STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055674	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Healthcare Center of Orange County	9021 Knott Ave Buena Park, CA 90620

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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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on interview, facility document review, and facility P&P review, the facility failed to respond to the concerns brought up by the residents during the Resident Council meetings on 3/19 and 5/5/25, regarding the call lights not being answered in a timely manner. This failure had the potential for the residents' identified issue to not be resolved and a decline in quality of care for the residents. Findings: Review of the facility's P&P titled Resident Council revised 4/2017 showed the following: - the purpose of the resident council was to provide a forum for discussion of concerns and suggestions for improvement; - a Resident Council Response Form should be utilized to track issues and their resolution. The facility department related to any issues should be responsible for addressing the items of concern. Review of the Resident Council minutes dated 3/19/25, under the Resident Interview and Nursing Department sections showed the call lights were not answered in a timely manner and nurses told the residents to turn off their call lights because they will return with assistance, however, the nursing staff did not come back to assist the residents. There was no documentation to show this concern was addressed by the nursing department. Review of the Resident Council minutes dated 5/5/25, under the Resident Interview section showed the call lights were not answered in a timely manner and could take 20 minutes for staff assistance. There was no documentation to show this concern was addressed by the nursing department. During the resident council meeting on 6/3/25 at 1100 hours, Residents 23, 29, 30, and 34 stated the facility did not respond to the group's concern regarding the call lights and the issue was still ongoing. On 6/3/25 at 1222 hours, an interview and concurrent facility document review was conducted with the Activities Director. The Activities Director acknowledged the concerns presented during the March and May 2025 resident council meetings had not been resolved. The Activities Director stated she had brought up the call light issue with the nursing staff at the nurses' station. The Activities Director failed to show documentation of the Resident Council Response form or documentation she addressed the concern with the nursing staff. The Activities Director stated the above concern should have been followed up. (continued on next page)

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

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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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/4/25 at 0821 hours, an interview was conducted with the DON. When asked what the expectation of the Activities Director was when concerns were brought up during the resident council, the DON stated within 72 hours the Activities Director should inform the affected department of the concerns. The DON stated concerns brought up during the resident council should be addressed because it was the right of the resident to feel comfortable and safe at the place they resided. The DON was made aware of the resident council concern of the call lights not answered in a timely manner. On 6/4/25 at 0925 hours, a follow up interview was conducted with the Activities Director. The Activities Director stated her role in the resident council if invited, was to write the meeting minutes and fill out the Resident Council Response form with the residents' concerns. The Activities Director stated she should communicate with the respective department when concerns were brought up in the Resident Council meeting. The Resident Council Response form should be given to the respective department within 72 hours of the resident council meeting. The department had 10 days to return the form with their goals to the Activities Director. Then, the department has 30 days to implement their interventions. On 6/4/25 at 1026 hours, a follow-up interview was conducted with Resident 23. Resident 23 verified the facility did not address the call light concern that was brought up at the resident council meeting. Resident 23 stated she used the call light when she needed assistance to go to the bathroom or to grab an item not within reach. Resident 23 further stated she would wait around twenty to thirty minutes to get the help she needed. On 6/5/25 at 1508 hours, an interview as conducted with the DON, ADON, and DSD. The DON, ADON, and DSD were informed and acknowledged the above findings.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to maintain a homelike environment for one sampled resident (Resident 15). * Resident 15 resided in Room A. Resident 15 was observed sitting on her bed eating lunch. A pest was observed floating on the surface of Resident 15's milk. This failure had the potential to negatively impact the resident's quality of life. Findings: Medical record review for Resident 15 was initiated on 6/2/25. Resident 15 was admitted to the facility on [DATE]. On 6/2/25 at 1224 hours, a dining observation was conducted with Resident 15 in her room. Resident 15 was observed sitting on her bed eating lunch. A pest was observed floating on the surface of Resident 15's milk. Resident 15 stated she put her milk to the side because there was a bug in it. Resident 15 stated the bug in her milk made her feel nauseated and would not drink her milk anymore because of the bug. Resident 15 stated she has seen the bugs flying around but they have not landed on her food. On 6/2/25 at 1232 hours, a concurrent observation and interview was conducted with LVN 3. LVN 3 verified the findings. LVN 3 stated there was an insect inside Resident 15's milk cup and it was the first time she observed this. LVN 3 was then observed to take the milk cup away and leave the room. On 6/3/25 at 1004 hours, an interview was conducted with the Central Supply Supervisor. The Central Supply Supervisor stated the facility conducted pest control once a month and had not heard of any concerns with pests inside the residents' rooms. The Central Supply Supervisor was informed of and acknowledged the above findings.

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. Medical record review for Resident 15 was initiated on 6/2/25. Resident 15 was admitted to the facility on [DATE]. Review of Resident 15's H&P examination dated 5/11/25, showed Resident 15 had the capacity to understand and make decisions. Review of Resident 15's Order Summary Report dated 6/2/25, showed the following physician's orders: - dated 5/9/25, to administer aripiprazole oral tablet 5 mg, one tablet by mouth in the morning for bipolar disorder manifested by angry outbursts; and - dated 5/9/25, to administer trazodone oral tablet 50 mg, one tablet by mouth at bedtime for depression manifested by inability to sleep. - dated 5/11/25, for the use of the aripiprazole medication, to monitor for bipolar disorder manifested by angry outburst every day and night shift; - dated 5/9/25, for the use of the trazodone medication, to monitor for depression manifested by inability to sleep every day and night shift; - dated 5/9/25, for the use of aripiprazole and trazodone medications, to monitor orthostatic hypotension weekly every Sunday. Monitor the BP lying down and sitting position; Review of Resident 15's MAR for May 2025 showed the following: - Resident 15 had been administered the aripiprazole medication daily from 5/10 through 5/31/25; - Resident 15 had been administered the trazodone medication daily from 5/9 through 5/31/25; - on 5/11/25, the BP readings were NA for the sitting and lying position, and 117/66 mmHg; - on 5/18/25, the BP readings were 122 for the sitting and lying position, and 122/69 mmHg; - Resident 15 had manifested behaviors of angry outbursts on 5/22, 5/23, and 5/27/25; and - Resident 15 had manifested behaviors of inability to sleep at night on 5/27/25. Further review of Resident 15's medical record failed to show documented evidence non-pharmacological interventions were provided for the use of the aripiprazole and trazodone medications. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/5/25 at 1143 hours, a concurrent interview and medical record review was conducted with the DON. The DON verified Resident 15 was being monitored for the side effect of the orthostatic hypotension. The DON stated the orthostatic blood pressures were taken laying down, sitting, and standing, and the nurse would check for a discrepancy if the BP went down. The DON stated they documented the BP in the MAR. The DON verified Resident 15's orthostatic BP were not accurately completed per the documentation on the MAR. The DON was asked about non-pharmacological interventions provided for the use of Resident 15's psychotropic medication. The DON stated they did not provide non-pharmacological interventions for the residents who were on routine psychotropic medications. Based on interview and medical record review the facility failed to ensure three of five final sampled residents (Residents 15, 30, and 58) reviewed for unnecessary medications were free from the unnecessary psychotropic medications. * The facility failed to ensure Resident 15's orthostatic blood pressure was accurately monitored as ordered by the physician for the use of the psychotropic medications. In addition, the facility failed to implement the non-pharmacological interventions for Resident 15's use of the aripiprazole (antipsychotic), and trazodone (antidepressant) medications. * The facility failed to ensure non-pharmacological interventions were implemented for Resident 30's physician's order of ativan (anti-anxiety medication) and risperidone (antipsychotic medication) medications. * The facility failed to ensure non-pharmacological interventions were implemented for Resident 58's physician's order of escitalopram medication (antidepressant medication). These failures had the potential for adverse effects from the psychotropic medications and the potential for not providing the correct data to the prescriber to adjust the dosage of psychotropic medications. Findings: Review of the facility's P&P titled Psychotropic Medication Use dated 7/2022 showed non-pharmacological approaches are used (unless contraindicated) to minimize the need for medications, permit the lowest possible dose, and allow for discontinuation of medications when possible. The residents on psychotropic medications receive gradual dose reductions (coupled with non-pharmacological interventions), unless clinically contraindicated, in an effort to discontinue these medications. Review of facility's P&P titled Antipsychotic Medication Use revised 12/2016 showed the diagnoses alone do not warrant the use of the antipsychotic medication. In addition to the above criteria, antipsychotic medications will generally only be considered if the following conditions are also met: a. The behavioral symptoms present a danger to the resident or other; AND (1) The symptoms are identified as being due to mania or psychosis (such as auditory, visual, or other hallucinations; delusions, paranoia or grandiosity); or (2) Behavioral interventions have been attempted and included in the plan of care, except in an emergency .(c) pertinent non-pharmacological interventions must be attempted, unless contraindicated, and documented following the resolution of the acute psychiatric situation. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. a. Medical record review for Resident 30 was initiated on 6/2/25. Resident 30 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 30's MDS assessment Section C Cognitive Patterns dated 3/28/25, showed a BIMS score of 14, indicating the individual's cognitive function is intact. Review of Resident 30's Order Summary Report dated 6/3/25, showed the following physician's orders: - dated 9/13/24, to monitor episodes of anxiety manifested by persistently concerned about money (regarding money inheritance from sister). - dated 9/13/24, to administer risperidone 3 mg one tablet by mouth at bedtime for schizophrenia manifested by paranoid delusions of persecution. - dated 4/23/25, to monitor episodes of psychotic behavior (paranoid delusions of persecution). - dated 5/25/25, to administer lorazepam 0.5 mg one tablet by mouth every six hours as needed for anxiety until 6/11/25 (end on 6/11/25) Review of Resident 30's care plan report showed a care plan problem dated 5/27/25, addressing Resident 30's use of anti-anxiety medication for anxiety disorder manifested by persistently concerned with money (regarding money inheritance from sister). The interventions included 1. Tally behavior anxiety manifested by verbalization of feeling anxious. 2. Approach patient in calm manner 3. Notify MD if any changes. Review of Resident 30's MAR for May 2025 showed Resident 30 had the episodes of persistently concerned about money (regarding money inheritance from sister) as follows: - on 5/1, 5/9, 5/10, 5/15, 5/24, 5/29, and 5/31/25, three episodes during the day shift, - on 5/1 and 5/9/25, three episodes during the evening shift, - on 5/2 and 5/16/25, five episodes during the day shift and five episodes during the evening shift, - on 5/17 and 5/21/25, 5/23, 5/30/25, four episodes during the day shift, - on 5/23/25, two episodes during the evening shift, - on 5/24 and 5/25/25, one episode during the evening shift, and - on 5/30/25, four episodes during the evening shift, Review of Resident 30's MAR for May 2025 showed Resident 30 had the episodes of psychotic behavior (paranoid delusions of persecution) as follows: - on 5/16 and 5/17/25, four episodes during the day shift, and (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- on 5/24/25, three episodes during the day shift. Review of Resident 30's MAR and Licensed Progress Notes for May 2025 showed no documentation that non-pharmacological interventions were implemented prior to administration of the lorazepam and risperidone medications by the licensed nurses except on one of the Licensed Progress note dated 5/17/25 at 0418 hours, showed Resident 30 requested for ativan which was given as ordered PRN. Behavior also distracted by encouraging him to write to friends which he usually do and calms him down. Review of Resident 30's care plan report showed a care plan problem dated 8/7/25, addressing Resident 30's use of psychotropic medication related to disease process schizophrenia manifested by paranoid delusions of persecutions. The interventions included to discuss with MD, family regarding ongoing need for the use of the medication; and review the behaviors/interventions and alternate therapies attempted and their effectiveness as per the facility process. b. Medical record review for Resident 58 was initiated on 6/2/25. Resident 58 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 58's H&P examination dated 11/6/24, showed Resident 58 has the capacity to understand and make decisions. Review of Resident 58's MDS assessment Section C Cognitive Patterns dated 2/27/25, showed a BIMS score of 15, indicating the individual's cognitive function is intact. Review of Resident 58's Order Summary Report dated 6/3/25, showed the following physician's orders: - dated 1/17/25, to administer escitalopram 5 mg one tablet one time a day for depression manifested by sad facial expression. - dated 1/17/25, to monitor episodes of depression manifested by sad facial expression every day and nights shift and tally by hashmarks every day and night shift. Review of Resident 58's MAR for May 2025 showed Resident 30 had the episodes of psychotic behavior (paranoid delusions of persecution) as follows: - on 5/5, 5/6, 5/12, and 5/22/25, one episode during the night shift, - on 5/7, 5/12, 5/14, 5/26, and 5/28/25, one episode during the day shift, -on 5/13 and 5/31/25, two episodes during the night shift, - on 5/21/25, two episodes during the day shift, and - on 5/27/25, three episodes during the night shift. Review of Resident 58's MAR and Licensed Progress Notes for the month of May 2025, showed no documentation that non-pharmacological interventions were implemented prior to administration of escitalopram medication by the licensed nurses. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 58's care plan report showed a care plan problem dated 6/3/25, addressing Resident 58's use of the anti-depressant medication related to depression manifested by sad facial expressions. The interventions included to administer anti-depressant medications as ordered by the physician. Monitor/document side effects and effectiveness every shift. Monitor and document the monthly psychotropic behavior for possible GDR if indicated. Educate the resident/family/caregivers about risks, benefits and the side effects and/or toxic symptoms of escitalopram. On 6/3/25 at 1435 hours, an interview and a concurrent medical record review for Residents 30 and 58 was conducted with RN 3. RN 3 was asked what was the facility process on non-pharmacological interventions intended on the residents' prescribed use of the psychotropic medications and/or anti-psychotic medications. RN 3 stated non-pharmacological interventions should be provided to the residents prescribed with the psychotropic and anti-psychotic medications. RN 3 verified she could not find any documentation in MAR and Licensed Progress Notes that non-pharmacological interventions were provided to Residents 30 and 58. On 6/5/25 at 1350 hours, an interview was conducted with the DON. The DON verified the above findings.

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, facility document review, and facility P&P review, the facility to failed to ensure the discharge instructions were documented for one of three sampled residents reviewed for closed records (Resident 100). This failure had the potential for Resident 100 to have an inappropriate discharge. Findings: Review of the facility's P&P titled Transfer or Discharge Documentation dated 12/2016 showed when a resident is transferred or discharged , details of the transfer or discharge will be documented in the medical record and appropriate information will be communicated to the receiving health care facility or provider. Closed medical record review for closed Resident 100 was initiated on 6/4/25. Resident 100 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 100's Advance Directive Acknowledgement dated 12/19/24, showed Resident 100 had no decision making capacity. Review of Resident 100's H&P examination dated 1/23/25, showed Resident 100 could make needs known but could not make medical decisions. Review of Resident 100's POLST (Physician Orders for Life-Sustaining Treatment) dated 1/24/25, showed Resident 100's family member was the legally recognized decisionmaker. Review of Resident 100's Physician Order dated 3/25/25, showed an order to discharge the resident to home with family on 4/2/25, with Home Health for PT/OT/ST services, RN/LVN services for medication management, wound care, indwelling urinary foley catheter care; and CHHA services. Review of Resident 100's Discharge Planning Review dated 4/2/25, showed the following: - Resident 100's initial discharge goals : return to the community. - Does the resident have an interest in receiving information regarding to the community? - No. - Will the resident have a caregiver after discharge? - Yes. - Yes, please specify. - Home health caregiver and wife. - Complete only if A0310H =1 (A0310. Type of MDS assessment dated [DATE], showed 1, Type of discharge: 1. planned discharge (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At the time of discharge, did your facility provide resident's reconciled medication list to the resident, family and/or caregiver? The boxes are not filled out or was left blank on the following: No - current reconciled medication list not provided to the patient, family and/or caregiver. Yes -current reconciled medication list not provided to the patient, family and/or caregiver. Review of Transfer/Discharge Report dated 4/2/25, showed the list of the discharged medications with medications instructions sent with Resident 100; however, there was no documentation of the wound care and indwelling urinary foley catheter care instructions. The Transfer/Discharge Report also showed no documentation of Resident 100's wife's name, date, and signature to show the discharge medications instructions was received by the legally recognized decisionmaker. Review of Resident 100's Discharge Instruction Form dated 4/2/25, showed a blank documentation, no information provided on all the following sections: - Patient information - Responsible parties - Primary Physician(s) - Pharmacy - In home care or services - Medical equipment arrangements - Housing arrangements - Medication education - Prevention and disease management education - Emergency contact information - Brief medical history - Current treatments and therapies - Scheduled appointments and tests - If problems arise during discharge, please contact the following individual(s) at the nursing facility - Signatures - Allergies - Medications (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Signature and date Review of Resident 100's Order summary Report dated 6//4/25 showed the following physician's orders: - dated 1/8/25, for indwelling urinary foley catheter size 16 Fr/10 cc connected to drainage bag, change as necessary if with leakage, soilage, or dislodged (diagnosis: catheter wound management). - dated 1/22/25, for indwelling urinary foley catheter care every day and night. - dated 1/27/25, for indwelling urinary foley catheter bedside drainage bag as necessary. - dated 3/17/25, for right second toe necrosis, cleanse with Dakin's 0.125%solution (topical antiseptic widely used to clean wounds) and apply silvadene (used for wound management) and cover with dry dressing and wrap with kerlix (roll gauze) daily for 21 days, then reevaluate and notify MD of any changes - dated 3/17/25, for right second toe necrosis, cleanse with sterile saline, pat dry and apply betadine solution and cover with dry dressing daily and wrap with kerlix daily for 21 days, then re-evaluate and notify MD of any changes. - dated 3/25/25, for right foot multiple dry scabs, cleanse with sterile saline, pat dry and apply betadine solution and cover with dry dressing daily for 30 days, then reevaluate and notify MD for any changes. - dated 3/25/25, for right pinky toe scab, cleanse with sterile saline, pat dry and apply betadine solution and cover with dry dressing daily for 30 days, then reevaluate and notify MD of any changes. - dated 3/25/25, for right shin dry scab, cleanse with sterile saline, pat dry, apply betadine solution and cover with dry dressing daily for 30 days, then re-evaluate and notify MD of any changes. - dated, 3/25/25, for sacrococcyx pressure injury, cleanse with Dakin's solution 0.125%, pat dry and apply santyl ointment with collagen powder (use for wound management) and pack lightly with calcium alginate and cover with dry dressing daily for 21 days, then reevaluate and notify MD of any changes. - dated 3/27/25, for right leg angiogram on 4/9/25 at 08:30 AM. On 6/4/25 at 1344 hours, an interview and concurrent closed medical record review for Resident 100 was conducted with LVN 4. LVN 4 was asked what was the facility process on providing the discharge instructions to the residents being discharged to home. LVN 4 stated the resident's representative should be provided with the discharge instructions. LVN was asked if she could show any documentation that Resident 100 was provided with discharge instructions on the medication management, wound care, and indwelling urinary foley catheter care. LVN verified the discharge instructions form was all blank. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/4/25 at 1354 hours, an interview and a concurrent medical record review was conducted with Medical Records Coordinator. The Medical Records Coordinator was asked if the Discharge Instruction Form should have been filled out. The Medical Records Coordinator verified Resident 100's Discharge Instructions Form should not be blank and should have been filled out. On 6/5/25 at 1350 hours, an interview was conducted with the DON. The DON verified the above findings.

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Healthcare Center of Orange County	9021 Knott Ave Buena Park, CA 90620

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and medical record review, the facility failed to accurately complete the MDS assessments for two of three residents reviewed for closed records (Residents 71 and 101). This failure had the potential to negatively affect the residents' well-being because the medical record information was not accurate. Findings: 1. Closed medical record review for Resident 101 was initiated on 6/4/25. Resident 101 was admitted to the facility on [DATE]. Review of the Resident 101's Physician's Order dated 4/14/25, showed an order to discharge the resident to a board and care under palliative and hospice care. Review of the Resident 101's Progress Notes Dated 4/14/25 at 1603 hours, showed at 1603 hours Resident 101 left the facility via gurney to the board and care under palliative and hospice care. Review of Resident 101's MDS assessment dated [DATE], under the section discharge status showed the resident was discharged to the short-term general hospital. On 6/4/25 at 0149 hours, and interview and concurrent closed medical record review for Resident 101 was conducted with the MDS Coordinator. The MDS Coordinator verified Resident 101's MDS assessment showed the resident was transferred to the acute care hospital; however, it should show Resident 101 was discharged to the board and care. On 6/5/25 at 0933 hours, an interview was conducted with the DON. The DON acknowledged the above findings. 2. Review of the facility's P&P titled MDS Completion and Submission Timeframe revised 7/2017 showed the facility will conduct and submit resident assessments in accordance with current federal and state submission. Review of Facility's P&P titled Electronic Transmissionof the MDS revised 11/2019 showed all the MDS assessments (e.g.admission, annual, significant change, quarterly review, etc.) and discharge and renetry of records are completed and electronically encoded into our facility's MDS information system and transmitted to CMS'QIES Assessment Submission and Processing (ASAP) system in accordance with current OBRA regulations governing the transmission of MDS data. Closed medical record review for Resident 71 was initiated on 6/5/25. Resident 71 was admitted to the facility on [DATE]. Review of Resident 71's Physician Order dated 1/2/25, showed an order to discharge the resident to home under the hospice care. Review of Resident 71's MDS assessment dated [DATE], showed the resident's discharge return was not anticipated, in-progress. (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of the Resident 71's Licensed Progress Note dated 1/3/25, showed the resident was discharged to home. On 6/5/25 at 1207 hours, an interview and concurrent closed medical record review was conducted with the MDS Coordinator. The MDS Coordinator was asked to review Resident 71's MDS assessment dated [DATE]. The MDS Coordinator acknowledged it was blank, missed, and not completed. The MDS Coordinator verified Resident 71's MDS discharge assessment should have been completed. On 6/5/25 at 1350 hours, an interview was conducted with the DON. The DON verified the above findings.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and medical record review, the facility failed to coordinate an assessment with the PASARR program for one of two final sampled residents (Resident 15) reviewed for PASARR when the resident had an updated diagnosis of depression, schizoaffective disorder, bipolar disorder, and anxiety disorder. This failure posed the risk for Resident 15 not receiving the necessary specialized services specific to treat mental illness. Findings: Medical record review for Resident 15 was initiated on 6/2/25. Resident 15 was admitted to the facility on [DATE], with diagnoses including depression, schizoaffective disorder, bipolar disorder, and anxiety disorder. Review of Resident 15's PASARR Level I Screening dated 5/9/25, showed the facility marked no when the question asked does the individual have a serious diagnosed mental disorder such as depressive disorder, anxiety disorder, panic disorder, schizophrenia and/or schizoaffective disorder, or symptoms of psychosis, delusions, and/or mood disturbance. Additionally, the facility had marked no when the question asked if the individual had been prescribed psychotropic medications for serious mental illness. Further review of Resident 15's PASARR failed to show a new PASARR was completed after the resident's medical record was updated to show the diagnosis of depression, schizoaffective disorder, bipolar disorder, and anxiety disorder and that Resident 15 had been prescribed medications for these mental illnesses. Review of Resident 15's H&P examination dated 5/11/25, showed Resident 15 had the capacity to understand and make decisions. Review of Resident 15's MDS admission assessment dated [DATE], showed Resident 15 had active diagnoses of anxiety, depression and schizophrenia. Additionally, the MDS assessment showed Resident 15 was taking antipsychotic, antianxiety, and antidepressant medications. On 6/4/25 at 0854 hours, an interview and concurrent medical record review was conducted with the MDS Assistant. The MDS Assistant stated on admission, they would check if the resident had a PASARR completed from the acute care hospital. The MDS Assistant verified the above findings. The MDS Assistant verified a new PASARR should have been completed with the updated diagnoses and medications listed on the MDS admission assessment. The MDS Assistant stated she would submit a new PASARR and modify the MDS admission assessment in Section A.

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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** Based on observation, interview, and medical record review, the facility failed to ensure the comprehensive care plan was implemented for one of 22 final sampled residents (Resident 63). * The facility failed to implement the comprehensive plan for contact isolation precautions for Clostridium difficile, for Resident 63. This failure placed the resident at risk for not being provided appropriate, consistent, and individualized care. Findings: Medical record review for Resident 63 was initiated on 6/2/25. Resident 63 was admitted to the facility on [DATE]. Review of Resident 63's physician's order dated 5/27/25, showed an order to give Vancomycin (antibiotic) 125 mg via GT every 12 hours for Clostridium difficile colitis until 6/14/25. Review of Resident 63's care plan titled At Risk for Decrease Socialization due to Contact Isolation initiated 5/27/25, showed an intervention for contact isolation precautions for Clostridium difficile. On 6/5/25 at 0849 hours, an observation and medical record review was conducted with LVN 9. A sign which read Enhanced Barrier Precautions (EBP) was observed posted at the entrance to Resident 63's room (Room D). A review of Resident 63's active physician's orders was then conducted with LVN 9. LVN 9 verified Resident 63 had a physician's order for contact isolation precautions for Clostridium difficile colitis. LVN 9 stated the sign showing EBP which was posted at the entrance to Room D was incorrect, as Resident 63 had an order for Contact Isolation Precautions. On 6/5/25 at 0856 hours, an observation and concurrent interview was conducted with CNA 3. CNA 3 was observed having entered Room D carrying a plastic bag containing bed linens. CNA 3 set the plastic bag onto Resident 63's bed. CNA 3 failed to donn gloves and only donned a gown after having entered Room D. CNA 3 verified the findings and stated she should have donned the gown and gloves before entering Room D. CNA 3 was asked for the type of precautions implemented for Resident 63, to which she replied, EBP as posted at the entrance to Room D. CNA 3 was unaware Resident 63 had an order for contact isolation for Clostridium difficile. On 6/5/25 at 1000 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified the facility failed to implement contact precautions for Clostridium difficile in accordance with Resident 63's care plan titled At Risk for Decrease Socialization due to Contact Isolation initiated on 5/27/25.

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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** * The facility failed to ensure RNA services were provided as ordered by the physician for Resident 10. 4. On 6/2/25 at 1115 hours, Resident 10 was observed lying on his bed. Resident 10's left arm was observed in a flexed position. Medical record review for Resident 10 was initiated on 6/2/25. Resident 10 was admitted to the facility on [DATE]. Review of the Resident 10's Order Listing Report, showed the following physician's order dated 2/21/25: - for RNA for PROM (passive range of motion) exercise to bilateral upper and lower extremities every day for times a week as tolerated - for RNA to apply bilateral PRAFO (pressure relief ankle foot orthosis) four to six hours, every day five times a week, as tolerated. - for RNA to apply bilateral WHFO (wrist hand finger orthosis) four to six hours, every day five times a week, as tolerated. Review of Resident 10's Care Plan dated 2/21/25, showed the care plan problem addressing Resident 10's alteration in musculoskeletal status. The goal was to maintain the current ROM functions. The interventions included for the RNA to perform the PROM exercises to all the extremities, PRAFO bilateral to apply up to four to six hours, WHFO bilateral to apply up to four to six hours, everyday five times a week as tolerated. Review of Resident 10's MDS assessment dated [DATE], showed Resident 10's ROM functions were impaired for the bilateral upper and lower extremities. Review of Resident 10's documentation for RNA services from 5/1- 5/31/25 (four and half weeks), showed RNA services for PROM bilateral upper and lower extremities, bilateral PRAFO, and left WHFO was provided on 5/1, 5/2, 5/5, 5/8, 5/9, 5/13, 5/15, 5/16, 5/20, 5/21, 5/22, 5/23, 5/27, and 5/30/25. Total of 14 RNA services were provided in four and half weeks and Resident 10 had missed eight days of RNA services. Further review of the documentation of the RNA services failed to show if any of the RNA services for the right WHFO was provided to Resident 10 on 5/2025. There was no documented evidence to explain why the RNA services were not provided as ordered by the physician. On 6/4/25 at 0932 hours, an interview was conducted with RNA 1. RNA 1 stated some days, the facility was short of the RNAs and sometimes they got reassigned to be CNAs to care for the residents. RNA 1 stated when he got reassigned to be a CNA to care for the residents then he could not provide the RNA services to the residents in the facility. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/4/25 at 0950 hours, an interview and concurrent medical record review for Resident 10 was conducted with RN 1. RN 1 verified the above findings and stated RNA services were not provided to Resident 10 as ordered by the physician. RN 1 stated some days the facility had to reassign RNA to work as a CNA, so they can not provide RNA services to all the residents every day. RN 1 acknowledged the RNA services should have been provided as ordered by the physician. On 6/5/25 at 0933 hours, an interview was conducted with the DON. The DON acknowledged the above findings. 5. On 6/2/25 at 0835 hours, Resident 5 was observed lying on her bed. Resident 5's bilateral hands were observed contracted. Medical record review for Resident 5 was initiated on 6/2/25. Resident 5 was admitted to the facility on [DATE]. Review of Resident 5's Order Summary Report showed the following physician's orders dated 6/7/23: - for RNA to provide left and right hand rolls for four hours every day five times a week or as tolerated; - for RNA to provide PROM exercise on left lower and upper extremities every day five times a week or as tolerated; and - for RNA to provide PROM exercise on right lower and upper extremities every day five times a week or as tolerated. Review of Resident 5's plan of care dated 8/25/24, showed a care plan problem which addressed Resident 5's requirement for an RNA program. The goal was to maintain the ROM in all the extremities for three months. The interventions included for the RNA to perform PROM to the bilateral upper and lower extremities five times a week, for the RNA to apply a right and left hand roll for four hours everyday five times a week as tolerated, and for the RNA to apply a right elbow splint for four hours everyday five times a week as tolerated. Review of Resident 5's MDS assessment dated [DATE], showed Resident 5's ROM functions were impaired for the bilateral upper and lower extremities. Review of Resident 5's Documentation Survey Report dated 6/5/25, showed the RNA services provided from 5/1 - 5/31/25 (four and a half weeks), showed the RNA services for the PROM and splint/brace assistance was documented on 5/1, 5/5, 5/6, 5/7 (marked with NA), 5/8, 5/12, 5/23, 5/26, and 5/29/25, which was less than five times per week as per the physician orders. There was no documented evidence to explain why the RNA services were not provided as ordered by the physician. On 6/4/25 at 1347 hours, an interview and medical record review was conducted with RNA 1. RNA 1 stated he was assigned as an RNA, and sometimes would work on the floor as a CNA. RNA 1 stated he would document the RNA service was provided after providing the treatment under the task section on PCC. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/5/25 at 0950 hours, an interview and concurrent medical record review for Resident 5 was conducted with RN 2. RN 2 verified the above findings. RN 2 stated if they were short of CNAs, the RNA would be pulled to work on the floor. RN 2 verified there was no documented evidence Resident 5 had received the RNA services five times a week as ordered by the physician. Based on interview and medical record review, and facility P&P review, the facility failed to provide the RNA services as ordered for five of five final sampled residents (Resident 5, 10, 30, 58, and 67) reviewed for RNA services. * The facility failed to ensure Residents 30, 58, and 67's RNA services were provided as ordered by the physician. * The facility failed to ensure the RNA services were provided as ordered by the physician for Residents 5 and 10. These failures had the potential for decline in the residents' ROM functions and mobility. Findings: Review of the facility's P&P titled Restorative Nursing Services revised 7/2017 showed the residents will receive restorative nursing care as needed to help promote optimal safety and independence. Restorative goals and objectives are individualized and resident-centered and are outlined in the resident's plan of care. 1. Medical record review for Resident 30 was initiated on 6/2/25. Resident 30 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 30's MDS Assessment Section C Cognitive Patterns dated 3/28/25, showed a BIMS score of 14, indicating that the individual's cognitive function was intact. Review of Resident 30's H&P examination dated 4/16/25, showed Resident 30 with past medical history of functional quadriplegia. Review of Resident 30's Care Plan Report revised on 5/23/25, showed a care plan problem addressing Resident 30 had limited physical mobility. The nursing interventions included RNA for ambulation with front wheel walker daily five times a week as tolerated. Review of Resident 30's Order Summary Report dated 6/3/25, showed the physician's order dated 12/21/24, for the RNA services for ambulation with front wheel walker five times a week as tolerated. Review of Resident 30's documentation for RNA services on Restorative Walking Program from 5/7/25 - 6/4/25 (four weeks) , showed RNA services for restorative walking program was provided on 5/7, 5/17, 5/20, 5/23, 5/24, 5/28, 6/1, 6/2, and 6/4/25. Total of nine RNA services were provided in four weeks. The documentation showed Resident 30 had missed 11 days of RNA services. On 6/4/25 at 1024 hours, an interview was conducted with Resident 30. Resident 30 was asked how his walking exercises with the RNAs was. Resident 30 stated he preferred his ambulation exercises five times a week but somehow the exercises were not done. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Medical record review for Resident 58 was initiated on 6/2/25. Resident 58 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 58's H&P examination dated 11/6/24, showed Resident 58 had the capacity to understand and make decisions. Review of Resident 58's MDS assessment Section GG on functional limitations in range of motion dated 5/31/25, showed Resident 58 had impairment on one side of her upper extremity and had impairment on one side of her lower extremity. Review of Resident 58's Order Summary Report dated 6/3/25, showed the following physician's orders dated 11/6/25: - for RNA for AAROM exercises on the LUE daily five times a week as tolerated, - for RNA for AAROM exercises on the right hip daily five times a week as tolerated, and - for RNA for AAROM exercises on the RUE daily five times a week as tolerated. Review of Resident 58's Care Plan Report revised on 6/3/25, showed a care plan problem addressing Resident 30 had ADL deficit related to ventilator dependent respiratory failure, hypertension, hyperlipidemia, chronic obstructive pulmonary disease, post status gastrostomy placement. post status tracheostomy placement, hypothyroidism, gastroesophageal reflux with nursing interventions included RNA as per the MD order. Review of Resident 58's documentation for RNA services from 5/6/25 to 6/3/25 (four weeks), showed RNA services for RNA for AAROM exercises on the LUE daily five times a week as tolerated, AAROM exercises on the right hip daily five times a week as tolerated, and AAROM exercises on the RUE daily five times a week as tolerated was provided on 5/6, 5/8, 5/9, 5/13, 5/15, 5/16, 5/21, 5/22, 5/23, 5/27, 5/29, 6/2, and 6/3/25. Total of 13 RNA services were provided in four weeks and Resident 58 had missed seven days of RNA services. On 6/4/25 at 0934 hours, an interview was conducted with Resident 58. Resident 58 was asked how her RNA exercises program was. Resident 58 stated there were times her exercises were not provided, and she hoped she would be provided of the RNA exercises. 3. Medical record review for Resident 67 was initiated on 6/2/25. Resident 67 was admitted to the facility on [DATE]. Review of Resident 67's H&P examination dated 5/7/25, showed Resident 67 had no capacity to understand and make decisions. Review of Resident 67's Order Summary Report showed the following physician's orders dated 5/8/25: - for RNA for PROM exercises to the LLE daily five times a week as tolerated, - for RNA for PROM exercises to the LUE daily five times a week as tolerated, (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- for RNA for PROM exercises to the RLE daily five times a week as tolerated and - for RNA for PROM exercises to the RUE daily five times a week as tolerated. Review of Resident 67's MDS assessment Section GG on functional abilities dated 5/13/25, showed Resident 67 had impairment on one side on his upper extremity and has impairment on one side on his lower extremity. Review of Resident 67's Care Plan Report revised on 5/7/25, showed a care plan problem addressing the alteration in musculoskeletal related to: multiple contracture, and osteoarthritis. The interventions included for RNA program as ordered. Review of Resident 67's documentation for RNA services from 5/15 to 6/6/25 (three weeks and one day), showed RNA services for PROM exercises to the LLE daily five times a week as tolerated, PROM exercises to the LUE daily five times a week as tolerated, PROM exercises to the RLE daily five times a week as tolerated, and PROM exercises to RUE daily five times a week as tolerated were provided on 5/15, 5/16, 5/19, 5/20, 5/21, 5/22, 5/23, 5/27, 5/28, 5/29, 5/30, 6/3, 6/5, and 6/6/25. Total of 14 RNA services were provided in 16 days. Resident 67 had missed two days of RNA services. On 6/4/25 at 1332 hours, an interview was conducted with RNA 1. RNA 1 was asked how many times a week was he providing RNA exercises to his assigned residents. RNA 1 stated he was pulled out on the floor as a CNA at times, made him unable to provide RNA exercises to his assigned residents. On 6/3/25 at 1058 hours, an interview and a concurrent medical record review for Resident 30 was conducted with RN 3. RN 3 was showed the gaps in RNAs documentation on RNA services provided to the above residents. RNA 3 verified the missed RNA services for Residents 30, 58, and 67 and acknowledged the RNA services were missed at times due to the RNAs being pulled out as CNAs on the floor. On 6/5/25 at 1350 hours, an interview was conducted with the DON. The DON verified the above findings.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to monitor the onset of weight loss for one final sampled resident (Resident 33) reviewed for nutrition. * The facility failed to address Resident 33's weight loss of 28 lbs in two days after admission and another weight loss of 3 lbs after three days. This failure had the potential for Resident 33's condition to go unmonitored and cause delay in treatment. Findings: Review of the facility's P&P titled Weight Assessment revised dated 8/2008 showed the multidisciplinary team will strive to prevent, monitor, and intervene for desirable weight loss for our residents. The nursing staff will measure resident weights on admission, the next day, and the weekly for 2 weeks thereafter. If no weight concerns are noted at this point, weights will be measured monthly thereafter. Any weight change of 5% or more since the last weight assessment will be retaken the next day for confirmation. If the weight is verified, nursing will immediately notify the Dietitian in writing. Verbal notification must be confirmed in writing. The P&P also showed the following: the threshold for significant unplanned and undesired weight loss will be based on the following criteria a. 1 month - 5% weight loss is significant; greater than 5% is severe. b. 3 months - 7.5% weight loss is significant; greater than 7.5% is severe. c. 6 months - 10% weight loss is significant; greater than 10% is severe. Review of the facility's P&P titled Nutrition (Impaired)/Unplanned Weight Loss - Clinical Protocol revised 9/2017 showed under the monitoring section, the physician and staff will monitor nutritional status, an individual's response to interventions, and possible complications of such interventions (for example, additional weight gain or loss, nausea, or vomiting). Medical record review for Resident 33 was initiated on 6/2/25. Resident 33 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Residents 33's MDS assessment dated [DATE], showed Resident 33's BIMS score was 15 (meaning cognitively intact). Review of Resident 33's Weight Summary showed the following dates and weights: - on 3/20/25, weight of 219 lbs; - on 3/22/25, weight of 191 lbs; - on 3/25/25, weight of 188 lbs; - on 4/1/25, weight of 191 lbs; (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- on 5/21/25, weight of 192 lbs Review of Resident 33's Order Summary Report dated 6/3/25, showed an order dated 3/27/25, for regular diet, regular texture thin consistency. Review of Resident 33's medical record did not show documented evidence Resident 33 was assessed or monitored for the significant weight loss. Further review of Resident 33's medical record did not show a documentation the facility communicated and followed up with Resident 33's physician regarding the significant weight loss. The weight summary document showed Resident 33 loss 28 lbs two days after readmission and 27 lbs from 3/20/25 (readmission) to 5/21/25. There was no documented evidence the resident's weight loss of 28 lbs on 3/22/25, was address or explain the reason for the significant weight change. Review of Resident 33 Care Plan Report shows a care plan revised 3/26/25, addressing the resident had nutritional problem or potential nutritional problem related to refusing therapeutic diet and risks for fluctuation of weight due to dialysis, on and off refusal to go to dialysis treatment. The goal included will have no significant weight loss/gain every week or monthly. Further review of care plan failed to show documented evidence the goal included the specific weight loss/gain the facility will consider as significant to the resident. On 6/4/25 at 0806 hours, a concurrent meal observation and interview was conducted with Resident 33. Resident 33 was observed eating breakfast. Resident 33 stated the food was good and the dietary staff were providing food preferences. Resident 33 further stated when the food came out and was delivered, the resident had no appetite to eat. On 6/4/25 at 1550 hours, an interview and concurrent medical record review was conducted with the DON. The DON failed to show documented evidence the resident's weight was rechecked after the resident had a weight loss of 28 lbs two days after the admission. The DON stated Resident 33 should have been monitored after the weight loss of 28 lbs. The DON acknowledged there was no documentation to explain the resident's weight loss of 28 lbs in two days after the admission. The DON further verified there was no documented evidence a change of condition was completed for the weight loss.

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	055674	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Healthcare Center of Orange County	9021 Knott Ave Buena Park, CA 90620

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the appropriate care and services for the use of GT for two of four final sampled residents (Resident 27 and 72) and one nonsampled resident (Resident 54) reviewed for GT use. * The facility failed to ensure the physician's orders for the route of medication administration for Resident 27 was accurate. The medication route was ordered to be oral instead of the GT. * The facility failed to ensure a diet order was obtained from the physician for Residents 27, 54, and 72. * The facility failed to ensure Resident 27 and 72's HOB (head of bed) was elevated at a minimum of a 30 degree angle during the enteral feeding via GT, to reduce the risk of aspiration. These failures posed the risk of complications related to the use of the GT for Residents 27, 54, and 72. Findings: Review of the facility's P&P titled Administering Medications revised 4/2019 showed to verify the right resident, right medication, right dosage, right time, and right route of administration before giving the medication to the resident. Review of the facility's P&P titled Enteral Tube Feeding via Continuous Pump revised 11/2018 showed to position the head of the bed at 30 to 45 degrees for feeding, unless medically contraindicated. 1. Medical record review for Resident 27 was initiated on 6/4/25. Resident 27 was admitted to the facility on [DATE]. Review of Resident 27's MDS assessment dated [DATE], showed Resident 27 had a feeding tube and had a medical diagnosis of dysphagia (difficulty swallowing). a. Review of Resident 27's Order Summary Report dated 6/4/25, showed the following orders: - dated 5/18/25, to administer 81 milligrams of aspirin (blood thinner medication) by mouth one time a day for stroke prophylaxis. -dated 5/19/25, to administer one tablet of multivitamin-minerals by mouth one time a day for supplement. Review of Resident 27's MAR for May 2025 showed Resident 27 was administered the following medications: - dated 5/1 to 5/11/25 and 5/19 to 5/31/25, Resident 27 was administered the aspirin medication and signed for by the licensed nurse as administered via the oral route. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 5/20 to 5/31/25, Resident 27 was administered the multi-vitamin medication and signed for by the licensed nurse as administered via the oral route. Review of Resident 27's MAR for June 2025 showed Resident 27 was administered the aspirin and multi-vitamin medication from 6/1 to 6/4/25, and signed for by the licensed nurse as administered via the oral route. On 6/4/25 at 1122 hours, an interview and concurrent medical record review for Resident 27 was conducted with LVN 4. LVN 4 reviewed Resident 27's medical record and verified the above findings. LVN 4 stated Resident 27 had a GT and all of Resident 27's medications should be administered via GT because Resident 27 cannot have anything by mouth. LVN 4 further stated the ordered route for the above medications should be changed to accurately reflect the care that the resident was receiving, which was to receive the medications via GT. b. Review of Resident 27's Order Summary Report dated 6/4/25, did not show a diet order. Review of Resident 27's Nutritional Assessment V2 dated 5/20/25, showed Resident 27 had swallowing problems. On 6/4/25 at 1113 hours, an interview and concurrent medical record review for Resident 27 was conducted with LVN 3. LVN 3 stated all the residents should have a diet ordered, including the residents who had a GT. LVN 3 verified Resident 27 did not have a diet ordered. LVN 3 further stated the expectation when a resident did not have a diet ordered was to contact the physician to obtain a diet order or a swallow study. On 6/5/25 at 0914 hours, an interview was conducted with the DON. The DON stated all the residents were required to have a diet ordered, including the residents who had a GT. A diet order should be included in the admission orders and if there was no order the expectation was to notify the physician to obtain a NPO (nothing by mouth) order or speech therapy evaluation for a diet order. The DON further stated a diet order was important to ensure it was safe to give a resident anything, such as water, by mouth. c. Review of Resident 27's Order Summary Report dated 6/4/25, showed the following orders: - dated 5/18/25, to administer Jevity 1.5 (enteral feeding formula) via pump at 60 ml per hour for 20 hours per day, to provide 1200 ml/1800 kcals, and start at 1100 hours, and continue until the required dose is completed. - dated 5/18/25, to elevate the HOB at 30 to 45 degrees at all times during feeding and for at least 30 to 40 minutes after the feeding has stopped. On 6/2/25 at 1055 hours, Resident 27 was observed lying in bed and receiving the enteral feeding with the HOB elevated less than 30 degrees. On 6/2/25 at 1106 hours, an observation and concurrent interview was conducted with LVN 2. LVN 2 verified Resident 27's HOB was elevated less than 30 degrees while the resident was receiving the enteral tube feeding. LVN 2 stated Resident 27's HOB should have been elevated at 30 to 40 degrees to help the resident's digestion with enteral feeding. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/4/25 at 0821 hours, an interview was conducted with the DON. The DON stated when the resident was receiving the enteral feeding the expectation was to monitor the resident to ensure they tolerated the feedings and to elevate the HOB at least 30 degrees and above to prevent aspiration pneumonia (lung infection when food, liquid, or other material are inhaled into the lungs). On 6/5/25 at 1508 hours, an interview as conducted with the DON, ADON, and DSD. The DON, ADON, and DSD were informed and acknowledged the above findings. 2. Medical record review for Resident 72 was initiated on 6/4/25. Resident 72 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 72's MDS assessment dated [DATE], showed Resident 72 had dysphagia. a. Review of Resident 72's Order Summary Report dated 6/4/25, did not show a diet order. Review of Resident 72's Nutrition Assessment V2 dated 2/11/25, showed Resident 72 had swallowing problems. On 6/4/25 at 0939 hours, an interview and concurrent medical record review for Resident 72 was conducted with RN 1. RN 1 stated all the residents were required to have a diet order, including the residents who had a GT. A diet order should be included in the resident's admission orders, and the licensed nurse would notify the resident's physician if an order needed to be changed or discontinued. RN 1 verified there was no diet order for Resident 72. RN 1 further stated the residents should have a diet order to make sure they had the appropriate diet for chewing and swallowing. On 6/5/25 at 0914 hours, an interview was conducted with the DON. The DON stated all the residents were required to have a diet ordered, including the residents who had a GT. A diet order should be included in the admission orders and if there was no physician's order, the expectation was to notify the resident's physician to obtain a NPO (nothing by mouth) order or speech therapy evaluation for a diet order. The DON further stated a diet order was important to ensure it was safe to give a resident anything, such as water, by mouth. b. Review of Resident 72's Order Summary Report dated 6/4/25, showed the following orders: - dated 2/28/25, to elevate the HOB at 30 to 45 degrees at all times during feeding and for at least 30 to 40 minutes after the feeding has stopped. - dated 3/26/25, to administer Nepro 1.8 (enteral feeding formula) at 45 ml an hour for 20 hours per day, to provide 900 ml/1620 kcals per day, start at 1100 hours, and continue until the required dose is completed. Review of Resident 72's plan of care dated 2/7/25, showed a care plan addressing Resident 72's dysphagia diagnosis. The interventions included to elevate the HOB at 45 degrees during and thirty minutes after tube feeds. On 6/2/25 at 1120 hours, Resident 72 was observed lying in bed and receiving the enteral feeding with the HOB elevated less than 30 degrees. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/2/25 at 1130 hours, an observation and concurrent interview for Resident 72 was conducted with LVN 1. LVN 1 verified Resident 72's HOB was elevated less than 30 degrees while the resident was receiving the enteral tube feeding. LVN 1 stated Resident 72's HOB should have been elevated at 30 to 45 degrees to prevent aspiration. On 6/4/25 at 0821 hours, an interview was conducted with the DON. The DON stated when the resident was receiving the enteral feeding the expectation was to monitor the resident to ensure they were tolerating the feedings and to elevate the HOB at least 30 degrees and above to prevent aspiration pneumonia (lung infection when food, liquid, or other material are inhaled into the lungs). On 6/5/25 at 1508 hours, an interview as conducted with the DON, ADON, and DSD. The DON, ADON, and DSD were informed and acknowledged the above findings. 3. Medical record review for Resident 54 was initiated on 6/4/25. Resident 54 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 54's Nutrition Assessment V2 dated 4/29/25, showed Resident 54 had swallowing problems. Review of Resident 54's MDS assessment dated [DATE], showed Resident 54 had a feeding tube. Review of Resident 54's Order Summary Report dated 6/4/25, did not show a diet order. On 6/4/25 at 0939 hours, an interview and concurrent medical record review for Resident 54 was conducted with RN 1. RN 1 stated all the residents were required to have a diet order, including the residents who had a GT. A diet order should be included in the admission orders for the resident, the licensed nurse would notify the resident's physician if an order needs to be changed or discontinued. RN 1 verified there was no diet order for Resident 54. RN 1 further stated residents should have a diet order to make sure they had the appropriate diet for chewing and swallowing. On 6/5/25 at 0914 hours, an interview was conducted with the DON. The DON stated all the residents were required to have a diet ordered, including the residents who had a GT. A diet order should be included in the admission orders and if there was no order the expectation was to notify the resident's physician to obtain a NPO (nothing by mouth) order or speech therapy evaluation for a diet order. The DON further stated a diet order was important to ensure it was safe to give a resident anything, such as water, by mouth. On 6/5/25 at 1508 hours, an interview as conducted with the DON, ADON, and DSD. The DON, ADON, and DSD were informed and acknowledged the above findings.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to maintain the IV accesses for one nonsampled resident (Resident 45) who had peripheral IV (PIV) access. * The facility failed to properly label Resident 45's PIV access and discontinue the PIV catheter per the facility's P&P. This failure posed the risk of Resident 45 developing complications related to the use of the peripheral IV catheter. Findings: Review of the facility's P&P titled Peripheral IV Catheter Insertion revised 4/2016 showed the label on the dressing should include date and time of dressing placement, initials, gauge size, and length of catheter. Remove the peripheral catheter if it has not been used for 24 hours or if therapy is discontinued. On 6/2/25 at 0918 hours, an observation of Resident 45 was conducted in Resident 45's room. Resident 45 was observed to have a PIV on his right arm. The PIV was not observed labeled. On 6/2/25 at 0927 hours, a concurrent observation and interview was conducted with RN 3. RN 3 stated Resident 45 had no IV orders. RN 3 observed and verified the above findings. RN 3 stated the IV site should be labeled with the day it was inserted and initials. RN 3 stated the last time Resident 45's IV was used was last week. On 6/2/25 at 1621 hours, a follow up interview was conducted with RN 3. RN 3 stated Resident 45's PIV was started on 5/25/25 for the antibiotics. RN 3 stated the IV antibiotics were discontinued on 5/29/25 and Resident 45 was started on oral antibiotics on 5/29/25. RN 3 stated the PIV should be discontinued after the IV antibiotics were completed and should be discontinued right away. RN 3 stated it should be discontinued because Resident 45 did not need it and it could cause an infection. Medical record review for Resident 45 was initiated on 6/2/25. Resident 45 was admitted to the facility on [DATE]. Review of Resident 45's telephone physician's order dated 5/25/25, showed an order for meropenem IV solution reconstituted, use one gram IV every eight hours for leukocytosis (increased white blood cells) for seven days. Review of Resident 45's telephone physician's order dated 5/29/25, showed an order to discontinue meropenem IV solution reconstituted, use one gram IV every eight hours for leukocytosis (increased white blood cells) for seven days. Review of Resident 45's Order Summary Report dated 6/2/25, showed a physician's order dated 5/30/25, for amoxicillin oral capsule (antibiotic) 500 mg, give one capsule via GT three times a day for urinary tract infection for five days. However, there were no active physician's orders for an IV medication or for IV maintenance. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/3/25 at 1433 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. The DON stated the PIV should be labeled with the date of the insertion and initials of the staff that started the IV line. The DON stated the PIV should be discontinued within 24 hours if infiltrated, if it needed to be replaced, or if the antibiotics were finished to prevent infection at the site.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure adequate respiratory services. * The facility failed to ensure an adequate number of portable oxygen tanks were kept on site for use in an emergency for the residents with a physician's order for continuous supplemental oxygen therapy for 51 of 52 residents who resided in the subacute unit and four of 41 residents who resided in skilled nursing unit. * The facility's total number of portable oxygen tanks consisted of 46 tanks (43 E tanks and three H tanks). However, a total of 55 residents in the facility had a physician's order for a continuous supplemental oxygen. Failure to ensure an adequate number of portable oxygen tanks were available on site, for the residents who required continuous supplemental oxygen, posed the risk for negative health outcomes in the event of an emergency, in which the building was rendered unsafe and an evacuation of the residents from the facility was necessary. * The facility failed to ensure one of 22 final sampled residents (Resident 30) BiPap machine (bilevel positive airway pressure, type of medical device that is commonly used to help people with breathing difficulties during sleep) and stand was maintained in a clean and sanitary condition. This failure had the potential to adversely affect the health and well-being Resident 30 and posed the risk for equipment contamination and respiratory complications. Findings: 1. Review of facility's Order Listing Report dated 6/2/25, showed 51 residents who resided in the subacute unit and four residents who resided in the skilled nursing unit, had a physician's order for continuous supplemental oxygen therapy. On 6/2/25 at 1001 hours, an observation, interview, and concurrent medical record review was conducted with RT 1. An inventory of the facility's portable oxygen tanks was conducted with RT 1. A total of 43 E oxygen tanks and three H oxygen tanks were observed stored at several locations throughout the facility. RT 1 verified the facility's total number of onsite portable oxygen tanks consisted of 46 tanks (43 E tanks and three H tanks). However, a total of 55 residents in the facility had an active physician's order for continuous supplemental oxygen. RT 1 verified in the event of an emergency in which the building was rendered unsafe (e.g. an earthquake) and an evacuation of the residents from the facility was necessary, the facility did not have enough portable oxygen tanks available (46 tanks), to supply all the residents (55 residents) with orders for continuous supplemental oxygen, with oxygen during an evacuation of the facility. Cross reference F838. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of the facility's P&P titled CPAP/BiPap Support dated 3/2015 showed general guidelines for cleaning. Specific cleaning instructions are obtained from the manufacturer/supplier for the PAP device. These guidelines are for single-resident use cleaning. Machine cleaning: Wipe machine with warm, soapy water and rinse at least once a week and as needed. Humidifier (if used): a. use clean, distilled water only in the humidifier chamber. b. clean humidifier weekly and air dry. c. to disinfect, place vinegar-water solution (1:3) in clean humidifier. Soak for 30 minutes and rinse thoroughly. 6. Filter cleaning; a. rinse washable filter under running water once a week to remove dust and debris. Replace this filter at least once a year. 7. Masks, nasal pillows and tubing: Clean daily by placing in warm, soapy water and soaking/agitating for 5 minutes. Mild dish detergent is recommended. Rinse with warm water and allow it to air dry between uses. 8. Headgear (strap): Wash with warm water and mild detergent as needed. Allow to air dry. Medical record review for Resident 30 was initiated on 6/2/25. Resident 30 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 30's H&P examination dated 9/14/24, showed Resident 30 had the capacity to understand and make decisions. Review of Resident 30's Order Summary Report dated 6/3/25, showed the physician's order dated 9/13/24, to apply the BIPAP per nasal cannula mask. Settings: Pressure 5 cmH2O at bedtime until morning for diagnosis: acute respiratory failure with hypoxia. Review of Resident 30's licensed progress notes, MAR and TAR for June 2025 showed no documentation Resident 30's BiPAP machine and stand was cleaned. On 6/2/25 at 0948 hours, during the initial tour of the facility, Resident 30 was not in his room, however, Resident 30's BiPAP machine basket and stand was observed to contain an overflowing trash of used facial tissues, crumpled papers, empty soda cans collected in clear plastic bag and an unlabeled urinal. On 6/2/25 at 1128 hours, an observation and a concurrent interview was conducted with Resident 30. The BiPAP machine basket was still observed to be with overflowing trash, used soda cans and an unlabeled urinal. Resident 30 was asked when his BiPAP machine was last cleaned. Resident 30 stated he asked the facility staff to clean his BiPAP machine, but they did not. On 6/2/25 at 1131 hours, an observation and a concurrent interview was conducted with LVN 3. LVN 3 saw the overflowing trash, empty soda cans in a clear plastic bag and unlabeled urinal found on Resident 30's BiPAP machine basket and stand. LVN 3 was asked what the facility's process was on maintaining the cleanliness of the BiPAP machine. LVN 3 verified Resident 30's BiPAP should have been maintained clean for infection prevention and control. LVN 3 acknowledged Resident 30's urinal should have been labeled and not hung on a BiPAP machine stand. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/5/25 AT 0948 hours, an interview and a concurrent medical record review for Resident 30 was conducted with LVN 4. LVN 4 was asked when Resident 30's BiPAP machine was recently cleaned. LVN 4 stated it was usually cleaned every Sunday. LVN 4 was informed on Resident 30's BiPAP machine basket and stand was overflowing with trash, empty soda cans placed in a clear plastic bag and unlabeled urinal last 6/2/25, on a Monday. LVN 4 stated since it was found to be with overflowing trash last Monday 6/2/25, she verified that it was not cleaned the day before 6/1/25, a Sunday. LVN 4 acknowledged there was no documentation she could find from Resident 30's MAR, TAR, and licensed progress notes that Resident 30's BiPAP machine was cleaned. On 6/5/25 at 1350 hours, an interview was conducted with the DON. The DON verified the above findings.

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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** Based on interview, medical record review, and facility P&P review, the facility failed to provide the pharmaceutical services to meet the resident's needs for one of five final sampled residents (Resident 78) reviewed for unnecessary medications. * The facility failed to ensure Resident 78's enoxaparin (anticoagulant medication) injection sites were rotated. This failure had the potential for poor health outcome for Resident 78. Findings: Review of the facility's P&P titled Subcutaneous Injections dated March 2011 showed the licensed nurses should verify the physician's order including the resident's name, drug name, dose, time, and route of administration. The procedures included the following: - To assist the resident to a comfortable position and asked to relax the arm, leg, or abdomen depending on the site chosen for the injection. Medical record review for Resident 78 was initiated on 6/5/25. Resident 78 was admitted to the facility on [DATE]. Review of Resident 78's Order Summary Report dated 6/4/25, showed a physician's order dated 3/18/25, to administer enoxaparin sodium injection 40 mg subcutaneously two time a day for DVT prophylaxis. Rotate the site. Review of Resident 597's Location of Administration Report for May 2025 for Resident 78's enoxaparin injection showed the injection sites were not rotated on the following dates and times: - On 5/11/25 at 0549 hours, the enoxaparin medication was administered subcutaneously to the left lower quadrant of the abdomen. - On 5/11/25 at 1820 hours, the enoxaparin medication was administered subcutaneously to the left lower quadrant of the abdomen. - On 5/12/25 at 0529 hours, the enoxaparin medication was administered subcutaneously to the left lower quadrant of the abdomen. - On 5/15/25 at 0039 hours, the enoxaparin medication was administered subcutaneously to the left lower quadrant of the abdomen. - On 5/15/25 at 2359 hours, the enoxaparin medication was administered subcutaneously to the left lower quadrant of the abdomen. - On 5/16/25 at 0621 hours, the enoxaparin medication was administered subcutaneously to the left lower quadrant of the abdomen. (continued on next page)

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 5/21/25 at 1923 hours, the enoxaparin medication was administered subcutaneously to the right lower quadrant of the abdomen. - On 5/22/25 at 0604 hours, the enoxaparin medication was administered subcutaneously to the right lower quadrant of the abdomen. - On 5/23/25 at 1749 hours, the enoxaparin medication was administered subcutaneously to the right lower quadrant of the abdomen. - On 5/24/25 at 0530 hours, the enoxaparin medication was administered subcutaneously to the right lower quadrant of the abdomen. - On 5/27/25 at 0502 hours, the enoxaparin medication was administered subcutaneously to the left lower quadrant of the abdomen. - On 5/27/25 at 0229 hours, the enoxaparin medication was administered subcutaneously to the right lower quadrant of the abdomen. On 6/5/25 at 1146 hours, an interview and concurrent medical record review for Resident 78 was conducted with LVN 2. LVN 2 verified Resident 78 was on anticoagulant medication for DVT prophylaxis and monitored for any signs and symptoms for bleeding. LVN 2 was asked what the things were she need to remember when administering the enoxaparin medication injection to the resident. LVN 2 stated she would verify the physician's order and check the last injection sites administered by the licensed nurse from the MAR and would rotate the injection sites. LVN 2 was asked why it was important for the administration of injection sites to rotate. LVN 2 stated to prevent any pain or bruising on the injection sites. LVN 2 was asked to review the previous injection sites administered by licensed nurses for the enoxaparin injections. LVN 2 verified the previous injections sites documented in the MAR were not rotated. On 6/5/25 at 1046 hours, an interview and concurrent medical record review for Resident 78 was conducted with RN 2. RN 2 was asked what the facility's process for the licensed nurse was when administering a subcutaneous injection. RN 2 stated the licensed nurses should check, verify the physician's order for the correct medication and to rotate the injections sites. RN 2 stated the rotation of injections sites was needed to lessen the pain or discomfort of the resident. RN 2 was asked about Resident 78's enoxaparin injection medication for DVT prophylaxis. RN 2 verified the physician's order for the enoxaparin injection medication for DVT prophylaxis including the instruction to rotate the sites. RN 2 was asked to review the MAR for Resident 78's administration of enoxaparin medication injection sites. RN 2 reviewed the MAR and verified the injections sites were not rotated. RN 2 stated the administration injections sites should have been rotated. On 6/5/25 at 1027 hours, an interview and concurrent medical record review for Resident 78 was conducted with the DON. The DON stated she expected the licensed nurses would follow the facility's P&P on administering medications. The DON was informed and verified the above findings.

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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** Based on observation, interview, medical record review, and facility P&P review, the facility failed to identify and report a medication irregularity to the facility for one of 22 final sampled residents (Resident 42). * Resident 42 had a physician's order for docusate sodium medication; however, there was no specified dose indicated on the order. This failure posed the risk for Resident 42 to have adverse consequences from the medication. Findings. Review of the facility's P&P titled Medication Utilization and Prescribing- Clinical Protocol dated 4/2018 showed the consultant pharmacist should use the monthly and interim drug regimen review to help identify potentially problematic medications, including medications regimens that are not supported based on clinical signs and symptoms. On 6/3/25 at 0752 hours, a medication administration observation was conducted with LVN 1 for Resident 42. LVN 1 was observed preparing for the following medications in the medication cup for each medication. - one tablet of docusate sodium 100 mg; - one tablet of pepcid (medication that treats and prevents heartburn from acid indigestion and upset stomach) 20 mg; - 5 ml of iron syrup (supplement) 220 mg/5 ml; - one tablet of folic Acid (supplement), one mg; - one tablet of metoprolol (medication that lowers the blood pressure) 100 mg; - one tablet of multivitamin with minerals (supplement); and, - two tablets of vitamin D3 (supplement) 1000 IU. LVN 1 then crushed the above medications, mixed them separately in the water and administered the above medications through the GT. Medical record review for Resident 42 was initiated on 6/3/25. Resident 42 was admitted to the facility on [DATE]. Review of the Resident 42's Order Summary Report showed an order dated 7/1/24, for docusate sodium one tablet via GT two times a day for bowel management. Hold for loose stools to give at 0900 hours and 2100 hours. Further review of the physician's order did not show the specified dose of the medication to be administered. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 42's MAR from 5/1 to 6/3/25 showed an order dated 7/1/24, for docusate sodium one tablet via GT two times a day for bowel management. Further review of the MAR did not show the specified dose of the docusate sodium medication. In addition, the MAR showed Resident 42 had been receiving the above medication. Review of the Resident 42's medication regimen review document titled Note to Attending Physician/Prescriber dated 3/13/25 and 4/8/25, did not show if the medication regimen review identified the physician's order for the medication docusate sodium without the specified dose. On 6/3/25 at 1035 hours, an interview and concurrent medical record review for Resident 42 was conducted with LVN 1. LVN 1 verified the physician's order did not specify the dose of the medication. In addition, LVN 1 verified he administered one tablet of docusate sodium 100 mg medication. LVN 1 stated facility had tablet of 100 mg docusate sodium, and did not have other doses of docusate sodium in tablets, so he assumed it was 100 mg tablet and administered the medication. LVN 1 acknowledged there were other doses of docusate sodium tablet was available in the market and should have clarified the dose of the above medication with the physician before administering the medication to the Resident 42. LVN 1 stated Resident 42 had been receiving the above medication since it was ordered on 7/1/24. On 6/5/25 at 0933 hours, an interview was conducted with the DON. The DON acknowledged the above findings. On 6/5/25 at 1153 hours, a telephone interview was conducted with the Pharmacy Consultant. The Pharmacy Consultant was informed of the above findings. The Pharmacy Consultant stated each medication should have a specified dose. The Pharmacy Consultant further stated medication doses were also reviewed during the monthly medication regimen review. The Pharmacy Consultant stated the above medication order for the docusate sodium for Resident 42 without the specified dose was missed during the monthly review of the medication regimen and should have been identified during the monthly medication regimen review. Cross reference to F759, example #2

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. Review of the facility's P&P titled Administering Medication through an Enteral Tube dated 11/2018 showed under the section preparation showed to verify that there is a physician's medication order for this procedure. Further review of the P&P showed to check the label, confirm the medication name and dose with the MAR . to calculate the medication dose and to re-check the calculation. On 6/3/25 at 0752 hours, a medication administration observation was conducted with LVN 1 for Resident 42. LVN 1 was observed preparing for the following medications in the seperate medication cup for each medication: - one tablet of docusate sodium (stool softener), 100 mg; - one tablet of pepcid (medication that treats and prevents heartburn from acid indigestion and upset stomach) 20 mg; - 5 ml of iron syrup (supplement), 220 mg/5 ml; - one tablet of folic acid (supplement), 1 mg; - one tablet of metoprolol (medication that lowers the blood pressure), 100 mg; - one tablet of multivitamin with minerals (supplement); and, - two tablets of vitamin D3 (supplement) 1000 IU. LVN 1 was then observed crushing the above medication, mixing separately in the water, and administering the above medication through the GT. Medical record review for Resident 42 was initiated on 6/3/25. Resident 42 was admitted to the facility on [DATE]. Review of the Resident 42's Order Summary Report showed a physician's order dated 7/1/24, for docusate sodium one tablet via GT two times a day for bowel management. Hold for loose stools to give at 0900 hours and 2100 hours. Further review of the physician's order did not show the dose of the medication to be administered. Review of the MAR dated 5/1 to 5/31/25 and 6/1 to 6/3/25 showed an order dated 7/1/24, for docusate sodium one tablet via GT two times a day for bowel management. Further review of the MAR did not show the dose of the above medication and also showed Resident 42 had been receiving the above medication. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/3/25 at 1035 hours, an interview and concurrent medical record review for Resident 42 was conducted with LVN 1. LVN 1 verified the physician's order did not specify the dose of the medication. In addition, LVN 1 verified he administered the medication docusate sodium 100 mg, one tablet. LVN 1 stated the facility had tablets of 100 mg docusate sodium, and did not have other doses of docusate sodium in tablets, so he thought it was 100 mg tablet and administered the medication. LVN 1 acknowledged there were other doses of docusate sodium tablet was available in the market and should have clarified the dose of the above medication with the physician before administering the medication to the Resident 42. LVN 1 verified the Resident 42 had order for the medication docusate sodium tablet with out specified dose since 7/1/24, and the resident was receiving the above medication. On 6/5/25 at 0933 hours, an interview was conducted with the DON. The DON acknowledged the above findings and stated every medication should have the dose specified and LVN 1 should have clarified the medication dose before administering the medication docusate sodium 100 mg to Resident 42. Cross reference F756 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the medication error rate was below 5%. The facility's medication error rate was 14.29%. Two of four licensed nurses (LVNs 1 and 6) were found to have made errors during the medication administration observation for two nonsampled residents (Residents 42 and 79). * LVN 6 failed to ensure the full dosages for three of nine prescribed medications were administered to Resident 79 as per the physician's orders. * The facility failed to ensure LVN 1 verified the dose of the medication before administration of the medication docusate sodium (stool softener) for Resident 42. These failures had the potential to negatively affect the residents' health. Findings: 1. On 6/3/25 at 0801 hours, a medication administration observation for Resident 79 was conducted with LVN 6. LVN 6 prepared the following medications for Resident 79: - artificial tears lubricant (eye drop, use for dry eye) - aspirin (nonsteroidal anti-inflammatory medication) 81 one tablet - clopidogrel (anti-platelet medication) 75 mg one tablet - famotidine (medication to reduce stomach acid production) 20 mg one tablet - heparin (anticoagulant medication) 5000 unit one vials - iron (supplement) 7.5 ml - multi vitamins with minerals (supplement) one tablet (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- povidone external swab, one packet swab - Pro-stat (supplement) 30 ml - vitamin C (supplement) 5 ml - vitamin D3 (supplement) 25 mcg (1000 IU) one tablet LVN 6 separately crushed the five tablet medications, placed them in a cup and individually labeled with the names of the medications. LVN 6 administered the medications individually via GT. After the administration, the medication cups used were inspected for medication residue with LVN 6. LVN 6 verified the medication cups for aspirin, vitamin D3, and multivitamins with minerals still had medication residue. Medical record review for Resident 79 was initiated on 6/2/25. Resident 79 was admitted on [DATE], and readmitted to the facility on [DATE]. Review of Resident 79's Order Summary Report dated 6/3/25, showed the following physician's orders dated 5/8/25 at 0900 hours, to administer the following: - multiple vitamins with minerals one tablet via GT one time a day; - cholecalciferol 25 mcg (1000 UT) one tablet via GT in the morning; - aspirin 81 mg chewable one tablet via GT one time a day; - clopidogrel bisulfate 75 mg one tablet via GT one time a day; - famotidine 20 mg one tablet via GT one time a day; - ferrous sulfate oral solution 220 mg/5 ml, give 7.5 ml via GT in the morning; - heparin injection 5000 unit/ml inject one ml subcutaneously two times a day; - polyvinyl alcohol ophthalmic solution 1.4% instill two drop in both eyes four times a day; -dated 5/8/25, to administer Pro-stat sugar free oral liquid (Amino Acids-Protein Hydrolysate) 30 ml via GT every 12 hours; - vitamin C 500 mg/5 ml, give 5 ml via GT in the morning; and - Povidone-Iodine external swab 10% one applicator in each nostril every 12 hours. On 6/5/25 at 1415 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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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. 3. Review of the facility's P&P titled Storage of Medications revised 4/2019 showed the facility stores all the drugs and biologicals in a safe, secure, and orderly manner. Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light, and humidity controls. On 6/2/25 at 0945 hours, a concurrent observation and interview was conducted with Resident 47 in her room. Resident 47 was observed with a clean dressing over her below the knee amputation stump. A clear medicine cup was observed filled with a dark liquid and placed on top of her nightstand. Resident 47 stated she did not know what was in the medicine cup. On 6/2/25 at 0950 hours, a concurrent observation and interview was conducted with the DON in Resident 47's room. The medicine cup was filled with a dark liquid was observed on Resident 47's nightstand. The DON was observed to pick up the medicine cup and smell the dark liquid. The DON stated it was Betadine (an antiseptic solution which helps prevent skin infections), it should not be kept at the bedside and proceeded to take the medicine cup out of Resident 47's room. On 6/3/25 at 1433 hours, a follow up interview was conducted with the DON. The DON stated the Betadine was a medication and was prescribed to the resident as a treatment. The DON stated they were not allowed to keep it at the bedside because it could spill, or some might think they had to drink it. Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary pharmacy services to ensure proper medication storage. * The facility failed to ensure the expired medications were removed from the medication cart. * Medication Cart A was left unlocked in an area where the resident, other staff or visitor could access it * The facility failed to ensure the betadine medication was not stored at Resident 47's bedside. These failures had the potential to negatively impact the residents' well-being, and medication errors. Findings: Review of the facility's P&P titled Storage of Medications revised 4/2019 showed the discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed. 1. a. On 6/3/25 at 1117 hours, an inspection for Medication Cart A was conducted with LVN 2. During the inspection of Medication Cart A, the following was observed: - one bottle of Instant hand sanitizer non-sterile with expiration date 6/1/23 (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LVN 2 verified the above findings. b. On 6/3/25 at 1145 hours, an inspection for Medication Cart B was conducted with LVN 7. During the inspection of Medication Cart B, the following was observed: - one bottle of Curad iodoform packing strip with expiration date of 1/10/25 LVN 7 verified the above findings. 2. Review of the facility's P&P titled Storage of Medication revised 4/2019 showed the facility stores all the drugs and biologicals in a safe, secure, and orderly manner. Unlocked medication carts are not left unattended. On 6/3/25 at 0859 hours, a concurrent observation and interview was conducted with LVN 2. LVN 2 left the medication cart unlocked and went into a resident's room to administer the medications. LVN 2 verified the medication cart was not locked when she went inside the resident's room to administer medications. On 6/5/25 at 1415 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the food safety and sanitation guidelines were followed as evidenced by: * The can opener blade's coating was observed to be removed. * Two frying pans were observed to have grayish black residue. * Strainer was observed to be with white residue. * An opened box of gloves was placed on top of plates where clean plates were stored. * The roof surface of the microwave used by residents was observed to be scattered food residue. These failures posed the risk for food borne illnesses for the 39 residents who consumed food prepared in the kitchen. Findings: Review of the facility's Matrix dated 6/2/25, showed 39 of 93 residents who resided in the facility consumed food prepared in the kitchen. According to the USDA Food Code 2022, Section 4-601.11 Equipment, Food -Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES AND UTENSILS shall be clean to sight and touch. (C) NonFOOD -CONTACT SURFACES OF EQUIPMENT shall be kept free of an accumulation of dust, dirt, food residue and other debris. On 6/2/25 at 0756 hours, an initial tour and a concurrent interview was conducted with the Dietary Service Supervisor. The following observations were noticeable for further inquiries to the Dietary Service Supervisor during the initial tour: - the Dietary Service Supervisor was asked to pull out the can opener blade located near the preparation table. The can opener's blade coating was observed to be removed or stripped. - two frying pans that was hung together with other clean pots and pans were observed to have grayish black residue. - one strainer that was hung together with other clean pots and pans was observed to be with white residue. The Dietary Service Supervisor verified the can opener, two frying pans, and strainer would be disposed of and would change to a new one. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/3/25 at 0844 hours, an observation on the dishwashing area and a concurrent interview was conducted with the Kitchen Dishwasher. An opened box of gloves was observed to be placed on top of white plates where clean plates were stored. The Kitchen Dishwasher verified the opened box of gloves should have not been placed in the shelf where clean plates were stored. On 6/3/25 at 1356 hours, an observation on residents' microwave and a concurrent interview was conducted with LVN 1. The roof surface of residents' microwave was observed to be with scattered yellow brown residue. On 6/5/25 at 1350 hours, an interview was conducted with the DON. The DON verified the above findings.

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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. Based on observation, interview, and facility P&P review, the facility failed to dispose and store the trash in a sanitary manner. Three of four dumpster were observed overflowing with trash which prevented the lids from fully closing. This failure had the potential to harbor pests and for pest contamination. * Two of five dumpster bins were observed to be overflowing with trash which prevented the lids from fully closing. * Seven sharps' disposal containers were not properly disposed in the biohazard waste dumpster bins in the Infectious Waste Matter Room. These had the potential to attract and harbor pests and/ or rodents and potentially cause spread of diseases. Findings: According to the US Food Code 2013, 5-501.113, Covering Receptacles, receptacle units for refuse shall be kept covered with tight fitting lids after they are filled. On 6/2/25 at 1056 hours, an observation of the trash disposal and concurrent interview was conducted with the Central Supply Supervisor. One recyclable dumpster bin and one regular trash dumpster bin were observed to be overflowing with trash which prevented the lids from fully closing. Scattered trash such as used gloves, used masks, red straw, ketchup sachet, white plastic, and a portable table were found scattered on the ground where the recyclable dumpster bin was located. The Central Supply Supervisor verified the dumpster bins should not be overflowing, should be closed and the ground where the dumpster bins were located should always be maintained clean to pest prevention and control. On 6/2/25 at 1102 hours, an observation on sharps disposal in the Infectious Waste Matter Room and a concurrent interview was conducted with the Central Supply Supervisor. There were two biohazard dumpsters in the Infectious Waste Matter Room. Two sharps disposable containers were observed to be placed on top of one biohazard dumpster bin and five sharps disposable containers were placed on top of another biohazard dumpster bin. The Central Supply Supervisor verified the sharps disposable containers should be properly disposed in the biohazard dumpster bins to prevent spread of diseases. On 6/2/25 at 1105 hours, an observation where the facility's generator machine was located and a concurrent interview was conducted with the Central Supply Supervisor. A rolling cart containing two wheels of a wheelchair, wrecked filing cabinet, and a pot was observed to be beside the generator machine. The Central Supply Supervisor acknowledged the trash should not be in the generator machine area and should have been disposed in the recyclable dumpster bin. The Central Supply Supervisor stated he would throw them away after the interview. On 6/5/25 at 1350 hours, an interview was conducted with the DON. The DON verified the above findings.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and facility document review, the facility failed to determine the number of portable oxygen tanks needed to conduct an emergency evacuation of residents who required continuous supplemental oxygen therapy for 51 of 52 residents who resided in the subacute unit and four of 41 residents who resided in skilled nursing unit. * The total number of residents residing in the facility (subacute unit and skilled nursing unit) who had an active physician's order for continuous supplemental oxygen was 55. However, the facility had a total inventory of 46 full oxygen tanks on site. This posed the risk for negative health outcomes for the residents in the event of an emergent evacuation from the facility. Findings: Review of the Facility assessment dated [DATE], showed the central supply staff would monitor the availability of supplies in the facility. Emergency supplies were being monitored and replenished daily, weekly, and monthly. Further review of the Facility Assessment failed to show information specific to the number of portable oxygen tanks needed to be stored on site (for residents who required continuous supplemental oxygen) in the event of an emergency in which the building was rendered unsafe and an evacuation of the residents from the facility was necessary. On 6/4/25 at 1414 hours, an interview and concurrent facility document review was conducted with the Assistant Administrator. The Assistant Administrator stated the annual Facility Assessment was conducted to determine the care residents needed and to determine what resources were necessary to provide care for residents during day-to-day operations and in the event of an emergency. The Assistant Administrator reviewed the Facility assessment dated [DATE], and verified the Facility Assessment failed to show the number of portable oxygen tanks the facility needed to store on site, in order to conduct a resident evacuation (for residents with orders for continuous oxygen therapy) in the event of an emergency (e.g. earthquake). The Assistant Administrator verified past facility assessments included information specific to the average number of residents who received continuous oxygen therapy and included a section which indicated the total number of portable oxygen tanks needed onsite. The Assistant Administrator stated the current facility assessment (dated 4/1/25) should have included this information to ensure the facility could safely evacuate residents (with orders for continuous oxygen) in the event of an emergent evacuation of the facility. The Assistant Administrator verified the facility's Order Listing Report dated 6/2/25, showed 51 residents who resided in the subacute unit and four residents who resided in the skilled nursing unit, had an active physician's order for continuous supplemental oxygen therapy. The Assistant Administrator was informed on 6/2/25, an inventory of the facility's portable oxygen tanks was conducted with RT 1. A total of 43 E oxygen tanks and three H oxygen tanks were observed stored on site within the facility. (continued on next page)

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Healthcare Center of Orange County	9021 Knott Ave Buena Park, CA 90620

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Assistant Administrator verified if the 55 residents who required continuous supplemental oxygen (as of 6/2/25), had to be transferred outside of the building in the event of an earthquake that damaged and rendered the building unsafe, the facility's inventory of 46 full oxygen tanks would be insufficient to provide those residents with continuous oxygen during an emergent transfer from the building.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and medical record review, the facility failed to ensure the medical records for two of 22 final sampled residents (Residents 58 and 33) were complete and accurate. * The facility failed to ensure Resident 58's physician's order dated 1/29/25, on NPO diet, NPO texture, NPO consistency was discontinued (NPO stands for nil per os or nothing by mouth). * The facility failed to ensure Resident 33's blood pressure access site was accurately documented in the resident's medical record. These failures had the potential for the residents' care needs not being met as their medical information was incomplete and inaccurate. Findings: 1. Medical record review for Resident 58 was initiated on 6/2/25. Resident 58 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 58's Order Summary Report dated 6/2/25, showed a physician's orders: - dated 1/29/25, for NPO diet, NPO texture, NPO consistency. - dated 5/13/25, for NAS (No added salt) diet pureed texture , regular/thin consistency for oral gratification. On 6/2/25 at 1238 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 was asked about Resident 58's physician's orders on NPO diet and NAS diet for oral gratification. RN 1 showed documentation Resident 58 was offered for oral gratification since 5/13/25, however, RN 1 verified the physician's order dated 1/29/25, on NPO diet was missed to be discontinued and should have been discontinued to avoid confusion. On 6/5/25 at 1350 hours, an interview was conducted with the DON. The DON verified the above findings. 2. Review of the facility's P&P titled Hemodialysis Catheters-Access and Care of revised 2/2023 showed do not use the resident's access arm to take the blood pressure. Medical record review for Resident 33 was initiated on 6/2/25. Resident 33 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 33's Order Summary Report dated 6/3/25, showed an order dated 3/21/25, for no blood pressure, IV, IM and blood draw on the left upper extremity AV shunt. Review of Residents 33's MDS assessment dated [DATE], showed Resident 33's BIMS score was 15 (meaning cognitively intact). (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 33's Weights and Vitals Summary from 5/16 to 5/31/25, showed documentation the BP readings were obtained from the left arm one to three times each day. For example: - On 5/21/25 at 0520 hours, a BP reading of 116/70 mmHg on the left arm - On 5/23/25 at 0452 hours, a BP reading of 148/80 mmHg on the left arm - On 5/23/25 at 2318 hours, a BP reading of 128/75 mmHg on the left arm - On 5/24/25 at 1004 hours, a BP reading of 155/89 mmHg on the left arm - On 5/24/25 at 1245 hours, a BP reading of 132/56 mmHg on the left arm - On 5/24/25 at 2038 hours, a BP reading of 143/66 mmHg on the left arm - On 5/25/25 at 0934 hours, a BP reading of 156/86 mmHg on the left arm - On 5/25/25 at 2039 hours, a BP reading of 132/74 mmHg on the left arm - On 5/26/25 at 0101 hours, a BP reading of 130/72 mmHg on the left arm - On 5/26/25 at 0945 hours, a BP reading of 158/89 mmHg on the left arm - On 5/27/25 at 1535 hours, a BP reading of 121/66 mmHg on the left arm - On 5/31/25 at 0935 hours, a BP reading of 100/53 mmHg on the left arm - On 5/31/25 at 1423 hours, a BP reading of 128/74 mmHg on the left arm On 6/4/25 at 0806 hours, an observation and concurrent interview with Resident 33 was conducted. Resident 33 was observed lying in bed with an AV shunt to the left upper arm. Resident 33 stated the left upper arm AV shunt was use for the hemodialysis and did not allow the licensed nurse to take blood pressure on his left arm. On 6/4/25 at 1349 hours, an interview and concurrent medical record review for Resident 33 was conducted with LVN 3. LVN 3 verified the licensed nurses' documentation of BP showed Resident 33's blood pressure(s) were obtained from the resident's left upper extremity. On 6/4/25 at 1403 hours, an interview and concurrent medical record review for Resident 33 was conducted with LVN 5. The LVN 5 verified and acknowledged he documented a BP reading on the left arm. On 6/4/25 at 1451 hours, an interview and concurrent medical record review for Resident 33 was conducted with the DON. The DON verified the findings and stated the blood pressure should not have been taken on the left upper arm for Resident 33.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to implement the infection control program and practices designed to provide a safe and sanitary environment to help prevent the development and transmission of communicable diseases, for one final sampled resident (Resident 63) and five nonsampled residents (Residents 8, 21, 42, 66 and 79). * The facility failed to follow the physician's order for contact isolation, for Clostridium Difficile colitis, for Resident 63, as evidenced by the following. The facility failed to place Resident 63 in a private room. The LVN failed to utilize a designated blood pressure cuff and thermometer for Resident 63 while obtaining vital signs. The CNA failed to donn PPE in accordance with contact isolation precautions. The facility failed to post a sign at the entrance to Resident 63's room showing Resident 63 had a physician's order for contact isolation. Additionally, the IP provided Resident 63's physician with incomplete information specific to Resident 63 no longer exhibiting episodes of diarrhea/loose stools. * The facility failed to ensure there was signage for isolation precautions posted outside of Room B, whose residents were on enhanced barrier precautions (Residents 8 and 66). * The facility failed to develop a facility specific water management program. * The facility failed to ensure a staff member did not transport the dirty linens against her clean scrubs. The dirty linens were from a resident on enhanced barrier precautions (Resident 21). * The facility failed to ensure LVN 1 performed hand hygiene during medication administration for Resident 42. * The facility failed to ensure LVN 6 performed hand hygiene during medication administration for Resident 79. These failures had the potential for the spread of infection to the residents, staff and visitors in the facility. Findings: Review of the facility's P&P titled Isolation Categories of Transmission Based Precaution revised 10/2018 showed when a resident is placed on transmission-based precautions, appropriate notification is placed on the room entrance door so that personnel and visitors are aware of the need for and type of precaution. The signage informs the staff of the type of CDC precautions, instructions for use of PPE, and/or instructions to see a nurse before entering the room. Contact Precautions: The individual on contact precautions will be placed in a private room if possible. Staff and visitors will wear a disposable gown upon entering the room and remove before leaving the room and avoid touching potentially contaminated surface with clothing after gown is removed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's P&P titled Clostridium Difficile (undated) showed while a resident is in isolation for Clostridium Difficile, gloves and a gown should be worn when giving direct care or having contact with the Clostridium Difficile resident's environment. Non-critical care equipment including thermometers, sphygmomanometers and stethoscopes should be dedicated to the Clostridium Difficile resident. 1. Medical record review for Resident 63 was initiated on 6/2/25. Resident 63 was admitted to the facility on [DATE]. Review of Resident 63's Order Summary Report showed a physician's order dated 5/27/25, for contact isolation precaution for Clostridium Difficile colitis until 7/8/25. Review of Resident 63's physician's order dated 5/27/25, showed an order to give Vancomycin (antibiotic) 125 mg via GT every 12 hours for Clostridium Difficile colitis until 6/14/25. On 6/5/25 at 0849 hours, an observation, medical record review, and concurrent interview was conducted with LVN 9. A sign which read Enhanced Barrier Precautions (EBP) was observed posted at the entrance to Resident 63's room (Room D). LVN 9 was observed obtaining vital signs from the three residents who resided in Room D (Residents 63, 44 and 60). LVN 9 stated he utilized the same blood pressure cuff and thermometer to obtain the three residents blood pressure and temperature (Residents 44 and 60 did not have a diagnosis of Clostridium Difficile). A review of Resident 63's active physician's orders was then conducted with LVN 9. LVN 9 verified Resident 63 had a physician's order for contact isolation precautions for Clostridium Difficile colitis. LVN 9 stated in accordance with the physician's order for contact isolation for Clostridium Difficile colitis and the facility's P&P for Clostridium Difficile, LVN 9 stated he should have utilized a designated blood pressure cuff and thermometer for Resident 63. Additionally, LVN 9 stated the sign showing EBP which was posted at the entrance to Room D was incorrect, as Resident 63 had an order for Contact Isolation Precautions. On 6/5/25 at 0856 hours, an observation and concurrent interview was conducted with CNA 3. CNA 3 was observed having entered Room D carrying a plastic bag containing bed linens. CNA 3 set the plastic bag onto Resident 63's bed. CNA 3 failed to donn gloves and only donned a gown after having entered Room D. CNA 3 verified the findings and stated she should have donned the gown and gloves before entering Room D. CNA 3 was asked the type of precautions implemented for Resident 63, to which she replied, EBP as posted at the entrance to Room D. (CNA 3 was unaware Resident 63 had an order for contact isolation for Clostridium Difficile). On 6/5/25 at 0912 hours, an interview and concurrent medical record review was conducted with the IP. The IP stated Resident 63 was readmitted to the facility from the acute care hospital on 5/27/25, with a diagnosis of Clostridium Difficile and an order for contact isolation for Clostridium Difficile. Review of Resident 63's Infection Control Note dated 5/30/25 1450 hours, showed the IP documented to discontinue the contact isolation for Resident 63, as Resident 63 was asymptomatic. The IP stated she contacted Resident 63's physician on 5/30/25, and informed Resident 63's physician Resident 63 was asymptomatic (however, the IP verified she failed to discontinue the order for contact isolation for Clostridium Difficile). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The IP was asked if she reviewed Resident 63's medical record specific to whether Resident 63 continued to have loose stools/diarrhea before having informed Resident 63's physician that Resident 63 was asymptomatic. The IP stated she failed to review Resident 63's medical record specific to whether Resident 63 continued to have loose stools/diarrhea after being readmitted to the facility status post diagnosis of Clostridium Difficile colitis. A review of Resident 63's Bowel Elimination record was then conducted with the IP. Resident 63's Bowel Elimination record showed (from the date of Residents 63's readmission [DATE]) to the date she informed Resident 63's physician (5/30/25) Resident 63 had four episodes of loose stools/diarrhea. Additionally, Resident 63 had episodes of loose stool/diarrhea on 6/1, 6/2, and 6/3/25. The IP verified the findings and stated she was incorrect having relayed to the physician (on 5/30/25) that Resident 63 was asymptomatic. The IP stated as per the CDC guidelines a resident diagnosed with Clostridium Difficile needed to be free from loose stools/diarrhea for two consecutive days before being considered asymptomatic, and Resident 63 had not met this criterion. Cross reference F656. 5. Review of the facility's P&P titled Handwashing/Hand Hygiene dated 8/2019 showed the facility considered hand hygiene the primary means to prevent the spread of the infection. All personnel shall follow the hand washing/hand hygiene procedures to help prevent the spread of the infection to other personnel, resident and visitor. The facility staff to use an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap and water for the following situations: - Before and after direct contact with the residents, and, - After contact with objects (e.g. medical equipment) in the immediate vicinity of the resident. On 6/3/24 at 0840 hours, medication administration observation was conducted for LVN 1 to Resident 42. LVN 1 was observed performing hand hygiene, wearing gown and gloves and taking the vital sign of the Resident 42. LVN 1 was then observed touching the GT feeding pump of another resident in the room and continued to take the vital sign of Resident 42. LVN 1 was not observed removing gloves and performing hand hygiene after touching the GT feeding pump of another resident in the room and before continue to take the vital sign of Resident 42. On 6/3/25 at 0924 hours, an interview and concurrent record review for Resident 42 was conducted with LVN 1. LVN 1 verified the above observation and stated he should have performed hand hygiene after touching GT feeding pump of another resident in the room and before he continued taking the vital signs of Resident 42. On 6/5/25 at 0933 hours, an interview was conducted with the DON. The DON acknowledged the above findings. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the CDC's guidelines titled Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) dated 4/2/24, showed when implementing contact precautions or Enhanced Barrier Precautions (EBP), it is critical to ensure that staff have awareness of the facility's expectations about hand hygiene and gown/glove use, initial and refresher training, and access to appropriate supplies. To accomplish this: Post clear signage on the door or wall outside of the resident room indicating the type of precautions and required PPE. For EBP, signage should also clearly indicate the high-contact resident care activities that require the use of gown and gloves. On 6/2/25 at 0816 hours and 6/3/25 at 0811 hours, Room B (which Residents 8 and 66 resided in) was observed with an isolation cart filled with isolation gowns in front of the room. There was a signage posted to show how to don and doff PPE, however, there was no signage posted to show what type of isolation precautions were required to enter Room B. a. Medical record review for Resident 8 was initiated on 6/2/25. Resident 8 was readmitted to the facility on [DATE]. Review of Resident 8's Order Summary Report dated 6/2/25, showed a physician's order dated 4/15/25, for enhanced standard precautions for candida auris (a fungus that can cause severe, often multidrug-resistant, infections). b. Medical record review for Resident 66 was initiated on 6/2/25. Resident 66 was admitted to the facility on [DATE]. Review of Resident 66's Order Summary Report dated 6/2/25, showed a physician's order dated 9/23/24, for enhanced barrier precautions for candida auris and carbapenem-resistant pseudomonas aeruginosa (a bacteria which is a common cause of infections in healthcare settings and are particularly dangerous for patients with chronic lung diseases) sputum. On 6/3/25 at 1408 hours, a concurrent observation and interview was conducted with the IP. The IP stated all the residents' rooms in the subacute unit were on EBP (including Room B). The IP stated every visitors and CNAs were educated about the EBP and they put a signage outside of the room, gowns, and wipes. The IP stated they would have to read everything on the signage posted and the signage was required. The IP was informed of and verified there was no signage posted outside of Room B to show the room was under EBP. The IP was observed obtaining an EBP signage and posting it outside of Room B. 3. Review of the CMS QSO 17-30 titled Requirement to Reduce Legionella Risk in Healthcare Facility Water Systems to Prevent Cases and Outbreaks of Legionnaires' Disease revised 7/2018 showed the facilities must develop and adhere to policies and procedures that inhibit microbial growth in building water systems that reduce the risk of growth and spread of Legionella and other opportunistic pathogens in water. Facilities must have water management plans and documentation that, at a minimum, ensure each facility: - Conducts a facility risk assessment to identify where Legionella and other opportunistic waterborne pathogens (e.g. Pseudomonas, Acinetobacter, Burkholderia, Stenotrophomonas, nontuberculous mycobacteria, and fungi) could grow and spread in the facility water system. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Develops and implements a water management program that considers the ASHRAE (American Society of Heating, Refrigerating, and Air-Conditioning Engineers) industry standard and the CDC toolkit. - Specifies testing protocols and acceptable ranges for control measures and document the results of testing and corrective actions taken when control limits are not maintained. - Maintains compliance with other applicable federal, state, and local requirements. Review of the facility's P&P titled Policy for Legionnaire's Disease revised 6/2017 showed it is the policy of the facility to have a plan for the prevention of Legionnaire's disease. Under the section titled Process to Develop a Water Management Program showed the following: - The facility will develop a Water Management Program which will be reviewed annually. - The facility will complete Water Flow Diagram specific to the facility to identify risk areas in which Legionella can grow. - The facility will determine risk areas by completing the Building Water System Process Flowchart and implement controls and indicate where these controls are located by completing the Control Area Monitoring Flowchart. - During routine inspections of control areas, the facility will attempt to reduce areas of concern with the specific plans that have been developed. Preventative maintenance plans have been developed for each control area. Further review of the facility's water management program binder failed to show the Building Water System Process Flowchart, and the Control Area Monitoring Flowchart were completed as per the facility's P&P. In addition, the CDC toolkit titled Developing a Legionella Water Management Program was in the facility's water management binder, however, there was no documented evidence of a facility water management program which specified testing protocols, acceptable ranges for control measures, and corrective actions taken when control limits were not maintained. On 6/3/25 at 1600 hours an interview and concurrent facility document review was conducted with the Adminstrator Assistant. The facility's P&P and water management binder was reviewed. The Adminstrator Assistant stated what was in their water management binder was what they had. The Adminstrator Assistant was able to provide the risk assessment created for the facility. The Adminstrator Assistant was unable to provide documented evidence the facility had a facility specific water management program and flowcharts per their facility P&P. The Adminstrator Assistant acknowledged the findings. On 6/3/25 at 1609 hours, an interview and concurrent facility document review was conducted with the Case Manager. The Case Manager stated she was the previous IP. The facility's P&P and water management binder was reviewed. The Case Manager stated they had the CDC toolkit titled Developing a Legionella Water Management Program in their water management binder as a reference. The Case Manager was unable to provide documented evidence the facility had a facility specific water management program and flowcharts per their facility P&P. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Review of the facility's P&P titled Standard Precautions revised 10/2018 showed the linen soiled with blood, body fluids, secretions, excretions are handled and processed in a manner that prevents skin and mucous membrane exposures, contamination of clothing, and avoids transfer of microorganisms to other residents and environments. On 6/3/25 at 1408 hours, a concurrent observation and interview was conducted with the IP. The IP stated all the residents' rooms in the subacute unit were on EBP (which included Room C). On 6/4/25 at 1319 hours, CNA 2 was observed inside of Room C carrying Resident 21's dirty linens with only the gloves on. CNA 2 was observed carrying the dirty linens against her scrubs to the linen cart placed outside of Room C. Room C was observed with signage posted outside the room, for EBP. The EBP signage showed the providers and staff must wear gloves and a gown for the following high-contact resident care activities: dressing, bathing/showering, transferring, changing linens, and providing hygiene. On 6/4/25 at 1329 hours, an interview was conducted with CNA 2. CNA 2 stated she gave a bed bath to Resident 21. CNA 2 stated Resident 21 was incontinent, wet with urine, and had to change her. CNA 2 verified Resident 21 was on EBP and stated she had worn an isolation gown and gloves during the bed bath, however, removed the gown inside the room before going out. CNA 2 verified she did not wear the isolation gown to transport Resident 21's dirty linen to the linen cart outside Room B and acknowledged she was carrying the linens against her scrubs. On 6/5/25 at 1007 hours, an interview was conducted with the IP. The IP was informed and acknowledged the above findings. The IP stated the staff should transport the dirty linen to the linen cart prior to removing the isolation gown to prevent the spread of infection. 6. Review of the facility's P&P titled Handwashing/Hand Hygiene revised 8/2019 showed the facility considered hand hygiene the primary means to prevent the spread of infection. Perform hand hygiene after removing gloves. On 6/3/25 at 0801 hours, a medication administration observation for Resident 79 was conducted with LVN 6. LVN 6 was observed removing the gloves and putting on another pair of gloves without performing hand hygiene. On 6/3/25 at 1058 hours, an interview was conducted with LVN 6. LVN 6 verified the above findings. On 6/5/25 at 1415 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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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** Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to offer the PCV 20, PCV 21, or PCV 15 (PCV 20 protects against 20 types of pneumococcal bacteria, PCV 15 protects against 15 types of pneumococcal bacteria, and PCV 21 protects against 21 types of pneumococcal bacteria), immunizations for one of five residents (Resident 15) reviewed for pneumococcal vaccination (a vaccine given to protect the resident from pneumococcal disease) in accordance with the CDC's recommendations. This failure increased the resident's risk for being inadequately vaccinated for the pneumococcal disease and its associated complications. Findings: Review of the facility's P&P titled Pneumococcal Vaccine revised October 2019 showed all residents will be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. Prior to or upon admission, the residents will be assessed for eligibility to receive the pneumococcal vaccine series and when indicated, offered the vaccine series within thirty (30) days of admission to the facility unless medically contraindicated or the resident has already been vaccinated. Assessment of pneumococcal vaccination status will be conducted within five (5) working days of the resident's admission if not conducted prior to admission. Administration of the pneumococcal vaccines or revaccinations will be made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination. Review of the CDC's Pneumococcal Vaccine Timing for Adults dated 10/2024 showed for adults 50 years or older who had only received the PPSV23 (23-valent pneumococcal polysaccharide vaccine, use for protected adults and children older than 2 years of age against invasive disease caused by the 23 capsular serotypes contained in the vaccine), to give one dose of PCV 20, PCV 21, or PCV 15 at least one year after the most recent PPSV 23 vaccination. Review of the CDC's Adult Immunization Schedule Notes dated 11/21/24, showed to administer recommended vaccines if vaccination history is incomplete or unknown. For adults 50 years or older who have previously received only PPSV23, give one dose of PCV 15, one dose of PCV 20, or one dose of PCV 21 at least one year after the last PPSV23 dose. If PCV 15 is used, no additional PPSV23 doses are recommended. Review of the new CDC guideline Morbidity and Mortality Weekly Report (MMWR) dated 1/8/25, showed Expanded Recommendations for Use of Pneumococcal Conjugate Vaccines Among Adults Aged 50 years or older: Recommendations of the Advisory Committee on Immunization Practices (ACIP) - United Stated, 2024. Review of the CDC MMWR Report titled Expanded Recommendations for Use of Pneumococcal Conjugate Vaccines Among Adults Aged 50 years or older: Recommendations of the Advisory Committee on Immunization Practices (ACIP) dated 1/8/25 showed on 10/23/24, the ACIP recommended a single dose of PCV for all adults 50 years or older who are PCV-naïve or who have unknown vaccination history. Medical record review for Resident 15 was initiated on 6/2/25. Resident 15 was admitted to the facility on [DATE]. (continued on next page)

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	055674	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Healthcare Center of Orange County	9021 Knott Ave Buena Park, CA 90620

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 15's Immunization Report dated 6/4/25 showed Resident 15 had a history of administration of the PPSV23 on 12/24/21. Review of Resident 15's CAIR2 (California Immunization Registry, a statewide computerized immunization information system for California residents) information dated 5/12/25, showed Resident 15's immunization record. The record showed the resident had only received one pneumococcal vaccination, PPSV23 on 12/24/21. Further Review of Resident 15's medical record failed to show Resident 15 was offered the PCV 20, PCV 21, or PCV 15 vaccinations after receiving the PPSV23 as per the CDC's guidelines. On 6/3/25 at 1408 hours, an interview and concurrent medical record review was conducted with the IP. The IP was asked how she knew if a resident's vaccinations were up to date. The IP stated she would base it one the CAIR2 data to determine if the pneumococcal vaccine was updated and would ask the resident's family member if the resident was updated with the vaccination. The IP stated she would review the vaccinations upon admission and yearly. The IP verified Resident 15 had received the PPSV23 on 12/24/21, outside of the facility and stated Resident 15 would not need a new vaccine until five years after the PPSV23 per their pharmacy consultant. The CDC recommendations were then reviewed with the IP. The IP verified Resident 15's pneumococcal vaccination was not up to date with the current CDC recommendations.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 2. On 6/3/25 at 1148 hours, an observation and concurrent interview was conducted with RN 1. The refrigerator in the facility to store the residents' medication located in Medication Room A was observed with thick ice buildup in the frozen storage area. The frozen storage area was observed inside medication refrigerator with no separate door for the frozen storage area. Multiple medications for multiple residents were observed stored in the refrigerator. RN 1 verified the observations and stated the above refrigerator was being defrosted every month and acknowledged refrigerator needed more frequent defrosting. On 6/5/25 at 0933 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. Based on observation, interview, and facility document review the facility failed to maintain the essential equipment in a clean and safe operating condition when: * The facility failed to ensure the quality control checks were performed for the glucometer in Medication Cart C. * The facility failed to ensure the frozen storage area inside the residents' medication refrigerator in Medication Room A was free of thick ice buildup. These failures had the potential for the essential equipment not to function in the way it was intended and exposed residents to unsafe practices and may lead to negative outcomes. Findings: 1. On 6/3/25 at 1158 hours, an inspection of the glucometer in Medication Cart C and concurrent facility document review and interview was conducted with LVN 8. LVN 8 stated there was one glucometer for each cart. When asked about glucometer calibration, LVN 8 stated the night shift nurses performed the glucometer calibration nightly between 1900 to 0700 hours. LVN 8 stated the glucometer calibration was documented in the quality control record. The LVN 8 verified there was no documentation to show the calibration was done on 6/1 and 6/2/25. On 6/5/25 at 1415 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. Medical record review for Resident 19 was initiated on 6/2/25. Resident 19 was admitted to the facility on [DATE]. Review of Resident 19's Order Summary Report showed an order dated 7/3/23, for bilateral siderails as an enabler to promote independence and bed mobility. Review of Resident 19's care plan titled Use of Siderails dated 12/2/24, showed the risk and benefits of side rails including entrapment and other injury such as death, were explained to Resident 19 and her responsible party. On 6/2/25 at 0947 hours, an observation and concurrent interview was conducted with Resident 19. Resident 19 was observed lying in her bed with the bilateral side rails elevated. Resident 19 stated she utilized the siderails to reposition herself in bed. On 6/5/25 at 1418 hours, an observation was conducted of Resident 19. Resident 19 was observed lying in her bed with the bilateral side rails elevated. Review of Resident 19's Bed Safety Checklist for Residents with Bed Rails undated, showed Zone 1 gaps (within the side rail) measured 10.5 inches and Zone 2 gaps (under the rail between rail and mattress) measured 10 inches. Further review of Resident 19's Bed Safety Checklist for Residents with Bed Rails (undated) showed Zones 1 and 2 gaps should measure less than 4.75 inches. On 6/5/25 at 1430 hours, an interview and concurrent facility record review was conducted with the Central Supply Supervisor. The Central Supply Supervisor stated the Maintenance Director who obtained Resident 19's bed measurements was not available for interview, however, the Central Supply Supervisor was familiar with the facility's Bed Safety Checklist for Residents with Bed rails form. The Central Supply Supervisor reviewed Resident 19's Bed Safety Checklist for Residents with Bed Rails undated form and verified the measurements for Resident 19's Zone 1 gaps (10.5 inches) and Zone 2 gaps (10 inches) were not within the 4.75-inch dimensions established by the FDA, and in accordance with the facility's P&P titled Bed Safety revised 12/2007. The Central Supply Supervisor verified there was no documentation which showed the facility ensured Resident 10's Zones 1 and 2 gaps were within the dimensions established by the FDA, and in accordance with the facility's P&P titled Bed Safety revised 12/2007. 3. On 6/2/25 at 0830 hours, Resident 35 was observed laying in bed with bilateral upper siderails elevated. Medical record review for Resident 35 was initiated on 6/2/25. Resident 35 was readmitted to the facility on [DATE]. Review of Resident 35's Order summary Report dated 6/2/25, showed a physician's order dated 4/7/25, for bilateral one-half side rails as enabler and for seizure precautions and non-convulsive epilepsy per family request. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 35's Bed Rails assessment dated [DATE], showed the bilateral siderails were recommended to serve as an enabler to promote independence. Review of Resident 35's Bed Safety Checklist for Residents with siderails undated shows the measurement as follows: Zone 1 gaps within the siderails: <4¾ inches, measurement was 10 ½ inches; Zone 2 under the rail between rails and mattress: <4 ¾, measurement was 10 inches; Zone 3 space between the rails and mattress: <4 ¾ inches, measurement was 1 ¼ inches; Zone 4 under the rails at the end of the rails: <4 ¾ inches, measurement was 5 ½ inches; Zone 5 between split rails: possible neck or check entrapment: NA; Zone 6 gap between edge of rail and head or foot board, measurement was 2 7/8 inches; and Zone 7 gap between mattress and head or foot board, measurement was 3/12 inches. On 6/4/25 at 1542 hours, an interview was conducted with the Central Supply Supervisor. The Central Supply Supervisor stated the Maintenance Director was responsible for maintaining the resident beds. The Central Supply Supervisor stated the Maintenance Director told him they did not have logs for maintaining the beds and they did not have a regular schedule for maintaining the beds. The Central Supply Supervisor stated they would not know if all the beds have been serviced unless it is written down in the maintenance log. On 6/4/25 at 1618 hours, an interview and concurrent record review was conducted with RN 1. RN 1 verified Resident 35 had the bilateral upper siderails on her bed. RN 1 stated Resident 35 used the siderails for enabler and seizure precautions. On 6/5/25 at 0845 hours, a concurrent observation, interview, and facility record review for Resident 35 was conducted with the Central Supply Supervisor. The Central Supply Supervisor verified the Maintenance Director was responsible for the entrapment assessments and measurements for the beds. The Central Supply Supervisor verified the measurements on Resident 35's Bed Safety Checklist for Resident with Bed Rails form for Zones 1, 2, and 4 were measuring above the requirements per the stated guideline. The Central Supply Supervisor verified there was no documented evidence a follow up had occurred to correct the gaps for the findings for the three zones which were out of range. Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to implement P&P specific to FDA recommendation for side rails gap were accurate for the of three final sampled residents (Residents 19, 35, and 92) reviewed for bilateral side rails use. This failure had the potential to negatively impact the residents resulting in possible entrapment, serious injury, and death. Findings: (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, the term entrapment describes an event in which a patient/resident is caught, trapped, or entangled in the space in or about the bed rail, mattress, or hospital bed frame. Patient entrapments may result in deaths and serious injuries. These entrapment events have occurred in openings within the bed rails, between the bed rails and mattresses, under bed rails, between split rails, and between the bed rails and head or foot boards. The population most vulnerable to entrapment are elderly patients and residents, especially those who are frail, confused, restless, or who have uncontrolled body movement. The seven areas in the bed system where there is a potential for entrapment are: - Zone 1: within the rail; - Zone 2: under the rail, between the rail supports or next to a single rail support; - Zone 3: between the rail and the mattress; - Zone 4: under the rail, at the ends of the rail; - Zone 5: between split bed rails; - Zone 6: between the end of the rail and the side edge of the head or foot board; and - Zone 7: between the head or foot board and the mattress end. Review of the facility's P&P titled Bed safety revised 12/2007 showed the facility shall strive to provide a safe sleeping environment for the resident. To try to prevent deaths/injuries from the beds and related equipment (including the frame, mattress, siderails, headboard, footboard, and bed accessories), the facility shall promote the following approaches: - Inspection by maintenance staff of all the beds and related equipment as part of our regular bed safety program to identify risks and problems including potential entrapment risks; - Review the gaps within the bed system are within the dimensions established by the FDA. Review of the facility's Measurement Guideline Bed Safety Entrapment (undated) prior to measuring the zones, take the following measurement. If an adult's head or neck measurements are smaller than these standard measurements or an adult's chest depth is larger than 318 mm, consider implication for bed safety. - Head breadth (distance across the face from ear to ear: greater than 120 mm) - Neck breadth (diameter/width): greater than 60 mm - Chest Depth (anterior to posterior of chest): less than 318 mm 1. On 6/4/25 at 0910 hours, an observation and concurrent interview for Resident 92 with CNA 1 was conducted. Resident 92 was observed lying in bed with the bilateral upper siderails elevated. Resident 92 was awake alert and verbally responsive. CNA 1 verified Resident 92's bilateral upper side rails were elevated. CNA 1 stated Resident 92 used the siderails to assist with turning during care. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medical record review for Resident 92 was initiated on 6/2/25. Resident 92 was admitted to the facility on [DATE]. Review of Resident 92's H&P examination dated 1/31/25, showed Resident 92 had the capacity to understand and make decisions. Review of Resident 92's Informed Consent for a Bilateral upper siderails up as an enabler to promote independence and bed mobility dated 3/13/25, showed Resident 92's representative gave consent to the use of the bilateral siderails. Review of Resident 92's Order Summary Report showed a physician's order dated 3/13/25, for bilateral upper siderails up as an enabler to promote independence and bed mobility. Review of Resident 92's Bed Rail Entrapment Risk assessment dated [DATE], showed the Resident 92's head breadth was 508 mm, neck breadth was 393.7 mm, and chest depth was 1168.4 mm. Review of Resident 92's Bed Safety Checklist for the Residents with siderails (undated) shows the measurement as follows: Zone 1 gaps within the siderails: <4¾ inches, a measurement of 3 7/8 inches Zone 2 under the rail between rails and mattress: <4 ¾ inches, a measurement of 9 ½ inches Zone 3 space between the rails and mattress: <4 ¾ inches, a measurement of 1 inches Zone 4 under the rails at the end of the rails: <4 ¾ inches, a measurement of 3 ½ inches Zone 5 between split rails: possible neck or check entrapment: N/A Zone 6 gap between edge of rail and head or foot board, a measurement of 1 inches Zone 7 gap between mattress and head or foot board, a measurement of 1 inches On 6/5/25 at 0845 hours, a concurrent observation, interview and facility record review was conducted for Resident 92 with the Central Supply Supervisor. Resident 92 was observed in bed with the bilateral side rails elevated. The Central Supply Supervisor verified the measurements on the Bed Safety Checklist for Resident with siderails, Zone 2 measurement was higher than the recommended measurement, and there was no other documentation shows the gaps were fix. On 6/5/25 at 1501 hours, an interview with the Assistant Administrator and DON was conducted. The Assistant Administrator and DON verified and acknowledged above findings.