STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055706	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Orchard - Post Acute Care	12385 E. Washington Blvd Whittier, CA 90606

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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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44018 Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 21) were provided dignity and/or privacy during a medication pass. Licensed Vocational Nurse (LVN) 2 did not close Resident 21's door and/or pull the resident's privacy curtain during administration of medication via injection (medication adminitered using needle into the skin or muscle) into the resident's abdomen, while the resident's roommate was sitting across the room in Resident 21. This failure resulted the violation of Resident 21's right for privacy and dignity. Findings: During a review of Resident 21's Admission Record, indicated Resident 21 was admitted to the facility on [DATE] with diagnoses that included muscle weakness and type 2 diabetes mellitus (DM- a disease that occurs when the blood sugar is too high). During a review of Resident 21's History and Physical Examination (H&P) dated 2/7/2024, indicated Resident 21 did not have the capacity to understand and make decisions. During a review of Resident 21's Minimum Data Set (MDS, a standardized assessment and care-screening tool), dated 6/19/2024, indicated Resident 21 had severe impairment in cognitive (ability to think and reason) skills. The MDS indicated Resident 21 required substantial/maximal assistance (helper does more than half the effort) with lower body dressing and putting on/taking off footwear. The MDS also indicated Resident 21 required partial/moderate assistance (helper does less than half the effort) with toileting hygiene and shower/bathe self. During a review of Resident 21's Order Summary Report (a summary of all currently active physician orders), dated 7/25/24, indicated Resident 21 was ordered to administered Insulin Glargine (a medication used to treat DM) 100 unit/milliliter (mL) subcutaneous (SQ, injection given between the skin and the muscle) two times a day for DM (hold if blood sugar less than 90). During a medication pass observation, on 7/25/2024 at 8:12 AM. LVN 2 did not close the door or pull and close Resident 21's privacy curtain. Then LVN 2 lifted Resident 21's gown to the side and administered Insulin Glargine on the resident's abdomen. Resident 21's roommate was observed sitting in the wheelchair facing and in view of Resident 21. (continued on next page)

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

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/25/2024 at 9:37 AM, with LVN 2, LVN 2 stated he forgot to close the curtain while administering medication to Resident 21. LVN 2 stated he violated Resident 21's privacy and dignity. LVN 2 stated the resident's privacy and dignity should be maintained. During an interview with Director of Nursing (DON), on 7/25/24 at 11:25 AM, the DON stated the resident's privacy should be maintained always, by closing doors, curtains, and screens in order to assure adequate privacy during nursing care and treatment. During a review of facility's policies and procedures titled, Dignity and Privacy, dated 11/2021, indicated that the residents shall be examined and treated in a manner that maintain the privacy of their bodies. A closed door or drawn curtain shields the Resident from passers-by. People not involved in the care of the resident shall not be present without the resident's consent while they are being examined or treated. Staff members shall knock before entering the resident's room.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47882 Based on observation, interview and record review, the facility failed to accommodate the needs of one of one sampled resident (Resident 108) in accordance with the facility ' s policy and procedure by failing to ensure the call light (a device used by residents to signal his or her needs for assistance) was within reach. This deficient practice had the potential for Resident 108 not able to call the facility staff to ask for help or assistance especially during emergency. Findings: During a review of Resident 108's Admission Record, indicated the facility originally admitted Resident 108 on 12/19/2021 and readmitted on [DATE] with diagnoses that included cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area), dysarthria (difficulty speaking because the muscles use for speech are weak), and hemiplegia (paralysis that affects only one side of your body) hemiparesis (weakness or the inability to move on one side of the body) affecting right dominant side. During a review of Resident 108 ' s History and Physical Examination, dated 1/18/2024, indicated Resident 108 had the capacity to understand and make decisions. During a review of Resident 108's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 4/22/2024, indicated Resident 108 required partial/moderate assistance (helper does less than half the effort) with dressing, personal hygiene, roll left and right, and required substantial/maximal assist (helper does more than half the effort) toileting, shower, chair to bed transfer. During a concurrent observation and interview on 7/23/2024 at 9:30 AM with Certified Nurse Assistant (CNA) 1 and Licensed Vocational Nurse (LVN) 1, in Resident 108's room, Resident 108 shrugged (to lift or contract the shoulders especially to express aloofness, or uncertainty) when asked where was his call light? which was noted to be behind Resident 108 ' s television (TV) that Resident 108 could not reach. CNA 1 stated, Resident 108 was capable to use the call light and she was not sure why it was behind the TV. LVN 1 stated, the call light should be within reach for Resident 108 so he could get the assistance and accommodation he needs especially during an emergency. During an interview on 7/23/2024 at 11:30 AM with Registered Nurse (RN) 1, RN 1 stated, The call light should always be within reach of the resident no matter what their capacity, it is important so they can call for assistance and in case on emergency. During a review of Resident 108 ' s care plan (CP) for risk for falls related to right sided deficits, dated 12/19/2021, the CP intervention included to be sure the call light is within reach. During a review of Resident 108 ' s Fall Risk Evaluation, dated 5/3/2024, indicated Resident 108 was at medium risk for fall. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 108 ' s CP for communication problem related to Spanish speaking and unclear speech, revised 5/7/2024, the CP intervention included to ensure the call light is within reach. During a review of Resident 108 ' s CP for potential for pressure ulcer development related to immobility, revised 5/7/2024, the CP intervention included to ensure the call light is within reach. During an interview on 7/24/2024 at 9:23 AM with Director of Nurses (DON), DON stated, she expected the nurses to keep the call lights to the residents within reach to be used to call for assistance, to accommodate needs and/or emergency. During a review the facility ' s policy and procedure (P&P) titled, Communication- Call System, dated 1/1/2012, the P&P indicated; a) the facility will provide a call system to enable residents to alert the nursing staff from their room and toileting/bathing facilities, b) call cords will be placed within the resident ' s reach in the resident ' s room.

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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. 46779 Based on observation, interview, and record review, the facility failed to develop a resident specific comprehensive care plan in the management of dysuria (pain or discomfort when urinating) for one out of thirty sampled residents (Resident 101). This deficient practice had the potential to result in Resident 101 to experience recurrent dysuria and urinary tract infection (UTI, an illness in any part of urinary tract, the system of organs that makes urine). Findings: During a review of Resident 101's Admission Record, indicated the facility originally admitted Resident 101 on 12/13/22 and readmitted Resident 101 on 5/24/23 with diagnoses that include UTI and hemiplegia (paralysis of one side of the body). During a review of a Minimum Data Set (MDS, a standardized assessment and care planning screening tool), dated 5/20/24, indicated Resident 101 had severely impaired cognitive (ability to understand and make decisions) skills for daily decision making. The MDS indicated Resident 101 required setup or clean-up assistance with eating and oral hygiene, supervision with personal hygiene, and partial/moderate assistance with toileting hygiene, shower/bathe self and chair/bed-to-chair transfer. During a review of Resident 101's Change in Condition Evaluation (COC), dated 7/10/24, indicated Resident 101 complained of lower abdominal (the belly) pain and dysuria. Resident 101 was ordered by the physician to receive Pyridium 100 milligram (MG, measurement unit) for three days. During a concurrent observation and interview on 7/23/24 at 12:10 PM, Resident 101 was sitting on the wheelchair in the dining room. Resident 101 stated she had the recurrent UTI and dysuria about two weeks ago, and it was so painful for her whenever the symptoms returned. Resident 101 stated she needed the staff to assist her with toileting and perineal care. During a concurrent interview and record review on 7/25/24 at 11:50 PM, with Licensed Vocational Nurse (LVN) 3, Resident 101 ' s Care Plan (CP) was reviewed. LVN 3 stated Resident 101 complained of lower abdominal pain and dysuria on 7/10/24 and the COC evaluation was completed. LVN 3 stated after the COC evaluation was completed, the licensed nurses should have developed a care plan to address the resident ' s concern about dysuria. LVN 3 stated there was no documented evidence in Resident 101 ' s clinical record to indicate a care plan was developed to address dysuria. LVN 3 stated it was important to develop a care plan to address Resident 101' s dysuria and to intervene to monitor, treat and prevent the symptoms. During an interview on 7/26/24 at 9:22 AM, with the Director of Nursing (DON), the DON stated Resident 101 had a history of UTI and a recent episode of dysuria. The DON stated a care plan should be developed and implemented to address Resident 101's UTI and dysuria, including assessing signs and symptoms, proper perineal care, and administering medication as ordered. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility ' s policy and procedure (P&P) titled, Comprehensive Resident Centered Care Plan, dated 1/2022, indicated the facility should develop a comprehensive person-centered care plan for each resident to meet a resident ' s medical, nursing, mental and psychosocial needs.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 47882 Based on observation, interview, and record review the facility failed to provide necessary care and services to residents who was dependent with the staff to carry out activities of daily living (ADL), maintain grooming, and good personal hygiene for one of two sampled residents (Resident 454) by not shaving his facial hairs after a bed bath. This deficient practice had the potential to negatively affect Resident 454's physical appearance, dignity, and quality of life. Findings: During a review of Resident 454's Admission Record, indicated the facility admitted Resident 454 on 7/9/2024 with diagnoses that included congestive heart failure (CHF) (the heart doesn't pump enough blood for your body's needs), muscle weakness, and abnormalities of gait and mobility. During a review of Resident 454's History and Physical Examination, dated 7/10/2024, indicated Resident 454 had the capacity to understand and make decisions. During a review of Resident 454 's Care Plan (CP) for ADL (Activities of Daily Living) Self-care performance Deficit related to diagnoses shortness of breath, CHF, and Glaucoma (eye condition where the optic nerve, which connects the eye to the brain, becomes damaged), revised 7/13/2024, the CP intervention included assisting resident with bathing, and for routine personal hygiene Resident 454 preferred being shaved. During a review of Resident 454's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 7/14/2024, indicated Resident 454 required partial/moderate assistance (helper does less than half the effort) with toileting, upper body dressing, personal hygiene, and required substantial/maximal assist (helper does more than half the effort) with bathing and lower body dressing. During a concurrent observation and interview on 7/23/2024 at 11:46 AM with Resident 454, in Resident 454's room, Resident 454 had thick growth of facial hair unshaven. Resident 454 stated, he felt dirty, he thought the staff forgot to shave him last week after his bath and hoped he gets a shave today. During an interview on 7/23/2024 at 11:51 AM with Certified Nurse Assistant (CNA) 7, CNA 7 stated, she should have shaved Resident 454 after his bed bath, so Resident 454 would have felt cleaner and better. CNA 7 stated, she was planning to shave Resident 454, she was just covering for another CNA ' s break. During an interview on 7/23/2024 at 12 PM with Licensed Vocational Nurse (LVN) 1, LVN 1 stated, Resident 454 should have been shaved after a bath, it violates resident's rights and dignity. During an interview on 7/23/2024 at 12:30 PM with Registered Nurse (RN) 1, RN 1 stated, Resident 454 should have been shaved for appearance as part of grooming, it violates resident's rights and dignity. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/24/2024 at 9:23 AM with DON, DON stated, Resident 454 should have been shaved as part of grooming care, it makes the Resident looks presentable, it violates resident rights and dignity. During a review of the facility ' s policy and procedure (P&P) titled, Resident Rights - Dignity and Respect, dated 11/2021, the P&P indicated: a) the policy of the facility that all residents be treated with kindness, dignity and respect, b) Residents will be appropriately dressed in clean clothes arranged comfortably on their persons and be well groomed.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47467 Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 143) with history of falls (move downward, typically rapidly and freely without control, from a higher to a lower level) was provided supervision, monitoring and assistance as indicated on the resident's care plan (a document that outlines the facility's plan to provide personalized care to a resident based on the resident's needs) of high risk for falls and facility's policy and procedure to prevent falls by failing to: 1. Ensure Resident 143's room was well lit and had adequate lighting and not kept dark, in accordance with the resident's care plan dated 6/8/2024, and 6/14,2024 to prevent hazards, falls and accidents. 2. Ensure Resident 143's care plan addressed high-risk factors identified on the resident's Fall Risk Evaluation dated 6/8/2024 to ensure an individualized care plan is developed that includes measurable objectives and timeframes. The care plan interventions will be developed to prevent falls by addressing the risk factors and will consider the elements of the evaluation that put the resident at risk. 3. Implement IDT's (Interdisciplinary Team, a team of staff that review and develop the resident's plan of care) recommendation and resident's care plan on 6/25/2024, to place Resident 143 on a Bowel and Bladder Schedule by offering the resident toilet use upon rising (the act of getting out of bed in the morning, or at some other time during the day), at mealtimes, at bedtimes and as needed. As a result, after the first fall in the facility on 6/25/2024, on 7/6/2024 at 4:20 AM, Resident 143 fell again on the floor with complaint of the right hip pain after the fall. An Xray (medical procedure that generate images of tissues and structures inside the body) was performed which revealed a right hip fracture (broken bone). Resident 143 was transferred to General Acute Care Hospital (GACH)'s Emergency Department (ED) on 7/6/2024 at 10:33 PM (18 hours after the resident fell on [DATE] at 4:20 AM) for further treatment and evaluation for severe, constant right hip pain. On 7/8/2024, Resident 143 had hemiarthroplasty (a surgical procedure that replaces only the ball portion of the hip joint, not the socket portion) right hip due to right femoral neck fracture (broken bone of the thigh bone near the hip joint). Findings: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 143's Admission Record, indicated Resident 143 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis that included dementia [the loss of cognitive functioning (thinking, remembering, and reasoning) to such an extent that it interferes with a person's daily life and activities], muscle weakness, abnormality of gait (a manner of walking) and mobility (ability to move freely), osteoporosis (a condition that causes bones to become weak and lose their strength, making them break more easily than normal bones), history of fall, fractures (broken bone) of lower end of right radius (one of two major bones in the forearm from the elbow to the wrist), fracture of right pubis (broken three main bones that make up the pelvis, a structure located between the abdomen and thighs). The record indicated, on 7/11/2024, Resident 143 was readmitted to the facility with a diagnosis of the right femur (thigh bone) fracture. During a review of Resident 143's Fall Risk Evaluation, dated 6/8/2024, indicated Resident 143 was at high risk for fall due to history of one (1) to two (2) falls in the past 3 months, and was regularly incontinent (no control of bladder to urinate and bowel to have bowel movement), and had balance problem. During a review of Resident 143's Care Plan, dated 6/8/2024, indicated Resident 143 was at risk for falls related to post (after) fall at home on 6/5/2024. The Care Plan indicated to ensure Resident 143 was free from falls and serious injury, the facility will anticipate the resident's needs, by providing a safe environment with adequate lighting, and will keep personal items within reach. The interventions also indicated the facility will review information from Resident 143's past falls and will attempt to determine cause of falls, record possible root causes, and alter/remove any potential causes of fall if possible. The care plan did not address the resident being at high risk for fall as indicated in the Fall Risk Evaluation dated 6/8/2024 to ensure the care plan include measurable objectives and interventions that addressed risk factors to prevent falls. During a review of Resident 143's Care Plan, dated 6/14/2024, indicated Resident 143 was at risk for fall due to osteoporosis, with the intervention to keep inside of resident's room well lit at night. During a review of Resident 143's Bowel and Bladder Evaluation, dated 6/8/2024, indicated Resident 143 was a likely candidate for Bowel and Bladder re-training (a program for toileting schedule when the nurse promotes a patient's toileting every two hours to avoid overfilling the bladder to decrease the chance of incontinence). During a review of Resident 143's History and Physical (H&P), dated 6/9/2024, indicated Resident 143 had fluctuating (changing) capacity to understand and make decisions. During a review of Resident 143's GACH record titled Physician Discharge Summary, dated 6/10/2024, indicated Resident 143 was admitted to GACH from 6/5/2024 to 6/8/2024 due to a fall at home that resulted in fractures of the right radius and the right pubis and received nonsurgical intervention for the right ramus (branch of the arm bone) fracture and, underwent an open reduction and internal fixation (ORIF, surgical procedure to fix a severe bone fracture. Open reduction means surgery is needed to realign the bone fracture into the normal position) of the right radius. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 143's Minimum Data Set (MDS, a comprehensive assessment and screening tool) dated 6/13/2024, indicated Resident 143's cognitive skills (ability to think, remember and reason) were moderately impaired, was dependent (full staff performance, resident does none of the effort to complete activity) in toileting hygiene [ability to maintain perineal (relating to the area between the anus and genitals) hygiene, adjust clothes before and after voiding or having a bowel movement) and toilet transfer (ability to get on and off a toilet or commode). The MDS indicated, Resident 143 required moderate assistance (helper lifts, holds, or supports trunk or limbs but provides less than half the effort) in walking 10 feet in the room and walking at least 50 feet and make two turns. During the same review of Resident 143's MDS, dated [DATE], indicated, Resident 143 was frequently incontinent (unable to control bladder to urine and bowel to have a bowel movement), balance problem while standing/walking, and required the use of assistive devices (such as cane, walker, wheelchair) with urine and was on a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) to manage the resident's urinary continence. The MDS assessment did not address Resident 143's history of falling at home where the resident sustained a right radius and right pubis fracture on 6/5/2024 prior to admission to the facility on [DATE]. During a review of Resident 143's SBAR (Situation, Background, Assessment, Recommendation) Communication Form, (a form used for consistent process to facilitate concise, clear, focused communication in the facility), dated 6/25/2024 (no time indicated), indicated Resident 143 was found sitting on the floor outside of the bathroom and reported having pain at the level of 2/10 in pain scale (0 for no pain and 10 for severe pain) and Tylenol (pain medication) was given. During a review of Resident 143's Progress Notes-Nursing, dated 6/25/2024, documented by Licensed Vocational Nurse (LVN) 6 indicated on 6/25/2024 at approximately 1:45 AM, a Certified Nursing Assistant (CNA) (unspecified) found the resident sitting on the floor outside of bathroom. The record indicated Resident 143 stated she got up to use the bathroom without assistance. The record indicated Resident 143 received Tylenol for pain. During a review of Resident 143's Progress Notes-Nursing, dated 6/25/2024, documented by Registered Nurse (RN) 4, indicated on 6/25/2024 at 1:50 AM, a CNA (unspecified) found the resident sitting upright on the floor in front of the bathroom and 1 cm (centimeter, unit of length) skin tear was found on the resident's left knuckle of the middle finger. During a review of Resident 143's Fall Risk Evaluation, dated 6/25/2024, documented by RN 4 after the fall incident, indicated Resident 143 was at medium risk for fall due to history of 3 or more falls in the past 3 months. The record indicated Resident 143 had improved elimination status from regularly incontinent (no control bladder and bowel) to regularly continent and improved her gait/balance/ambulation that she no longer had balance problem. During a review of Resident 143's Post-Event IDT Review, dated 6/25/2024, indicated on 6/25/24 at around 1:50 AM, a facility's staff (unspecified who) found Resident 143 sitting upright on the floor in front of the bathroom. The record indicated, IDT recommended for Resident 143 to be placed on bowel and bladder scheduling by offering toileting upon rising, at mealtimes, at bedtimes and as need and the care plan needed update to include new interventions. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 143's Care Plan, dated 6/25/2024, the care plan indicated, Resident 143 had an actual fall and sustained a skin tear on left middle finger related to poor safety awareness. The care plan interventions indicated Resident 143 will be placed on Bowel and Bladder Scheduling by offering toilet use upon rising in bed, at mealtimes, at bedtimes and as needed (PRN). During a review of the facility's Fall Investigation, dated 6/26/2024, indicated on 6/25/24 at 1:50 AM, a CNA (unspecified) reported to RN 4 that Resident 143 fell . RN 4 went to the resident's room and found Resident 143 on the floor near the bathroom. The report indicated Resident 143 was alert and oriented, able to verbalize that she needed to use the bathroom. The report indicated Resident 143 stated she was walking then lost her balance and fell . The report also indicated the fall resulted in Resident 143's skin tear measuring one centimeter on the left knuckle of the middle finger and the IDT recommended for bowel and bladder scheduling to offer toileting upon rising, at mealtimes, at bedtimes and PRN. During a review of Resident 143's SBAR Communication Form, dated 7/6/2024, documented by LVN 6, the SBAR indicated on 7/6/2024 (unspecified time) Resident 143 had a fall that resulted in mild right hip pain. Tylenol (pain medication) was given. During a review of Resident 143's Order Summary Report, for July 2024, indicated the Resident 143's primary physician ordered on 7/6/2024 (unspecified time) to obtain X-Rays of the resident's bilateral (both sides) pelvis and hips post (after) fall. The order summary indicated to transfer the resident to General Acute Care Hospital for further evaluation. During a review of Resident 143's Progress Notes-Nursing, dated 7/6/2024, documented by LVN 6, indicated Resident 143 attempted to use the bathroom without assistance and sat down on the floor due to room being too dark. During a review of Resident 143's Progress Notes-Nursing, dated 7/6/2024, documented by RN 4, indicated on 7/6/2024 at 4:20 AM, a CNA (unspecified) found Resident 143 sitting upright on the floor next to her bed in the dark. The record indicated Resident 143 complained of 2/10 pain when performing both active (moving a part of your body without assistance) and passive (someone or something is creating the movement) range of motion (ROM) of the right lower extremity and refused to take pain medication. The record indicated Resident 143 reported that she needed to use the bathroom. The record indicated, Resident 143's primary physician was notified of incident and Xray was ordered. During a review of Resident 143's Progress Notes-Nursing, dated 7/6/2024, indicated on 7/6/2024 at approximately 6:25 PM, the ordered Xray was done on the right hip due to unwitnessed fall with result of fractured right hip. The record indicated, the result was reported to Resident 143's primary physician and was given an order to send the resident out to GACH. The record indicated Resident 143 was provided with her pain medication (Norco 5-325 mg) at approximately 9 PM. The record indicated Resident 143 was transferred to GACH at 10:15 PM. During a review of Resident 143's eMAR [electronic Medication Administration Record (MAR)]-Medication Administration Note, and MAR, dated 7/6/2024, indicated on 7/6/2024 at 11:48 AM, Resident 143 received Norco (pain medication) oral (given by mouth) tablet 5-325 mg (milligram, unit of weight) for moderate to severe pain (4-10) of the hip area with the pain level of 7/10. (continued on next page)

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	055706	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Orchard - Post Acute Care	12385 E. Washington Blvd Whittier, CA 90606

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 143's MAR, dated 7/6/2024, indicated on 7/6/2024 at 8:49 PM, Resident 143 was experiencing a level of 5/10 pain with no identified location of pain and was given Norco to relieve pain as ordered. During a review of Resident 143's GACH record titled, Physician History & Physical (H&P), dated 7/7/2024, indicated Resident 143 was admitted to GACH with a chief complaint of right hip pain after an unwitnessed fall on 7/6/2024. The record indicated, Resident 143 landed on her right hip after a mechanical fall (fall caused by outside or environmental factors) and experienced severe pain at the right hip and unable to put weight on the right leg. The record also indicated Resident 143 had sharp, constant, severe right hip pain with more pain when the resident moved her right leg. During a review of Resident 143's GACH's record titled, ED Note, dated 7/7/2024, indicated on 7/6/2023 at 10:33 PM, Resident 143 was admitted to GACH's ED for complaint of right hip pain. The record indicated Resident 143 had a history of dementia and had unwitnessed fall and Resident 143 stated that she was trying to stand up, lost her footing and fell . The record indicated on 7/6/2024 at 11:37 PM, a hip X-ray was done that showed a result of the right femoral neck fracture. The record indicated, Resident 143 required admission to GACH with orthopedic (the medical specialty that focuses on injuries and diseases of the body's bones and muscles system) consult for closed right femoral neck fracture related to fall. During a review of Resident 143's GACH's record titled, Orthopedic Surgery Consult, dated 7/7/2024, indicated on 7/6/2024, Resident 143 had a fall when she got up unsupervised injuring her right hip with immediate pain and unable to bear weight and get up. The record indicated Resident 143 needed hemiarthroplasty of the right hip due to right femoral neck fracture. During a review of Resident 143's GACH's record titled, Operative Report, dated 7/8/2024, indicated, on 7/8/2024 at 3:44 PM, Resident 143 underwent a surgical procedure for right hip hemiarthroplasty procedure. During a review of the facility's Written Investigation Summary Report (WISP), dated 7/11/2024, signed by the Director of Nurses (DON), indicated CNA 4's interview statement that on 7/6/2024, CNA 4 changed Resident 143's brief around 2:30 AM, then at 4:20 AM, while finishing care with another resident, CNA 4 heard a sound from Resident 143's room. CNA 4 quickly went inside the room and saw Resident 143 sitting on the floor next to her bed. CNA 4 instructed Resident 143 not to move as CNA 4 rushed to the nursing station and informed RN 4 of the resident's fall incident. RN 4 immediately went to assess Resident 143 while the resident was still sitting on the floor. CNA 4 and RN 4 assisted Resident 143 back to bed. During the same review of facility's WISP, dated 7/11/2024, indicated RN 4's interview statement that on 7/6/2024, RN 4 was at the nursing station around 4:20 AM when CNA 4 came to tell him that Resident 143 fell . RN 4 immediately went to the room and saw Resident 143 sitting on the floor on the right side of her bed facing the television, with her legs stretched forward. The record indicated Resident 143 got up by herself, tried to stand up, but she slipped, lost her balance, slid on the floor, landed on her buttocks and she leaned to the right side. The record indicated, RN 4 completed a body assessment and noted resident complained of pain at 2/10 on the pain scale when performing both active and passive ROM of the right lower extremity. The record indicated Resident 143 stated she wanted to use the bathroom on her own. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During the same review of facility's WISP, dated 7/11/2024, indicated on 7/6/2024, Resident 143's physician was notified and ordered to obtain X-Rays to bilateral hips and pelvis due to the resident's history of previous falls. The record indicated the result from the X-ray taken in the facility on 7/6/2024 revealed in a right hip fracture and the resident was sent to GACH for further evaluations and interventions. The record indicated, on 7/8/2024 at 11:10 AM, the DON spoke with Resident 143's GACH's physician regarding Resident 143's X-ray's result of the right femoral neck fracture and that the resident was scheduled for partial right hip replacement (a surgical procedure in which the hip joint is replaced by artificial part made of metal, ceramic, or plastic) later on 7/8/2024. During a concurrent observation and interview on 7/26/2024 at 7:45 AM, Resident 143 was sitting on the wheelchair next to her bed eating breakfast. Resident 143 stated she had right hip pain when moving from one position to another. Resident 143 stated she could not recall the last time she fell in the facility. Resident 143 stated, she had a habit of going to the bathroom every time she woke up, even when she did not feel the urge to urinate. Resident 143 stated, she always wanted to go to the bathroom first when she woke up because she would not have to worry about going to the bathroom later for at least a few hours. Resident 143 stated, she preferred to go to the bathroom than use an incontinent brief and/or bedpan. Resident 143 stated who would want the bedpan and pee in bed? During an interview on 7/26/2024 at 8:45 AM with CNA 4, CNA 4 stated, on 7/6/2024, she was assigned to Resident 143 during the night shift (11PM-7AM). CNA 4 stated, she changed Resident 143's incontinent brief around 2 AM before she went on break. CNA 4 stated, she came back from break and assisted another resident around 4:20 AM when she heard a sound from Resident 143's room. CNA 4 stated, she finished up assisting the other resident before she went to check on Resident 143 who was found on the floor. CNA 4 stated, Resident 143 told her that Resident 143 wanted to go to the bathroom but did not want to bother CNA 4 and did not call for help. CNA 4 stated, Resident 143 was forgetful. CNA 4 stated, Resident 143 was not on bowel and bladder scheduling program, and she did not offer Resident 143 with scheduled toilet use upon rising in bed, at bedtimes and as needed. CNA 4 stated, at nighttime, she would change Resident 143's incontinent brief in bed or as needed, and she did not offer the resident to go to the bathroom because of Resident 143's history of falls and fractures. During an interview on 7/26/2024 at 9:13 AM with RN 4, RN 4 stated he was the RN Supervisor for the night when Resident 143 fell on [DATE]. RN 4 stated, Resident 143's room was located at the end of the hallway and about five rooms away from Nursing Station (NS) 4. RN 4 stated, around 4:20 AM, he was sitting at NS 4 charting when he was notified by CNA 4 that Resident 143 was found on the floor. RN 4 stated, Resident 143 was sitting on the floor about three (3) feet away from her bed. RN 4 stated, Resident 143 previously fell in the facility on 6/25/2024 around 1-2 AM with the same reason that she wanted to go to the bathroom. RN 4 stated, he was working during the night of 6/25/2024 and he saw Resident 143 on the floor close to the bathroom. During an interview on 7/26/2024 at 9:53 AM, LVN 6 stated she was the Charge Nurse during the shift when Resident 143 fell on [DATE]. LVN 6 stated, Resident 143 told her that she wanted to go to the bathroom but did not want to bother or wake anybody up, so she stood up by herself and walked a few steps, then she got scared and uneasy because it was too dark, so she slid on the floor. LVN 6 stated, Resident 143 had another fall on 6/25/2024 with the same reason that Resident 143 wanted to go to the bathroom. LVN 6 stated, during the nighttime, the facility was usually dark. LVN 6 stated Resident 143 was very forgetful. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 7/26/2024 at 10:37 AM with Resident 143's family member (FAM) 1, FAM 1 stated, before admitted to the facility, Resident 143 fell at home. FAM 1 stated, Resident 143 was able to walk when she was first admitted to the facility. FAM 1 stated, after falling two times in the facility, the resident was no longer able to walk. During an interview on 7/26/2024 at 11:02 AM, CNA 4 stated, she usually had the bathroom's light on and have the bathroom's door opened wide so that it was not too dark in the resident's room. CNA 4 stated, there was no other light aside from the overhead light in the hallway outside the resident's room and the resident's bathroom light. CNA 4 stated, Resident 143's bed was by the window, which was far away from the bathroom and the entrance door. During a concurrent interview and record review on 7/26/2024 at 11:40 AM with CNA 7, Resident 143's CNA Tasks for July 2024 was reviewed. CNA 7 stated, Resident 143 was not on any bowel and bladder scheduling program. CNA 7 stated, if Resident 143 was on bowel and bladder program, there would be a charting system that would remind the CNA to offer the resident to the bathroom every two hours. CNA 7 stated, there was no task to offer Resident 143 to the bathroom every two hours. CNA 7 stated, she offered Resident 143 to the bathroom when the resident requested by pressing the call light only. During a concurrent interview and record review on 7/26/2024 at 1:45 PM with LVN 7, Resident 143's CNA Tasks, and Order Summary Report for July 2024 were reviewed. LVN 7 stated, Resident 143 had no documented evidence that Resident 143 was placed on any bowel and bladder scheduling program because she did not see any documentation in the CNA tasks or physician order. During a concurrent interview and record review of Resident 143's electronic record on 7/26/2024 at 2:52 PM with the DON, Resident 143's Tasks (an electronic record used by the CNA to indicate that the resident was offered and assisted to use the toilet on scheduled time), Medication Administration Record, Care plan, and Order Summary Report for June and July 2024 were reviewed. The DON stated, there was no documented evidence that Resident 143 was placed on a bowel and bladder schedule as indicated in the care plan. The DON stated there should be a documentation in the CNA Task that the CNAs asked and offered Resident 143 to go to the bathroom every two hours so they could assist the resident to prevent fall. The DON stated, she could not find any proof that the CNAs had been offering to assist Resident 143 to the bathroom. During a review of the facility's policy and procedure (P&P) titled, Fall Management System, revised 1/2024, the P&P indicated the following information: -It is the policy of the facility to provide an environment that remains as free of accident hazards as possible. It is also the policy of the facility to provide each resident with appropriate assessment and interventions to prevent falls and to minimize complications if a fall occurs. -Residents with high risk factors identified on the Fall Risk Evaluation will have an individualized care plan developed that includes measurable objectives and timeframes. The care plan interventions will be developed to prevent falls by addressing the risk factors and will consider the particular elements of the evaluation that put the resident at risk. -A review of the fall incident will include investigation to determine probable causal factors. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-The investigation will be reviewed by the Interdisciplinary Team. Fall IDT summary and recommendations will be documented in the resident's Clinical Record. -Resident's care plan will be updated. During a review of the facility's P&P titled, Fall Prevention - Falling STAR Program, revised 1/29/2020, the P&P indicated: -It is the policy of the facility to reduce the number and severity of falls and to identify high risk residents and take precautionary measures. -Interventions included: Appropriate toileting program to be followed, and staff to check at the beginning of every shift for correct application of safety devices.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46779 Based on observation, interview and record review, the facility failed to provide necessary respiratory care and services for one of four sampled residents (Resident 90) by failing to label with the date and time when first used and replacing the oral suctioning (a procedure involves inserting a small plastic tube attached to a suction machine into the mouth to remove saliva or secretion) canister (a container used in medical settings to collect waste material during suction procedure) of Resident 90. This deficient practice placed Resident 90 at risk for respiratory infection (any infectious disease of the parts of the body involved in breathing). Findings: During a review of Resident 90's Admission Record, indicated the facility originally admitted Resident 90 on 1/6/21 and readmitted on [DATE] with diagnoses that include hemiplegia (paralysis of one side of the body) and dysphagia (difficulty swallowing). During a review of a Minimum Data Set (MDS, a standardized assessment and care planning screening tool), dated 7/11/24, indicated Resident 90 had severely impaired cognitive (ability to understand and make decisions) skills for daily decision making. The MDS indicated Resident 90 required partial/moderate assistance with oral hygiene, substantial/maximal assistance with personal hygiene, and dependent with toileting hygiene, shower/bathe self and chair/bed-to-chair transfer. During a review of Resident 90's Order Summary Report, dated 7/25/24, indicated the physician ordered for Resident 90 to receive oral suction as needed for excessive secretions/congestion (a feeling of fullness in the nose or face), starting on 2/21/24. During a concurrent observation and interview on 7/23/24 at 8:47 AM, in Resident 90's room, with Licensed Vocational Nurse (LVN) 4, Resident 90 was lying in the bed. A portable suction machine with a suctioning canister attached on it was on Resident 90's nightstand. The suction canister contained 100 milliliter (ML, measurement of unit) clear liquid and a few white particles at the bottom of the canister. The canister was not dated or labeled. LVN 4 stated the canister was not labeled with the date when it was first used, and she did not know when it was changed last time. LVN 4 stated the licensed nurses were responsible to date and label with the date when first used and change the canister, but no nurse date and label the canister. LVN 4 stated she was not sure how often they were supposed to change the canister. LVN 4 stated Resident 90 would be at risk for infection if the canister was not changed as directed. During an interview on 7/25/24 at 11:52 AM, with LVN 3, LVN 3 stated he did not know how often an oral suctioning canister needed to be changed and no one had informed him about this information. LVN 3 stated it was important to date and label with date when first used and replace the canister to protect the resident from infection. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 7/26/24 at 9:20 AM, with the Director of Nursing, the facility's undated policy and procedure (P&P) titled, Medical Equipment-Storage, Labeling, Cleaning and Disinfecting, was reviewed. The P&P indicated suction canister should be emptied and cleaned as needed. The DON stated the P&P did not specifically indicate when a suction canister should be emptied and cleaned, but as the standard of practice in the facility, the licensed nurse should date, label, and replace the suction canister daily to prevent potential infection to the residents.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47467 Based on observation, interview, and record review, the facility failed to follow the facility policy and procedure titled Resident Care - Recognition and Management of Pain, dated 1/2021, for two (2) out of two (2) sampled residents (Resident 25, and 604) by failing to: 1. Ensure Certified Nurse Assistant (CNA) 6 immediately report to Licensed Vocational Nurse (LVN) 8, Resident 25's complaint of pain to ensure LVN 8 reassess the resident for the pain medication's effectiveness, and reassess Resident 25 ---was observed experiencing pain in his left leg's stump [the basal portion of a bodily part (as a limb) remaining after the rest is removed] on 7/23/2024 at 10:17 AM. 2. Ensure Resident 604 with pain in the shoulder, clavicle (the collar bone/the bone that connects the breastbone to the shoulder blade) and ribs due to fracture (broken bone) was provide pain medication timely to control pain. These deficient practices resulted in Resident 25 experiencing pain on 7/23/2024, and Resident 604 experiencing uncontrolled pain that had the potential to result in the decline in the ability to carry out activities of daily living and delayed healing. Findings: 1. During a review of Resident 25's Admission Record, the record indicated Resident 25 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis that included cellulitis of let lower limb, fracture of superior rim of left pubis, and acquired absence of left leg below knee. During a review of Resident 25's History and Physical, dated 12/5/2023, indicated Resident 25 had capacity to understand and make decisions. During a review of Resident 25's Minimum Data Set (MDS- a comprehensive assessment and screening tool) dated 6/7/2024, the record indicated Resident 25 ' s cognition was severely impaired (difficulty with or unable to make decisions, learn, and remember things) and needed moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides more than half the effort) in toileting hygiene (the ability to maintain perineal hygiene). During a review of Resident 25's Care plan, dated 1/18/2024, the record indicated Resident 25 had acute/chronic pain with the goal that the resident would verbalize adequate relief of pain and the interventions included to anticipate need for pain relief and respond immediately to any complaint of pain, to follow pain scale to medicate as ordered, to monitor/document for probable cause of each pain episode, and to monitor/record pain characteristics [quality, severity, anatomical (body structure) location, onset, duration, aggravating factors, and relieving factors]. During a review of Resident 25's Order Summary Report, dated 1/31/2024, indicated Resident 25 had a physician's order to assess the resident ' s pain every shift. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 25's Medication Administration Record (MAR), dated 7/23/24, the MAR indicated pain assessment for 7 AM to 3 PM shift was 0 (indicating no pain). During a concurrent observation and interview on 7/23/2024 at 10:17 AM in Resident 25's room, Resident 25 was observed lying on his right side touching his left leg's stump (a residual limb after an amputation) in the presence of CNA 6. Resident 25 stated, he had constant pain in his left stump. CNA 6 stated, she would let the nurses know. During an interview on 7/23/2024 at 11:03 AM (approximately one hour later) with Resident 25, Resident 25 stated, his left leg stump was still in pain with a level of 7/10 (pain scale with 0 as no pain and 10 as the worse pain a person has ever felt) and no staff had come to assist him yet or gave the resident medication for pain. During an interview on 7/23/2024 at 11:05 AM with CNA 6, CNA 6 stated she was busy assisting other residents, and forgot to let Resident 25's assigned Charge Nurse know the resident was in pain. During an interview on 7/23/2024 at 11:09 AM with Licensed Vocational Nurse (LVN) 8, LVN 8 stated, she got report around 8:50 AM in the morning from CNA 2 that Resident 25 was having pain in his left stump. LVN 8 stated, she went to let Resident 25 know that she gave his routine medications around 8:40 AM including his pain medications and told him to give it sometimes to take effect. LVN 8 stated, she did not receive report from CNA 6 related to Resident 25's pain. LVN 8 stated she reassessed Resident 25's pain in the morning after she gave Resident 25 his routine pain medication. During a concurrent observation and interview on 7/23/2024 at 11:15 AM with LVN 8 in Resident 25's room, Resident 25 was being changed by CNA 2. CNA 2 stated he just finished cleaning Resident 25 to get the resident ready for activities. LVN 8 stated, she must have mistaken another resident with Resident 25 when she administered the pain medication. LVN 8 stated, she did not reassess Resident 25's pain and stated, it should have been reassessed within one hour after the pain medication was given to make sure the medication was effective and if there was a need for a different intervention. During an interview on 7/23/2024 at 2:11 PM with the Director of Nurses (DON), the DON stated, CNA 6 should have reported Resident 25's pain to LVN 8 to have it addressed right away and LVN 8 should have reassess the resident's pain after one hour of pain medication's administration when the resident complained about pain. The DON confirmed that the resident should not be suffering from pain. During a review of the facility's policy and procedure (P&P) titled, Resident Care - Recognition and Management of Pain, dated 1/2021, the P&P indicated the facility assists each resident with pain management to maintain or achieve the highest practicable level of well-being and functioning by: Interviewing or observing the resident to determine if pain is present; Identifying circumstances when pain can be anticipated; Evaluating pain and working with the resident to develop a plan of care that considers their needs preferences and goals. The P&P also indicated: The resident will be evaluated for pain upon admission, quarterly, and with any change in their status, pain will be documented in the electronic health record (HER) using a scale of 1-10, monitor pain status every shift using either the numerical pain rating or Pain Advanced Dementia scoring guide, and the Interdisciplinary Care Plan will reflect the location and type of pain, pharmacological, and non-pharmacological interventions, with evaluation and revision as indicated. 50714 (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During an observation on 7/23/2024 at 10:47 AM, Resident 604 had a grimace on his face and grimacing. In a concurrent interview Resident 604 stated he had pain in his left clavicle and the facility had not managed his pain well since admission. During a concurrent interview and record review on 7/25/2024 at 11:15 AM with Registered Nurse (RN) 3 stated, according to Resident 604 ' s Medication Administration Record (MAR), dated 7/25/2024, Resident 604 did not receive Oxycodone/Acetaminophen (medication for moderate to severe pain) on 7/18/2024 for a pain level of 8 (severe pain) out of 10 (pain scale -0 no pain and 10-severe pain), and on 7/19/2024 for pain level of 8. RN 3 stated Resident 604 was admitted to the facility for pain management and rib fracture after a fall. RN 3 stated she could not explain why Resident 604 was not given pain medication on 7/18/2024 and 7/19/2024. RN 3 stated if the pain level was 8 out of 10, Resident 604 should have been given Oxycodone/Acetaminophen for pain relief and control. During a concurrent interview and record review on 7/25/2024 at 11:35 PM with the Director of Nursing (DON), the DON stated the staff did not follow the nursing process (a resident-centered, systematic, evidence-based approach to delivering high-quality nursing care that involves assessment, intervention and evaluation of care) for assessment and reassessment of pain. During a review of Resident 604's Care Plan, dated 7/14/2024, indicate Resident 604 has acute (sudden) and chronic (frequent) pain due to shoulder, clavicle and rib fracures. The care plan indicated Resident 604 would remain free from pain or at the level of discomfort acceptable to the resident by ensuring to monitor for verbal and non-verbal (moaning, restless, grunting, fast/slow breathing) pain and anticipate needs for pain relief and respond immediately for any complaint of pain. During a review of the facility ' s policy and procedure (P&P) titled, Resident Care - Recognition and Management of Pain, dated 1/2021, indicated the facility would interview/observe for the presence of pain, anticipate pain, work with the resident that considers their preferences/goals, and develop a plan for non-pharmacological and/or pharmacological interventions to manage pain. The P&P indicated if the pain was not managed by current orders, a licensed nurse will contact the physician.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 46779 Based on observation, interview and record review, the facility failed to provide an accessible-hemodialysis (a process of removing toxins and excess fluid in the blood by insering a plastic catheter or tube into the body using a machine) emergency kit (kit used in the event bleeding was observed in the hemodialysis site) for one of three sample residents (Resident 138) who received hemodialysis. This deficient practice had the potential to delay or unable to immediately provide interventions in an event of emergency to Resident 138 for complications such as trauma, and bleeding on the dialysis access site (a surgically created vein used to remove and return blood to the body during hemodialysis) that could lead to a significant blood loss and decline in the resident's wellbeing. Findings: During a review of Resident 138's Admission Record, indicated the facility admitted Resident 138 on 3/14/24 with diagnoses that include acute kidney failure (failure of the kidney to filter waste/toxins and excess fluids in the blood) and hypertension (high blood pressure). During a review of a Minimum Data Set (MDS, a standardized assessment and care planning screening tool), dated 6/10/24, indicated Resident 138 had severely impaired cognitive (ability to understand and make decisions) skills for daily decision making. The MDS indicated Resident 138 required substantial/maximal assistance with eating and oral hygiene, and dependent with toileting hygiene, shower/bathe self, personal hygiene, and chair/bed-to-chair transfer. During a review of Resident 138's Order Summary Report, dated 7/25/24, indicated Resident 138 to receive hemodialysis on every Tuesday, Thursday, and Saturday, ordered on 6/3/24. During a concurrent observation and interview on 7/23/24 at 3:40 PM, in Resident 138's room, with Licensed Vocational Nurse (LVN) 3, Resident 138 was lying on the bed with a permacath (a special catheter used for short-term dialysis treatment) wrapped in a clean dressing on her right upper chest. LVN 3 stated Resident 138 receives hemodialysis, and a dialysis emergency kit should be available at bed side. LVN 3 looked around Resident 138's bed and the walls and checked inside her nightstand and its drawer. LVN 3 stated he did not find the dialysis emergency kit at Resident 138's bedside. LVN 3 stated he did not know what was inside the dialysis emergency kit. LVN 3 stated the central supply prepared the kit and the licensed nurses were responsible to make sure a dialysis emergency kit was available at every dialysis's bedside in case of emergency, such as excessive bleeding from the dialysis access. During a concurrent observation and interview on 7/23/24 at 3:54 PM, in Resident 138's room, with Registered Nurse (RN) 2, RN 2 checked Resident 138 ' s bed side and stated there was no dialysis emergency kit at Resident 138's bedside. RN 2 stated a dialysis emergency kit should be available at every dialysis resident's bedside so the staff could get immediate access in case of emergency. RN 2 stated the central supply staff prepared the kit and placed it on the hook that was attached to the right side of the resident's nightstand. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 7/26/24 at 9:21 PM, with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Dialysis (Renal), Pre- and Post-Care, dated 12/2023, was reviewed. the DON stated the facility's dialysis policy did not indicate specifically a dialysis emergency kit should be placed at every dialysis resident's bedside, but as the standard of practice in the facility, a dialysis emergency kit, including gauzes and tourniquets, should be placed on the hook that was attached to the right side of the nightstand for every dialysis resident. The DON stated in case of emergency, the staff could have the immediate access to the emergency kit to prevent any harm to the dialysis residents. The DON stated all staff, including the licensed nurses and the central supply staff should know where to place and locate the dialysis emergency kit for the dialysis residents. The DON stated the licensed nurses should know what was inside of the dialysis emergency kit so they could better utilize the kit during an emergency.

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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** 44018 Based on observation, interview and record review, the facility failed to provide pharmaceutical (medication related) services to prevent consequences of medication-related adverse events (undesired effects) for two (2) out of three (3) sampled residents (Resident 21 and Resident 22) by failing to: 1. Administer PreserVision (medication used for dry eye) with food per physician's order for Resident 21. This failure had the potential to cause Resident 21 to have stomach irritation such as stomach pain, nausea, and vomiting. 2. Administer Metformin Hydrochloride (medication given to lower the blood sugar level) was administered with meals as ordered by the physician for Resident 22. This failure had the potential to result in Resident 22 to develop adverse reaction to the medication such as significant drop in blood sugar level. Findings: 1. During a review of Resident 21's Admission Record, indicated Resident 21 was admitted to the facility on [DATE] with diagnoses that included muscle weakness and type 2 diabetes mellitus (DM- a disease that occurs when the blood sugar is too high). During a review of Resident 21's History and Physical Examination (H&P), dated 2/7/2024, indicated Resident 21 did not have the capacity to understand and make decisions. During a review of Resident 21's Minimum Data Set (MDS, a standardized assessment and care-screening tool), dated 6/19/2024, indicated Resident 21 had severe impairment in cognitive (ability to think and reason) skills. The MDS indicated Resident 21 required substantial/maximal assistance (helper does more than half the effort) with lower body dressing and putting on/taking off footwear. The MDS also Resident 21 required partial/moderate assistance (helper does less than half the effort) with toileting hygiene and shower/bathe self. During a review of Resident 21's Order Summary Report (a summary of all currently active physician orders), dated 7/25/24, indicated the physician ordered Resident 21 to receive PreserVision to be given one capsule by mouth two times a day for mild dry - aged related macular degeneration (an eye disease that cause vision loss), administer with food. During a medication pass observation, on 7/25/2024 at 8:12 AM. Licensed Vocational Nurse (LVN) 2 administered PreserVision to Resident 21 without food and snack that were not observed on top of the medication cart or in the Resident 21's room. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During a review of Resident 22's Admission Record, indicated the resident was admitted to the facility on [DATE] with diagnoses that included muscle weakness, cirrhosis of liver (liver damage where healthy cells are replaced by scar tissue), and type II Diabetes Mellitus (a group of diseases that result in too much sugar in the blood). During a review of Resident 22's MDS, dated [DATE] indicated the resident had severe cognitive impairment. The MDS indicated the resident was assessed requiring required substantial/maximal assistance from staff for toileting hygiene, shower/bathe self, and lower body dressing. During a review of the History and Physical Examination, dated 1/18/2024, indicated Resident 22 had fluctuating capacity to understand and make decision. During a review of Resident 22's Order Summary report, dated 7/21/2024 indicated the physician ordered Resident 22 to receive Metformin Hydrochloride one tablet 1000 milligrams (mg, a unit of measurement) by mouth, one time a day for DM, to be given with meals (breakfast, lunch, and dinner). During a medication administration observation on 7/25/2024 at 9:50 AM, LVN 2 administered Metformin Hydrochloride to Resident 22 from a bubble pack (packaging in which medications are organized and sealed between a cardboard backing and clear plastic cover). LVN 2 and did not offer the resident food and there was no snack or food at bedside table. During a record review of Resident 22's Medication Administration Record (MAR), and physician orders with LVN 2 on 7/25/2024 at 10:12 AM, LVN 2 confirmed the physician ordered Resident 22 to administer Metformin with food and ordered Resident 21 to administer PreserVision with food. LVN 2 stated breakfast was served at 7:30 AM. The LVN 2 confirmed she did not offer snack or food to Resident 22 before administration of Metformin. LVN 2 stated it was important to take Metformin with meals to prevent hypoglycemia (low blood sugar). LVN 2 also stated he did not offer snack or food to Resident 21 before administration of PreserVision. LVN 2 further stated it was important to take PreserVision with food to prevent stomach irritation such as nausea, vomiting, and stomach pain. During an interview on 7/25/2024 at 11:25 AM, the DON stated the licensed nurses should have offered some snacks before administering Metformin and PrserVision to the resident. DON stated administering Metformin with food could prevent blood sugar drop and administering PreserVision with food to prevent stomach irritation. DON stated LVN 2 should administered medication in accordance with the orders. During a review of the facility's policy and procedure titled Administering Medications, revised dated 5/2021, the policy indicated that the facility to accurately prepare, administer and document oral medications. The procedure indicated to administer drug to resident: verify medication cards with medication sheets, read the label on the container as it is removed from the shelf and check label with medication card. Verify with another staff member if any questions.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47467 Based on observation, interview and record review, the facility failed to ensure the food served for one of two sampled residents (Residents 354) was palatable and hot food were served hot and/or above 120 degrees F (F-a measurement of temperature) as indicated in the facility's policy and procedure titled, Meal Service, dated 2023. This deficient practice had the potential to affect palatability of the food to the residents and to have poor meal intake that could lead to weight loss. Findings: During a review of Resident 354's Admission Record indicated Resident 354 was admitted to the facility on [DATE] with diagnosis that included iron deficiency anemia (low blood count), protein-calorie malnutrition (inadequate intake of food as a source of protein, calories, and other essential nutrients), hyperlipidemia (an abnormally high concentration of fat particles in the blood). During a review of Resident 354's Minimum Data Set (MDS- a comprehensive assessment and screening tool) dated 7/13/2024, indicated Resident 354 was cognitively intact (able to think, remember, and reason) and required setup or clean-up assistance (helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity) in eating. During a review of Resident 354's History and Physical, dated 7/8/2024, indicated, Resident 354 had capacity to understand and make decisions. During a review of Resident 354's Order Summary Report, dated 7/17/2024, indicated, Resident 354 had a physician ' s order of No Added Salt fortified (added nutrients to food) diet with regular texture thin liquid consistency, large portions of protein for all meals related to unspecified protein-calorie malnutrition. During a review of Resident 354's Care plan, dated 7/9/2024, indicated, Resident 354 had protein-calories malnutrition with the goal to maintain adequate nutritional status with interventions that included to honor resident rights to make personal dietary choices. During a concurrent observation and interview on 7/24/2024 at 1:05 PM in Resident 354's room, the resident's lunch tray delivered at bedside table by the Director of Staff Development Assistant (DSDA). Resident 354 was observed touching the hamburger and stated that it was too cold for his liking. Resident 354 added, he always received cold food during lunch time. Resident 354 stated, he could not eat if the food was cold because it decreases his appetite. During a concurrent observation and interview on 7/24/2024 at 1:06 PM with the DSDA checked the temperature of Resident 354's hamburger. The DSDA stated, the temperature of the hamburger was at 102. 9 degrees Fahrenheit. The DSDA stated, she did not know if the measured temperature was at the correct serving temperature. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/24/2024 at 1:18 PM with the Dietary Supervisor (DS), the DS stated, Resident 354 ' s hamburger on the hot plate was supposed to be above 120 F degrees Fahrenheit when it was delivered to the resident's bedside table. The DS stated, undesired food temperature could lead to the resident's dissatisfactory and decreased his appetite, which could potentially result in weight loss. During an interview on 7/26/2024 at 2:50 PM with the Director of Nurses (DON), the DON stated, when a hot food is served cold with low temperature, it could lead to the food not tasting good for the resident which could eventually discourage the resident to eat. During a review of the facility's policy and procedure titled, Meal Service, dated 2023, indicated: a. Meals that meet the nutritional needs of the resident will be served in an accurate and efficient manner and served at the appropriate temperatures, b. Temperature of the food when the resident receives it is based on palatability. The goal is to serve cold food cold and hot food hot. Recommended temperature at delivery to resident for hot entree was above or at 120-degree Fahrenheit.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46779 Based on observation, interview, and record review, the facility failed implement the facility's policy and procedure for infection control by failing to: 1. Store food in a sanitary manner to prevent growth of microorganisms that causes food borne illness (food poisoning: any illness resulting from the food spoilage of contaminated food, pathogenic bacteria, viruses, or parasites that contaminate food, as well as toxins) for residents in the facility by not checking the boxes of fruit and vegetables that was rotten and spoiled items. 2. Ensure the dietary aid to follow hand washing practices consistent with accepted standard of practice after touching trash bin prior to returning to work. These deficient practices had the potential to result in pathogen (germ) exposure to residents and placed residents at risk for a wide spread of infection (a process when a microorganism, such as bacteria, fungi, or a virus, enters a person's body and causes harm) and developing foodborne illness (also called food poisoning, caused by eating contaminated food or eating food not kept at appropriate temperatures.) with symptoms including upset stomach, stomach cramps, nausea, vomiting, diarrhea and fever and can lead to other serious medical complications and hospitalization . Findings: 1. During an observation on 7/23/24 at 8:53 AM, in the kitchen, observed three cantaloupes and one honeydew were in a bin, which was stored on the dry storage shelf. Three cantaloupes had multiple black marks on them. One cantaloupe had white and gray color molds on it. There was yellow color residual at the bottom of the bin with the melons. Two rotten onions with black and gray molds on them were stored in a separate bin in the dry storage. During an interview on 7/23/24 at 8:56 AM with the Dietary Supervisor (DS). The DS stated three cantaloupes were soggy to touch and had black marks on them, and one cantaloupe had molds on it. The DS stated the yellow residual at the bottom of the bin was from the rotten cantaloupes. The DS stated two onions had molds on them and they were rotten. The DS stated he and another dietary staff were responsible to check and dispose the rotten food. The DS stated these rotten items should had been thrown out. The DS stated if residents ate the rotten food, the residents would be at risk for food borne illness. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/25/24 at 2:14 PM, with the Corporate Registered Dietitian (CRD). The CRD stated before they serve the food for the resident, they would wash and check the food and if the food was spoiled, they would throw it away. The CRD stated if a melon had a black spot and had mold on it, they would wash it, check it, cut out the black part, and serve the good part. The CRD stated for the onions with molds grew on it, they would peel it, wash it, and check it, and cut out the molded part and would use the remaining of the onion if it was good. The CRD stated the facility did not break the food safety code when she was asked if it was ok to store the rotten cantaloupes in a dirty bin and the rotten onions in the storage area. The CRD stated she did not see how the facility failed on the food code by storing the melons with black spots and molds grew on it, which was stored in a bin with yellow juice residual from the melon on bottom, and onions with gray color molds in the dry storage. During a review of the facility's policy and procedure titled, Storing Produce, dated 2023, the P&P indicated, 1. Check boxes of fruit and vegetables for rotten, spoiled items. Check often prior to processing. Throw away all spoiled items; and 6. Fresh fruits such as apricots, avocados, peaches, melons, plums, pineapples, and pears may be stored at room temperature until ripe. When ripe, they should be stored in the refrigerator. 48481 2. During an observation on 7/24/2024 at 11:25 AM, in the kitchen, Dietary Aid (DA) 1 lifted a trash bin and moved it aside, then, she reached the hairnet bin on the wall to grab a clean hairnet. Afterwards, the DA 1 lifted and moved the trash bin back in place, then, returned to work in the tray line and food preparation area. During an interview on 7/24/24 at 11:26 AM, with the Dietary Supervisor (DS), the DS stated the DA 1 should have washed her hands after touching the trash can before touching clean objects and returning to work. During a review of the facility ' s policy and procedure titled, Hand Washing Procedure - Healthcare Menu Direct dated 2023, indicated, Hand Hygiene is important to prevent the spread of infection. PROCEDURE . and WHEN HANDS NEED TO BE WASHED: 8. Touching trash can or lid.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46779 Based on observation, interview, and record review, the facility failed implement the facility's policy and procedure on infection control to prevent spread of infection for four (4) out of seven (7) sampled residents (Resident 102, 25, 108, and 454) by failing to: 1. Ensure the nasal cannula (NC-a device used to deliver supplemental oxygen to people) tubing was changed at least every 7 days for Resident 102. 2. Ensure the NC was stored properly and not reused after it was observed touching the trashcan and the floor for Resident 25. 3. Ensure the G-tube (A tube inserted through the wall of the abdomen directly into the stomach) formula bottle tubing was dated for Resident 108. 4. Ensure the peripheral intravenous (a thin, flexible tube that is inserted into a vein, it is used to give intravenous fluids, blood transfusions, chemotherapy, and other drugs) (PIV) dressing was dated for Resident 454. These deficient practices had the potential to result in the residents' infection (a process when a microorganism, such as bacteria, fungi, or a virus, enters a person's body and causes harm) and a widespread of infection in the facility. Findings: 1. During a review of Resident 102 ' s Admission Record, indicated the facility initially admitted Resident 102 on [DATE] and readmitted on [DATE] with diagnoses that included dementia (a general term for the impaired ability to remember, think, or make decisions that interferes with doing everyday activities) and heart failure (a condition that develops when the heart does not pump enough blood for your body ' s needs). During a review of Resident 102's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated [DATE], indicated Resident 102 had severely impaired memory and cognitive (ability to think and reasonably) impairment. The MDS indicated Resident 102 required setup or clean-up assistance with eating and oral hygiene, and partial/moderate assistance with toileting hygiene, shower/baths self, person hygiene and chair/bed-to-chair transfer. During a review of Resident 102 ' s Order Summary Report, dated [DATE], indicated Resident 102 to receive oxygen at two and may titrate up to four liter per minute (LPM, measurement units) via nasal cannula as needed. The report indicated to change the nasal cannula weekly. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on [DATE] at 11:59 AM, with the MDS nurse, Resident 102 was sitting on a wheelchair with portable oxygen tank attached on the back of the wheelchair. Resident 102 was receiving oxygen at two LPM via a NC tubing which was dated [DATE]. The MDS nurse stated a NC should be changed every seven days. The MDS nurse stated Resident 102 ' s NC tubing had not been changed more than 7 days and potentially placed Resident 102 at risk for respiratory infection. During an interview on [DATE] at 9:19 AM, with the Director of Nurse (DON), the DON stated according to the facility policy, the staff should date the NC tubing and change it every 7 days to prevent infection. During a review of the facility ' s policy and procedure (P&P) titled, Use of Oxygen, dated ,d+[DATE], indicated Oxygen cannula will be changed at least every 7 days. 47467 2. During a review of Resident 25 ' s Admission Record indicated Resident 25 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis that included pneumonia (a severe lung infection), respiratory failure (a condition in which not enough oxygen passes from the lungs into the blood), chronic obstructive pulmonary disease with exacerbation (COPD - a lung disease characterized by long-term poor airflow), and asthma (a condition that is marked by difficulty in breathing with wheezing, a feeling of tightness in the chest, and coughing). During a review of Resident 25 ' s History and Physical, dated [DATE], indicated, Resident 25 had capacity to understand and make decisions. During a review of Resident 25 ' s Minimum Data Set (MDS- a comprehensive assessment and screening tool), dated [DATE], indicated Resident 25 ' s cognition was severely impaired (difficulty with or unable to make decisions, learn, and remember things) and needed setup or clean up assistance in eating and oral hygiene. During a review of Resident 25 ' s Order Summary Report, dated [DATE], indicated Resident 25 had a physician order for continuous oxygen at 2 LPM [Litters (unit of volume) per minute (unit of time)] via nasal cannula. During an observation on [DATE] at 9:14 AM, Resident 25 was not in his room. Resident 25 ' s oxygen concentrator was observed side by side the trashcan, the nasal cannula was observed not in use and not covered, and a portion of the nasal cannula tubing was touching the trashcan and the floor. During an observation on [DATE] at 12:44 PM, Resident 25 ' s nasal cannula dated [DATE] stored in a bag hanging beside the oxygen machine. (continued on next page)

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The Orchard - Post Acute Care	12385 E. Washington Blvd Whittier, CA 90606

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on [DATE] at 3:30 PM with Certified Nurse Assistant (CNA) 3, Resident 25 was observed in bed with nasal cannula, dated [DATE] being used and the oxygen prongs (small opening at the tip of the NC) that was touching the trashcan was on his nose. CNA 3 stated, when he tidied up Resident 25 ' s bed around 12:30 PM and noticed the nasal cannula hanging on the oxygen machine and not being stored properly so he put it in the bag. CNA 3 stated, when Resident 25 came back from the activity ' s room, he assisted Resident 25 to bed and reused the same nasal cannula tubing. During an interview on [DATE] at 10:06 AM with the Director of Staff Development (DSD), the DSD stated, once the nasal cannula was observed not being stored properly when not in use, it should already be discarded due to infection issue. The DSD stated, if the nasal cannula was touching the trash can, it was contaminated and could potentially cause respiratory infection if reused. During a review of the facility ' s policy and procedure (P&P) titled, Oxygen, Use of, revised [DATE], indicated, the tubing should be kept off the floor. Labeled and dated bags should be provided for cannulas and masks to be placed in when not in use. During a review of the facility ' s P&P titled, Infection Prevention and Control Program, revised ,d+[DATE], indicated, the facility is responsible to promote individual resident's rights and well-being while trying to prevent and control the spread of infection. The P&P also indicated the facility will provide areas, equipment, and supplies to implement its Infection Control Program with the goal of safe use of disposable and single use supplies and equipment; and effective cleaning and disinfecting equipment as needed. 47882 3. During a review of Resident 108's Admission Record, indicated the facility originally admitted Resident 188 on [DATE] and readmitted on [DATE] with diagnoses that included sepsis (a serious condition in which the body responds improperly to an infection), end stage renal disease (ESRD) (kidneys no longer work as they should to meet your body's needs), and diabetes (lifelong condition that causes a person's blood sugar level to become too high). During a review of Resident 108 ' s History and Physical Examination, dated [DATE], indicated Resident 108 had the capacity to understand and make decisions. During a review of Resident 108's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated [DATE], indicated Resident 108 required partial/moderate assistance (helper does less than half the effort) with dressing , personal hygiene, roll left and right, and required substantial/maximal assist (helper does more than half the effort) toileting, shower, chair to bed transfer. During a concurrent observation and interview on [DATE] at 9:35 AM with Licensed Vocational Nurse (LVN) 1 in Resident 108 ' s room, Resident 108 ' s G-tube formula bottle tubing was not dated. LVN 1 stated, the tubing attached to the G-tube formula should have been dated, so we know the last time it was changed. LVN 1 stated, it was an infection control issue, and it could affect Resident 108 ' s health if it ' s an old tubing, it could grow bacteria and potentially get the Resident sick. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 11:30 AM with Registered Nurse (RN) 1, RN 1 stated, the tubing attached to the G-tube formula bottle should be dated, it is the indication the last time it was changed. RN 1 stated the tubing is supposed to be changed within 24 hours. RN 1 stated, the tubing needs to be changed for sanitary and hygiene reasons and if the tubing is old, it could potentially grow bacteria and get the resident sick. During a review of Resident 108 ' s Care Plan (CP), for risk for infection related to indwelling device (G-tube), dated [DATE], the CP intervention included Enhance Barrier Precautions (EBP) (an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities) During an interview on [DATE] at 9:23 AM with Director of Nurses (DON), DON stated, the tubing attached to the G-tube formula bottle should be dated to indicate the last time it was changed. DON stated, the tubing needs to be changed within 24, because if it ' s an old tubing it could potentially grow bacteria and cause infection to the resident. During a review of the facility ' s P&P titled, Infection Prevention and Control Program, revised ,d+[DATE], indicated, the facility is responsible to promote individual resident's rights and well-being while trying to prevent and control the spread of infection. The P&P also indicated the facility will provide areas, equipment, and supplies to implement its Infection Control Program with the goal of safe use of disposable and single use supplies and equipment; and effective cleaning and disinfecting equipment as needed. 4. During a review of Resident 454's Admission Record, indicated the facility admitted Resident 454 on [DATE] with diagnoses that included chronic pulmonary edema (a condition caused by too much fluid in the lungs), severe chronic kidney disease (a long-term condition where the kidneys do not work as well as they should) and urinary tract infection (UTI) (an infection in any part of the urinary system). During a review of Resident 454 ' s History and Physical Examination, dated [DATE], indicated Resident 454 had the capacity to understand and make decisions. During a review of Resident 454's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated [DATE], indicated Resident 454 required partial/moderate assistance (helper does less than half the effort) with toileting, upper body dressing, personal hygiene, and required substantial/maximal assist (helper does more than half the effort) with bathing and lower body dressing. During a concurrent observation and interview on [DATE] at 11:46 AM with Resident 454 in Resident 454 room, PIV dressing on Resident ' s 454 right hand without a date. Resident 454 stated, he does not remember when the PIV was put on him and the last time it was used. During a concurrent interview with LVN 1 and RN 1 on [DATE] at 12:00 PM in Resident 454 ' s room, LVN 1 stated, the PIV dressing should have been dated, so we know the last time it was changed, it was an infection control issue, and if its old it could cause infiltration and/or infection. RN 1 stated, he is not sure why the PIV dressing was not dated indicating the last time it was changed. RN 1 stated, Not knowing the date, the PIV dressing could have been old and can cause infiltration or infection and affect the Residents 454 ' s health. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 454 ' s CP for risk for infection, revised [DATE], the CP intervention included maintain standard precaution (in the care of all patients to reduce the risk of transmission of microorganisms from both recognized and non-recognized sources of infection) when providing resident care. During a review of Resident 454 ' s CP for 3 episodes of diarrhea and cough, revised ,d+[DATE] 2024, the CP intervention included to provide IV hydration for 1 day to prevent possible dehydration. During an interview on [DATE] at 9:23 AM with DON, DON stated, the PIV dressing should have been dated so we know the last time it was changed, if the PIV is old, it could cause an infection and affect the Residents health. DON stated, ensuring the PIV dressing is dated is for infection prevention. During a review of the facility's policy and procedure (P&P) titled, Infusion Guidelines and Procedure, (undated), the P&P indicated; a) all peripheral IV (PIV) sites shall be monitored closely for signs of phlebitis (inflammation of a vein), b) all peripheral IV sites shall be rotated every 72 hours or sooner if phlebitis is suspected, unless otherwise ordered, c) All peripheral occlusive dressing shall be changed with the peripheral changed. During a review of the facility's P&P titled, Infection Prevention and Control Program, revised ,d+[DATE], indicated, the facility is responsible to promote individual resident's rights and well-being while trying to prevent and control the spread of infection. The P&P also indicated the facility will provide areas, equipment, and supplies to implement its Infection Control Program with the goal of safe use of disposable and single use supplies and equipment; and effective cleaning and disinfecting equipment as needed.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44018 Based on observation, interview, and record review, the facility failed to maintain a safe, sanitary, and hazard free environment for two (2) out of six (6) residents (Resident 255, and 64) by failing to: 1. Ensure the footrest (a base of support and elevates the legs) of a wheelchair was not placed in the doorway, blocking the residents and staffs from leaving and entering Resident 255 room. This failure had the potential for residents and staffs to be at risk for accident by tripping onto the footrest and result in a major injury. 2. Ensure the facility's staff timely empty two used urinals filled with the resident's urine for Resident 64. This failure resulted in Resident 64's complaint of foul urine odor, feeling unsanitary and uncomfortable with the smell. Findings: 1. During a review of Resident 255's Admission Record, indicated Resident 255 was admitted to the facility on [DATE] with diagnoses that included muscle weakness and anemia (a condition in which the blood does not have enough healthy red blood cell to carry oxygen all through the body). During a review of Resident 255's History and Physical Examination (H&P), dated 9/21/2023, indicated Resident 255 had the capacity to understand and make decisions. During a review of Resident 255's Minimum Data Set (MDS, a standardized assessment and care-screening tool), dated 6/19/2024, indicated Resident 255 had cognitive skill (ability to think and reason) was moderately impaired. The MDS indicated Resident 255 required partial/moderate assistance (helper does less than half the effort) with toileting hygiene, lower body dressing and putting on/taking off footwear. The MDS indicated Resident 255 used a wheelchair and ability to wheel at least 50 feet with two turns. During a concurrent observation and interview in Resident 255's room on 7/25/2024 at 8:10 AM, Resident 255 stated she would like to get out of the room, but the footrest was blocking her way. The footrests were observed on the floor by the door. During an interview with Licensed Vocational Nurse 2 (LVN 2) in Resident 255 ' s room, on 7/25/2024 at 9:37 AM, LVN 2 confirmed that the footrest was left on the floor by the entrance door of Resident 255 ' s room. LVN 2 stated that the footrests were blocking the residents from leaving and entering the room. LVN 2 stated it was a potential risk for falls and injuries to have a hazardous medical equipment blocking the pathway. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of facility ' s policy and procedure titled, Incidents and Accidents, revised dated 2/2023, indicated that facility to implement and maintain measures to avoid hazards and accidents. 47467 2. During a review of Resident 64 ' s Admission Record indicated Resident 64 was admitted to the facility on [DATE] with diagnosis that included muscle weakness, type 2 diabetes mellitus (condition that results in too much sugar circulating in the blood), hypertension (high blood pressure), and dementia [the loss of cognitive functioning (thinking, remembering, and reasoning) to such an extent that it interferes with a person's daily life and activities]. During a review of Resident 64's Minimum Data Set (MDS- a comprehensive assessment and screening tool) dated 7/8/2024, indicated Resident 64 was cognitively intact (able to think, remember, and reason). During a review of Resident 64's History and Physical, dated 7/5/2024, indicated, Resident 64 had capacity to understand and make decisions. During a concurrent observation and interview on 7/24/2024 at 9:10 AM in Resident 64 ' s room, two unemptied urinals were observed hanging on the resident's bedside table, one urinal was observed half full, and one urinal was observed one third full of urine. Resident 64 stated, Resident 64 had been urinating in the urinals since the night before and no staff members had come in to empty them. Resident 64 stated, the smell from unemptied urinals made him feel unsanitary and uncomfortable. During an interview on 7/24/2024 at 9:21 AM in Resident 64's room with Certified Nurse Assistant (CNA) 3, CNA 3 stated, he noticed the urinals with urine in them since he made his round around 7 AM, but he did not empty them because he usually wait until the end of the shift to empty the urinals or he would empty the urinal when the resident complained about the urine odor. During an interview on 7/25/2024 at 10:06 AM with the Director of Staff Development (DSD), the DSD stated, the urinals supposed to be emptied as soon as CNA 3 noticed them due to infection issue. During an interview on 7/26/2024 at 2:46 PM with the Director of Nurses (DON), the DON stated, CNA 3 should have empty them right away when he noticed there was urine in the urinals because of the bad smell, which could make the resident uncomfortable. The DON added, unemptied urinals could make the resident ' s environment unsanitary. During a review of the facility ' s policy and procedure (P&P) titled, Infection Prevention and Control Program, dated 10/2022, indicated the following information: -The facility is responsible to promote individual resident's rights and well-being while trying to prevent and control the spread of infection. -The facility will use effective methods for the safe refuse and infectious waste, consistent with all applicable local, state, and federal requirements for such disposal. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The facility will provide areas, equipment, and supplies to implement its Infection Control Program with the goal to safely use disposable and single use supplies and equipment; and effective cleaning and disinfecting equipment as needed.