing. Findings, During an initial facility tour with Licensed Vocational Nurse 2 (LVN 2), on 5/7/24 at 10:22 AM, three medications tubes were observed in the wash basin on top of Resident 26's bedside table: Fluocinonide (missing the cap), Hydrocortisone (missing the cap) and the unopened tube of Ketoconazole. In a concurrent interview LVN 2 stated the medications should not have been left on the bedside table of Resident 26 and should have capped them if they were to be used again because of infection control purposes. LVN 2 stated that the Treatment Nurse (TN) probably forgot to put them away after providing skin treatment to Resident 26. During a review of Resident 26's Record of Admission indicated the resident was originally admitted to the facility on [DATE] with diagnoses that included depression (a common and serious medical illness that negatively affects how the person feels, the way they think and how they act) and hypertension. During a review of Resident 26's Minimum Data Set (MDS, a standardized assessment and care-screening tool) dated 2/17/24 indicated the resident usually understood or made self-understood to others and had moderate impairment in cognitive skills. Resident 26 required partial/moderate assistance (helper does less than half the effort) from staff for toileting hygiene, shower/bath self, and lower body dressing. A review of Resident 26's History and Physical dated 9/20/23 indicated the resident has the capacity to understand and make decisions. A review of Resident 26's monthly physician's order for May 2024 indicated the resident was ordered for Fluocinonide on 2/9/24 to apply to scalp; Hydrocortisone on 6/1/23 to apply to buttock topically as needed for itchiness; and Ketoconazole on 1/12/24 to apply scalp for Seborrheic Dermatitis (skin condition that cause scaly patches, red skin, mainly on the scalp) wash scalp. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 5/7/24 at 3:18 PM, the Treatment Nurse 1 (TXN 1) stated that the Fluocinonide and Hydrocortisone should be covered with caps, or they were exposed to potential contaminant. TXN 1 stated he should put away Fluocinonide, Hydrocortisone, and Ketoconazole tubes back in the treatment cart for storage and not left at the bedside because the risk of infection and improper storage of supplies. A review of the facility's policy and procedure titled, Disposal of Medication and Medication Related Supplies, dated May 2022, indicated medications are removed from the medication cart or active supply immediately upon receipt of an order to discontinue (to avoid inadvertent administration). Medications awaiting disposal or return are stored in a locked secure area designated for that purpose until destroyed or picked up by pharmacy.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 47467 Based on observation, interview, and record review, the facility failed ensure one of two sampled residents (Resident 55) with history of weight loss was assessed and served food that the resident preferred. This failure had a potential to result in Residnet 55's continued or recurrent weight loss due to that could result in a decline in the resident's well being due to not receiving food items of her choices. Findings: A review of Resident 55's Admission Record indicated the facility admitted the resident on 3/27/24 with diagnoses that included type 2 diabetes mellitus (a disease that occurs when the body ' s blood sugar is too high) and protein-calorie malnutrition (a serious condition happens when a person ' s diet does not contain the right amount of nutrients), and muscle weakness. A review of Resident 55's Minimum Data Sheet (MDS, a standard assessment tool that measures health status), dated, indicated Resident 55's cognitive level was cognitively intact (able to process information, remember and reason), needed supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident competes activity. Assistance may be provided throughout the activity or intermittently) in eating, oral hygiene, upper body dressing, personal hygiene, and needed moderate assistance (helper does less than half the effort) in toileting hygiene, and shower. A review of Resident 55's History and Physical, dated 4/1/24, indicated Resident 55 had the capacity to understand and make decisions. A review of Resident 55's Care Plan, dated 3/29/24, indicated Resident 55 was at risk for impaired nutrition and the interventions included to encourage the resident participation in meal planning. A review of Resident 55's Care Plan, dated 3/28/24, indicated Resident 55 had nutritional problem or potential nutritional problem such as weight loss and dehydration (not sufficient fluid in the body) related to diet restrictions on therapeutic (medically prescribed) diet and the goal was to maintain adequate nutritional status as evidenced by maintaining the body weight. A review of Resident 55's Care Plan, dated 4/4/24, indicated Resident 55 had unplanned/unexpected weight loss related to variable intake of 26-100 percents and the interventions included to offer substitutes as requested. A review of Resident 55's Nutrition/Dietary Note, dated 5/6/24 at 2:26 PM, indicated Resident 55 had five (5) pounds or 5.3 percent weight loss in the last thirty (30) days. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and concurrent interview with Resident 55, on 5/7/24 at 1PM, Resident 55 stated, the facility's staff never asked what her food preferences were. Resident 55 stated, the facility usually brought her a lot of food that she did not like during mealtimes and told her to eat as much as she could. Resident 55 stated, she requested for food alternative before but was told that it was the facility's protocol that everyone had the same food. Resident 55 stated, she had been consuming about twenty percent of her food plates during mealtimes. During an interview on 5/9/24 at 1:30 PM with the Dietary Supervisor (DS), the DS stated, all residents must be screened for food preferences upon admission, and the information must be documented in the resident's record titled Profile. During a concurrent record review and interview on 5/9/24 at 3:52 pm with the Director of Nurses (DON), Resident 55's Profile record dated 3/29/24 was reviewed. The record indicated, the document was completed and signed by the DS on 5/7/24. The DON stated, he did not have any document to prove that the dietary assessment for likes and dislikes food was completed on 3/29/24 for Resident 55 by the DS. The DON stated it is the facility ' s protocol to respect the right of the resident for food preferences and failure to assess for food preferences upon admission could result in resident ' s risk for weight loss because of serve food not from resident' s liking list. A review of the facility's policy and procedure (P&P) titled, Dietary Profile and Resident Preference Interview, revised 4/21/22, indicated the following: 1. The Dietary Manager will complete a Dietary Profile for residents within 72 hours of admission to capture and update information regarding nutritional needs and preferences: Obtain the information requested on the Dietary Profile from the resident ' s medical record and resident interview. 2. The Dietary Department will provide residents with meals consistent with their preferences. If a preferred item is not available, a suitable substitute should be provided. 3. The Dietary Manager will sign and date the Dietary Profile on the date of completion.

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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. 46779 Based on observation, interview and record review, the facility failed to ensure Dietary Aide (DA) 1 washed her hands properly before touching the clean dishes after sorting the dirty dishes in a dish rack and pushing the dish rack into the dish washer. This deficient practice had the potential to cause food-borne illnesses (diseases are caused by eating food contaminated with bacteria, viruses, parasites or chemical substances) to the residents. Findings: During an observation on 5/6/24 at 9 AM, DA 1 was wearing a pair of vinyl exam gloves while sorting the dirty dishes on the counter on the left side of the dishwasher. After DA 1 put the dirty dishes on the dish rack and push the dish rack into the dishwasher, DA 1 dipped her hands with the vinyl exam gloves on into a red bucket with clean solution in it. Then, DA 1 took her hands with the gloves on out of the red bucket and touched the clean dishes on a dish rack. DA 1 moved the clean dishes on the dish rack to the drying cart. During a concurrent observation and interview on 5/6/24 at 9:01 AM with DA 1, DA 1 stated she washed her hands by dipping into the solution in the red bucket. DA 1 removed the gloves and dipped her hands into the solution in the red bucket. DA 1 stated the solution in the red bucket was the sanitizer solution for cleaning kitchen equipment. During an interview on 5/6/24 at 9:02 AM with DA 3, DA 3 stated the solution in the red bucket was the sanitizer solution for cleaning kitchen equipment, but it should not be used for cleaning hands. DA 3 stated the DA 1 should wash hands with soap and water after touching dirty dishes and before touching clean dishes. During an interview on 5/6/24 at 9:03 AM with DA 1, DA 1 stated she was busy, and she thought it would be faster to clean her hand by wearing gloves and dipping her hands into the sanitizer solution in the red bucket. DA 1 stated she should wash her hands with soap and water before touching the clean dishes to prevent residents contracting illness. During an interview on 5/6/24 at 9:15 AM with the Dietary Supervisor (DS), the DS stated the solution in the red bucket was the sanitizer solution used to clean kitchen equipment. The DS stated the dietary staff should not use it to clean hands. The DS stated the dietary staff should wash hands properly after they touched dirty dishes and before touching the clean dishes to prevent foodborne illness to the residents. During a review of the facility ' s policy and procedure titled, Dietary Department-Infection Control for Dietary Employee, dated 11/9/16, indicated proper handwashing by personnel will be done immediately before engaging in food preparation, including working with clean equipment and utensils and after handling soiled equipment or utensils.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 46779 Based on observation, interview, and record review, the facility failed to ensure one of two outdoor refuse containers (a waste container that a person controls that includes dumpsters, trash cans, garbage pails, and plastic trash bags) was placed in covered garbage cans. This failure had the potential to attract insects and harbor rodents and pests in the refuse area that can cause a wide spread of diseases and affect the residents, staff, and visitors. Findings: During a concurrent observation and interview on 5/6/24 at 9:05 AM, with Dietary Aide (DA) 2 at the facility's parking lot, the outdoor refuse container was observed with no secured lid covered. The open refuse container was one-third full, filled with several closed plastic bags of garbage and a foam plate with food items lying on top of the garbage bags. DA 2 stated the lid of the refuse container should be closed at all times. DA 2 stated she would report to the Maintenance Supervisor (MS). During an interview on 5/6/24 at 9:31 AM with the MS, the MS stated he was notified by the dietary staff that the lid of the outdoor refuse container was not closed just now. The MS stated the lid of the refuse container should be closed at all times to prevent infestation of insects and rodents, and to prevent illness to the residents, staff and visitors. During a review of the facility ' s policy and procedure titled, Garbage and Trash Can Use and Cleaning, dated 10/1/14, indicated, food waste will be placed in covered garbage and trash cans.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47882 Based on interview, and record review, the facility failed to ensure three of three sampled Residents (Residents 89, 77, and 193) were informed and verbalized understanding of the concept of the proposed arbitration (solving disputes with a neutral third party instead of the court) and the Binding Arbitration Agreement (BAA, a binding agreement by the parties to submit to arbitration all or certain disputes between them in respect of a defined legal relationship, whether contractual or not) before having Residents 89,77, and 193 signed and entered into a binding arbitration agreement. The deficient practice resulted in Residents 89, 77, and 193 unknowingly giving up their right to resolve any disputes with the facility through a court of law before a jury. Findings: During an interview on 5/9/2024 at 11:02 AM with Admission Director (AD), AD stated she was responsible for explaining and obtaining the BAA to the residents upon admission. The AD stated if the BAA was signed by the resident, the BAA was effective immediately. 1. A review of Resident 89's admission record indicated the resident was admitted to the facility on [DATE] with diagnoses that included bicondylar fracture of the right tibia (break of the upper part of the shinbone), generalized muscle weakness, and benign prostatic hyperplasia (an enlarged prostate). A review of Resident 89's History and Physical Examination, dated 4/21/2024, indicated Resident 89 had the capacity to understand and make decisions. A review of Minimum Data Set (MDS, a standardized assessment and care screening tool), date 4/27/2024, indicated Resident 89's cognitive skills (ability to make daily decisions) was intact. During a concurrent interview and record review on 5/9/2024 at 12:45 PM with Resident 89, Resident 89's BAA, dated 4/21/2024 was reviewed. Resident 89 stated, the document was not thoroughly explained to him. Resident 89 stated he thought the BAA was just a first step to settle dispute with the facility, and he can still go to court if the dispute was not settled. Resident 89 stated, he was still having discomfort when he was initially admitted to the facility and did not understand much about what he signed. 2. A review of Resident 77's admission record indicated the resident was admitted to the facility on [DATE] with diagnoses that included displaced comminuted supracondylar fracture (bone can crack just slightly or break into many pieces) of the humerus (upper arm bone), generalized muscle weakness, and osteoporosis (porous bone). A review of Resident 77's History and Physical Examination, dated 2/19/2024, indicated Resident 77 had the capacity to understand and make decisions. (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 4/7/2024, indicated Resident 77's cognitive skills (ability to make daily decisions) was mildly impaired. During a concurrent interview and record review on 5/9/2024 at 1PM with Resident 77, Resident 77's signed BAA, dated 1/1/2024 was reviewed. Resident 77 stated, she was not aware that she signed the BAA document, she did not remember agreeing to it the agreement. Resident 77 stated, she does not remember that the BAA was thoroughly explained to her upon admission. 3. A review of Resident 193's admission record indicated the resident was admitted to the facility on [DATE] with diagnoses that included right ankle and foot Charcot ' s joint (degeneration of foot and ankle), osteomyelitis (inflammation or swelling of bone tissue that is usually the result of an infection), and generalized muscle weakness. A review of Resident 193 ' s History and Physical Examination, dated 3/4/2024, indicated Resident 193 had the capacity to understand and make decisions. A review of the MDS, dated [DATE], indicated Resident 193 ' s cognitive skills (ability to make daily decisions) was intact. During a concurrent interview and record review on 5/9/2024 at 1:15 PM with Resident 193, Resident 193's signed BAA document, dated 2/23/2024 was reviewed. Resident 193 stated, she was not aware that by signing the BAA, she was giving up her right to settle dispute in a court of law before a jury. Resident 193 stated, when the BAA was given to her to sign, she was not aware it was a BAA because it was not explained to her, she thought it was just required papers to sign upon admission to the facility. Resident 193 stated, she was having discomfort upon admission to the facility when the BAA was signed, if it was explained to her better, she would have not signed it. During an interview on 5/9/2024 at 1:49 PM with AD, AD stated, she thought the BAA was just a first step to settle dispute between the facility and the residents, and thought, the resident who signed it still has the right to settle dispute in the court of law before the jury. AD stated, the BAA was not explained clearly, which violates resident rights. A review of facility document Binding Arbitration Agreement(BAA), revised 10/5/2020, tindicated in Article 1, 1.1 both parties to this contract , by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. A review of the facility's policy and procedure (P&P) titled, Arbitration Agreement, revised 5/25/2023, the P&P indicated, if the Facility presents an arbitration agreement to a Resident, the person presenting the arbitration agreement will: a) Explain the agreement to the Resident in a form and manner that they understand, and including the language the Resident understands; and b) confirm that the resident understands the agreement.

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	055664	A. Building B. Wing	05/09/2024

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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** 46779 Based on interview and record review, the facility staff failed to ensure one of two sampled residents (Resident 288) who was receiving hospice care services (hospice care is a type of health care that focuses on the palliation of a terminally ill patient's pain and symptoms and attending to their emotional and spriritual needs at the end of life) collaborated with hospice agency on the resident's plan of care by ensuring the plan of care was in the resident's medical record binder. This deficient practice had he potential to result in a delay or lack of coordination in delivery of hospice care and services to Resident 288. Findings: During a review of Resident 288's Admission Record indicated the facility originally admitted Resident 288 on 11/6/21 and readmitted on [DATE] with diagnoses that included encephalopathy (a disorder of brain function that often impairs consciousness) and fall. During a review of Resident 288's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 3/28/24, indicated Resident 288 was assessed with severely impaired memory and cognition (ability to think and reason). The MDS indicated Resident 288 required setup or clean-up assistance with eating and oral hygiene, partial/moderate assistance with toileting hygiene and personal hygiene, and substantial/maximal assistance with shower/bathe self, sit to lying, sit to stand, chair/bed-to-chair transfer, and toilet transfer. During a review of Resident 288's Order Summary Report, dated 4/29/24, indicated Resident 288 was admitted to hospice under routine level of care for terminal diagnosis of acute respiratory failure (a life-threatening condition that the lungs and the body could not get enough oxygen). During a review of Resident 288's Care Plan, dated 4/24/24, indicated the CP addressed the resident having a terminal prognosis related to the resident being admitted to hospice and the interventions including working cooperatively with hospice team to ensure the resident ' s spiritual, emotional, intellectual, physical and social needs are met. During an interview and record review on 5/8/24 at 1:25 PM with Registered Nurse (RN) 1, Resident 288's hospice binder was reviewed. RN 1 stated she had only been working in the facility for a few months and she was not clear about the collaboration between the facility and the hospice. RN 1 stated the hospice nurses came to the facility to visit Resident 288 once a week. RN 1 stated the facility nurses and the hospice staffs should communicate about the resident's care through the plan of care placed in the Hospice Binder. During a review of the Hospice Binder with RN 1, RN 1 stated she was unaware that the hospice licensed nurses visited Resident 288 twice a week rather than once a week. RN 1 stated there was no plan of care in Resident 288's Hospice Binder, and she would not know what care the hospice nurse would provide to Resident 288 and what the frequency of the visit from the hospice nurse would be. RN 1 stated the hospice plan of care should be kept in the Hospice Binder to ensure the delivery of the coordinated and consistent care to Resident 288. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/8/24 at 1:40 PM with the Social Services Supervisor (SSS), the SSS stated she did not have the hospice plan of care in Resident 288 ' s medical record and the hospice plan of care should be kept in the resident's medical record or hospice binder to ensure a good communication and collaboration between the facility staff and the hospice staff to provide consistent care to Resident 288. During an interview on 5/8/24 at 4:15 PM with the Director of Nursing (DON), the DON stated the facility did not have Resident 288's hospice plan of care in the medical record or the hospice binder. The DON stated the hospice plan of care should be kept in Resident 288's hospice binder and readily available for review, so the facility staff and the hospice staff would maintain a good communication and ensure coordinated and timely care to Resident 288. During a review of the updated facility's policy and procedure titled, Hospice and Nursing Facility Services Agreement, indicated hospice and facility each shall maintain a copy of each Patient's plan of Care in the respective clinical records maintained by each Party. During a review of the facility ' s policy and procedure titled, Hospice Care of Residents, dated 1/1/12, indicated Facility and Hospice Staff will collaborate on a regular basis concerning the resident's care and All documentation concerning hospice services will be maintained in the resident's medical record.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 47467 Based on observation, interview, and record review, the facility failed to ensure the facility staffs implemented the facility's policy and procedure titled Resident Isolation - Categories of Transmission-Based Precautions (precautions to prevent spread of infection) to wear isolation gown when taking care of one of two sampled residents (Resident 55). Resident 55 was ordered by the physician to be placed on contact isolation (precautions steps that healthcare facility visitors and staff need to follow before going into a patient's room, used for patients with diseases caused by bacteria and virus that are spread through direct and indirect contact). This failure had a potential to result in the spread of infection to the facility's staffs and residents and could cause a decline in other residents' health. Findings: A review of Resident 55 ' s Admission Record indicated the facility admitted the resident on 3/27/24 with diagnoses that included Methicillin Resistant Staphylococcus Aureus Infection [MRSA, a staphylococcus bacteria (a type of germ) that is resistant to certain antibiotics that usually cure staphylococcus infections], type 2 diabetes mellitus (a disease that occurs when the body ' s blood sugar is too high), protein-calorie malnutrition (a serious condition happens when a person ' s diet does not contain the right amount of nutrients), and muscle weakness. A review of Resident 55 ' s Minimum Data Sheet (MDS, a standard assessment tool that measures health status), dated, indicated Resident 55 ' s cognitive level was cognitively intact (able to process information, remember and reason), needed supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident competes activity. Assistance may be provided throughout the activity or intermittently) in eating, oral hygiene, upper body dressing, personal hygiene, and needed moderate assistance (helper does less than half the effort) in toileting hygiene, and shower. A review of Resident 55's History and Physical, dated 4/1/24, indicated Resident 55 had the capacity to understand and make decisions. A review of Resident 55's Order Summary Report, dated 5/1/24, indicated Resident 55 had a physician order started on 3/27/24 for contact isolation due to MRSA of the right hip wound. A review of Resident 55's Care plan, dated 3/28/24, indicated Resident 55 had MRSA of right hip wound and the interventions included contact isolation with instructions to wear gowns and masks when changing contaminated linens. During a concurrent observation and interview on 5/8/24 at 3:50 PM, with Certified Nurse Assistant (CNA) 4, CNA 4 was observed changing Resident 55's brief and linens with no gown on. CNA 4 stated, she was helping Resident 55 changing her soiled brief and linens. CNA 4 stated, Resident 55 was on contact isolation because of her infectious wound on her right hip. CNA 4 stated, I forgot to gown up, I ' m so sorry. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/8/24 at 3:58 PM, with the Director of Nurses (DON), the DON stated, if a resident is on contact isolation, the staff needs to strictly follow the protocol to gown up. The DON stated failure to follow the facility ' s protocol could pose a risk for contamination and a break in the infection control process, which could spread the infection to the staffs and other residents in the facility. During an interview on 5/9/24 at 1:43 PM, with Infection Prevention Nurse (IPN), the IPN stated, any resident with MRSA is placed on contact isolation and she expects the facility staff to follow the facility ' s protocols for it. The IPN stated, all staffs need to wear gloves and gown before going to the resident ' s room to prevent further transmission of the infection to other residents. The IPN added, there is a possibility of spreading MRSA infection to other residents and staff and cause a potential risk of decline in other residents' health. A review of the facility's policy and procedure (P&P) titled, Resident Isolation - Categories of Transmission-Based Precautions, dated 1/1/12, indicated the following for Contact Precautions: -Contact precautions are implemented for residents known or suspected to be infected or colonized with microorganisms that are transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident ' s environment. Examples of infections requiring Contact Precautions include wound infections or colonization with multi-drug resistant organisms (e.g, MRSA). -Gown is worn for interactions that may involve contact with the resident or potentially contaminated items in the resident ' s environment. -After removing gown, clothing is not allowed to contact potentially contaminated environmental surfaces.

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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** 47882 Based on observation, interview and record review, the facility failed to ensure the room space were at a minimum of 80 square feet (Sq. Ft.- a unit of measurement) for 2 out of 42 residents rooms (Rooms 25 & 26). The two resident rooms consisted of two beds each. room [ROOM NUMBER] was not occupied by a resident and room [ROOM NUMBER] was occupied by Resident 82. This deficient practice had the potential to negatively impact the quality-of-care and the ability of the nursing care to safely provide care and privacy to the residents. Findings: During an interview with the Administrator (ADM) on 5/7/2024 at 8:15 AM, he stated multiple rooms in the facility did not have the required 80 square feet of space per resident, but the facility has a room waiver (a permit approved by Centers for Medicare & Medicaid Services for rooms that did not meet the regulation requirement) in place and will request an additional waiver for this year. The ADM stated the room size had no impact on care of the residents. The ADM provided the Client Accommodation Analysis (CAA-document provided by the facility that included the room sizes in the facility) with current census. The ADM confirmed there was only one resident in room [ROOM NUMBER] and room [ROOM NUMBER] was unoccupied. A review of the Facility's Client Accommodations Analysis form date 5/6/2024, indicated the facility had two rooms that measured less than the required 80 square footages per resident in multiple bedrooms. A review of the facility's request for the room waiver dated 5/7/2024 indicated the variance will not compromise the health, welfare, and safety of the residents. The following resident bedrooms were: Room # # of beds # of residents Sq. Ft Sq. Ft. per resid room [ROOM NUMBER] 2 beds 1 residents 156 78 room [ROOM NUMBER] 2 beds unoccupied 156 78 During an interview on 5/7/2024 at 8:45 AM, the Assistant Director of Nurses (ADON) stated. the facility usually uses rooms [ROOM NUMBERS] for residents that needed to be on isolation or fall monitoring, and it is usually occupied by one resident at a time. During an observation on 5/7/2024 at 12:08 PM in rooms [ROOM NUMBERS], room [ROOM NUMBER] was occupied by Resident 82 who was observed sitting in a wheelchair, and room [ROOM NUMBER] was closed and there were no residents. A review of Resident 82's Minimum Data Set (MDS- a resident assessment and care planning too) dated 4/8/24, Resident 82 was admitted on [DATE] with diagnoses that included hypertension (high blood pressure). The MDS indicated Resident 82 had no cognitive (ability to process information) impairment. (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	During a concurrent observation and interview on 5/7/2024 at 12:10 PM, with Resident 82 in Resident 82's room (room [ROOM NUMBER]), Resident 82 was on a wheelchair, there was no clutters, resident able to move freely. Resident 82 stated, she had no issues about the room size, and the nurses are able to move around the room to care for her. During an interview on 5/7/2024 at 2:25 PM, with Licensed Vocational Nurse (LVN) 4, LVN 4 stated, Resident 82 was able to move around in her room without difficulty. LVN 4 stated, she was able to care for resident 82 in her room without issues. During an interview on 5/7/2024 at 2:40 PM, with certified nurse assistant (CNA) 1, CNA 1 stated, he had enough space in Resident 82's room to give her care. During the recertification survey from 5/6/2024 to 5/9/2024, there were no observed adverse effects as to the adequacy of space, nursing care, comfort, and privacy to the residents. The resident residing in the affected rooms with an application for variance were observed to have enough space to move freely inside the rooms. The resident inside the affected rooms had beds and side tables. There was an adequate room for the operation and use of the wheelchairs, walkers, or canes. The room variance did not affect the care and services provided to the residents when nursing staff were observed providing care to the residents. The facility indicated on the Room Waiver Request the rooms have enough space to provide for each resident's care, dignity, and privacy. The rooms are in accordance with the special needs of the residents and do not have any adverse effect on the residents' health and safety or impede the ability of any residents in the above listed room to attain his/her highest practicable wellbeing. The Department recommends the waiver of the rooms.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 47467 Based on observation and interview the facility failed to ensure one of one sampled resident (Resident 34) was provided with safe and comfortable environment by failing to ensure the resident's restroom had a functional toilet's handle. This failure resulted in Resident 34's feeling uncomfortable when manually flushing the toilet and lifting the toilet water tank lid by herself to manually flush the toilet, that could potentially cause accidents and injury to resident. Findings: A review of Resident 34's Admission Record indicated the facility admitted the resident on 1/20/24 with diagnoses that included peripheral vascular diseases [a systemic disorder that involves the narrowing of peripheral blood vessels (vessels situated away from the heart or the brain)], type 2 diabetes mellitus (a disease that occurs when the body's blood sugar is too high), protein-calorie malnutrition (a serious condition happens when a person ' s diet does not contain the right amount of nutrients), and muscle weakness. A review of Resident 34's Minimum Data Sheet (MDS, a standard assessment tool that measures health status), dated, indicated Resident 34's cognitive level was cognitively intact (able to process information, remember and reason), needed supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident competes activity. Assistance may be provided throughout the activity or intermittently) in eating, oral hygiene, upper and lower body dressing, personal hygiene, and needed substantial assistance (helper does more than half the effort) in toilet hygiene. A review of Resident 34's History and Physical, dated 2/14/24, indicated Resident 34 had the capacity to understand and make decisions. During a concurrent interview and observation on 5/6/24 at 3:30 PM, Resident 34 was walking to the restroom and tried to flush the toilet but was unsuccessful. Resident 34 demonstrated how she had been flushing the toilet for a week. Resident 34 was observed lifting up the water tank's lid and manually pulled up the flush lever located inside the water tank. Resident 34 stated, it was very uncomfortable for her to manually flush the toilet every time she uses the restroom. Resident 34 stated the water tank ' s cover was too heavy for her to lift, and she could accidentally drop the lid, which could lead to accident and injury to herself. During an interview on 5/6/24 at 3:49 PM, with the Maintenance Supervisor (MS), the MS stated, the house keepers usually clean the restroom daily and were responsible to check the toilet handle to make sure it's functional because the handle is very easy to break. The MS stated, he was not informed of any broken toilet ' s handle for Resident 34 ' s room. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/6/24 at 4:05 PM, with Certified Nurse Assistant (CNA) 3, CNA 3 stated, she found out that Resident 34's room's restroom had a broken toilet's handle on 5/3/24 when she assisted another resident to the toilet, but she forgot to report the broken toilet handle to the MS. During an interview on 5/6/24 at 4:18 PM, with the MS, the MS stated, he just spoke on the phone with the housekeeper that worked in the morning shift and was informed that she forgot to report the broken handle to him. The MS stated, the toilet handle was very easy to fix and as soon as he gets report from the housekeeper, he could fix it right away. The MS added, when a toilet handle was broken, the toilet would not flush, and it would cause unsanitary environment if the resident urinated or had bowel movement without flushing. During an interview on 5/9/24 at 3:52 PM, with the Director of Nurses (DON), the DON stated, the toilet handle should be fixed right away when CNA 3 found out that it was broken. The DON added, manually lifting the toilet's water tank cover could compromise the safety of Resident 34 and pose a danger and risk for accident and injury to the resident. A review of the facility's policy and procedure (P&P) titled, Maintenance Service, revised 1/1/12, indicated The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times.