Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055728	A. Building B. Wing	02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Santa Clarita Post-Acute Care Center	23801 Newhall Avenue Newhall, CA 91321

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 43988 Based on observation, interview, and record review, the facility failed to provide care in a manner that maintained or enhanced a resident's dignity and respect in full recognition of their individuality for one (1) of 1 sampled resident (Resident 249) reviewed under the dignity care area by failing to ensure the resident's urinary drainage bag (a container connected to a hollow tube inserted into the bladder to drain or collect urine) was provided with a privacy cover. This deficient practice had the potential to affect Resident 249's self-esteem, self-worth, and sense of independence. Findings: During a review of Resident 249's Admission Record, the admission record indicated the facility admitted Resident 249 on 2/5/2025 with diagnoses including urinary tract infection (UTI - an infection in the bladder or urinary tract), unsteadiness on feet, and generalized muscle weakness. During a review of Resident 249's Admission/Readmission Initial Assessment, dated 2/5/2025, the Admission/Readmission Initial Assessment form indicated Resident 249 was able to understand others and make her needs known. The Admission/Readmission Initial Assessment form indicated Resident 249 had an indwelling catheter (also known as a urinary catheter, a hollow tube inserted into the bladder to drain or collect urine) for urine retention. The Admission/Readmission Initial Assessment form further indicated Resident 249 required partial/moderate assistance to total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a review of Resident 249's History and Physical (H&P), dated 2/7/2025, the H&P indicated Resident 249 had the capacity to understand and make decisions. During a review of Resident 249's Order Summary Report, dated 2/5/2025, the Order Summary Report indicated Resident 249's physician ordered the following: - Indwelling catheter to straight drainage. Size: (16) Bulb: ten (10) every shift. - Provide urinary catheter care daily: Cleanse with NS then pat dry every day shift. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Monitor indwelling catheter for presence of sediment and cloudy urine. Notify MD if noted every shift. Document if present: Y for present N for not present. - Monitor for signs and symptoms of UTI every shift and notify physician (MD) if present every shift for indwelling catheter use. Document: (Y) If present (N) = If absent. - Change indwelling catheter. Size: (16) Bulb: (10) if plugged, leaking, or pulled out as needed. - Indwelling Catheter: ensure urinary catheter securement device is in place to prevent movement and urethral traction every day shift and as needed. During an observation, on 2/11/2025, at 10:07 a.m., inside Resident 249's room, Resident 249 laid in bed asleep with a urinary catheter drainage bag hanging on the side of the bed and did not have a privacy cover. During a concurrent observation and interview, on 2/11/2025, at 10:15 a.m., inside Resident 249's room, with the Quality Assurance Nurse (QAN), the QAN verified Resident 249's urinary catheter drainage bag did not have a privacy cover. The QAN stated urinary catheter drainage bags should have a privacy cover, and the staff should place it upon admission. The QAN stated the privacy cover should have been placed over Resident 249's urinary catheter drainage bag to preserve their dignity. During an interview, on 2/11/2025, at 12:00 p.m., with the Director of Nursing (DON), the DON stated urinary catheter drainage bags should have privacy covers at all times and should be placed over the drainage as soon as possible. The DON stated Resident 249's urinary catheter drainage should have a privacy cover as it may affect Resident 249's self-worth and self-esteem. The DON stated it was a dignity issue. During a review of the facility's policy and procedure (P&P) titled, Dignity, last reviewed on 6/27/2024, the P&P indicated: - Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, feeling of self-worth and self-esteem. - Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents such as helping the resident to keep urinary catheter bags covered.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 43988 Based on observation, interview, and record review, the facility failed to provide reasonable accommodation of resident needs and preferences by failing to ensure the call light (an alerting device for nurses or other nursing personnel to assist a resident when in need) was within reach for one (1) of 1 sampled resident (Resident 248) reviewed under the Environment task. This deficient practice had the potential to result in the delay of care and services and possible injury to residents when they are unable to call for assistance. Findings: During a review of Resident 248's Admission Record, the Admission Record indicated the facility admitted the resident on 1/24/2025 with diagnoses including fracture (a crack or break in a bone) of shaft of right tibia (also known as shin bone the large bone located between the knee and ankle), unsteadiness on feet, and generalized muscle weakness. During a review of Resident 248's History and Physical (H&P), dated 1/25/2025, the H&P indicated the resident can make her needs but cannot make medical decisions. During a review of Resident 248's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 1/30/2025, the MDS indicated the resident had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and required substantial/maximal assistance to total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a review of Resident 248's fall risk assessment, dated 1/24/2025, the fall risk assessment indicated the resident is a high risk for falls. During a review of Resident 248's care plan (CP) on risk for falls and injuries due to shaft right tibia fracture, initiated on 1/27/2025, the CP indicated to keep call light and bed controls within easy reach as one of the interventions to prevent falls. During a concurrent observation and interview, on 2/11/2025, at 11:05 a.m., inside Resident 248's room, with Registered Nurse (RN) 3, Resident 248's call light laid on the floor outside of the resident's reach. RN 3 stated Resident 248's call light was not clipped to the bed and was on the floor and not within Resident 248's reach. RN 3 stated prior to leaving the room, the staff should make sure all residents' call light should be within reach. RN 3 stated Resident 248's call light should have been clipped to the sheet and within the resident's reach so Resident 248 would be able to call for assistance when needed and prevent delay in the care the resident needed. During an interview, on 2/13/2025, at 1:00 p.m., with the Director of Nursing (DON), the DON stated the staff should ensure all residents' call light is within reach prior to leaving the room so the residents can call for assistance and the staff can attend to their needs. The DON stated Resident 248's call light should have been clipped to the sheet and within the resident's reach so the staff can attend and meet Resident 248's needs. (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 the facility's policy and procedure (P&P) titled, Answering the Call Light, last reviewed on 6/27/2024, the P&P indicated: - Ensure that the call light is accessible to the resident when in bed, from the toilet, from the toilet shower or bathing facility and from the floor. - Ensure timely responses to the resident's requests and needs.

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 38552 Based on observation, interview, and record review, the facility failed to promote the residents' right to examine the results of the most recent survey (a survey to determine compliance with state and federal regulations) of the facility by failing to post the most recent survey results in a place that is prominent and accessible (a place where individuals wishing to examine survey results do not have to ask to see them) to residents, family members, and legal representatives of residents for four of five resident council attendees (Resident 5, 13, 41, and 16). This deficient practice resulted in the residents' and their representatives not having access to examine the most recent survey results. Findings: During an interview, on 2/11/2025, at 10:24 a.m., with the resident council group interview attendees, Resident 5, Resident 13, Resident 41, and Resident 16 stated they do not know where to examine the most recent survey results. During a concurrent observation and interview, on 2/11/2025, at 10:50 a.m., in the lobby with the Activity Director (AD), the AD confirmed and stated the state survey results used to be placed in front of the business office, but was removed yesterday, 2/10/2025, because the facility was painting the walls. The AD stated the facility had a sign that indicated the survey results were available upon request. During a concurrent observation and interview, on 2/11/2025, at 11:10 a.m., the AD showed the posting indicating survey results available upon request. The AD stated the survey results were not readily available, but facility has it and would provide it upon request. During an interview, on 2/14/2025, at 11:50 a.m., with the Director of Nursing (DON), the DON stated the state inspection results should be available, so the residents know what the facility is working on. The DON stated it is important for state inspection results to be available so residents, visitors, and the public are aware of what the expected care of the residents is, and that this information is accessible for them to view. During a review of the facility's policy and procedure (P&P) titled, Survey Results, Examination of, last reviewed on 6/27/2024, the P&P indicated a copy of the most recent standard survey, including any subsequent extended surveys, follow-up revisits reports, etc., along with state approved plans of correction of noted deficiencies, is maintained in a 3-ring binder located in an area frequented by most residents, such as the main lobby or resident activity room.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43455 Based on observation, interview and record review, the facility failed to maintain resident's privacy by failing to pull/close the privacy curtains during medication administration affecting two (2) of three (3) sampled residents (Resident 5 and 196) observed during medication administration. This deficient practice had the potential to result in unauthorized exposure of the resident's treatment and care potentially resulting in psychosocial harm. Findings: During a review of Resident 5's Admission Record (a document containing demographic and diagnostic information), the Admission Record indicated the facility originally admitted the resident on 5/23/2007 and readmitted the resident on 10/13/2023 with diagnoses including hemiplegia (partial or complete paralysis on one side of the body) and hemiparesis (partial paralysis or weakness on one side of the body), bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration, making it difficult to carry out day-to-day tasks), depression (a health condition that causes constant feeling of sadness and loss of interest in activities that one would normally enjoy), and anxiety (a feeling of fear, dread, and uneasiness). During a review of Resident 5's Minimum Data Set (MDS - a resident assessment tool), dated 12/9/2024, the MDS indicated the resident was cognitively intact. During a review of Resident 196's Admission Record, the Admission Record indicated the facility originally admitted the resident on 1/31/2025 with diagnoses including hypertension (high blood pressure), atrial fibrillation (a type of irregular heart rhythm), and dysphagia (difficulty swallowing). During a review of Resident 196's MDS, dated [DATE], the MDS indicated the resident had mild cognitive impairment and was feeling down and depressed. During an observation, on 2/11/2025, at 9:39 a.m., Licensed Vocational Nurse (LVN) 5 administered medications to Resident 196. Resident 196's roommate laid in a bed next to Resident 196's bed with the privacy curtain between the two residents open. During an observation, on 2/11/2025, at 10:05 a.m., LVN 4 administered medications to Resident 5. Resident 5's roommate laid in a bed next to Resident 5's bed with the privacy curtain between the two residents open. During an interview, on 2/11/2025, at 10:32 a.m., with LVN 4, LVN 4 stated that LVN 4 failed to pull/close the privacy curtains when administering medications that morning, at 10:05 a.m., to Resident 5. LVN 4 stated resident privacy should be maintained during medical care. During an interview, on 2/11/2025, at 10:35 a.m., with LVN 5, LVN 5 stated that LVN 5 failed to pull/close the privacy curtains when administering medications that morning, at 9:39 a.m., to Resident 196. LVN 5 stated resident privacy should be maintained during medical care. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 2/13/2025, at 12:47 p.m., with the Director of Nursing (DON), the DON stated it was important to safeguard and protect resident dignity by respecting their right to privacy during any medical care. The DON stated resident privacy during medication administration includes pulling/closing the privacy curtains between beds. The DON stated LVN 4 and LVN 5 failed to provide privacy by failing to pull/close the privacy curtains during medication administration on 2/11/2025 to Resident 5 and 196. During a review of the facility's policy and procedures (P&P), titled Quality of Life - Dignity, last reviewed 6/27/2024, the P&P indicated, Residents' private space and property are respected at all times. Staff promote, maintain and protect resident privacy .during assistance with personal and during treatment procedures.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38552 Based on observation, interview, and record review, the facility: 1. Failed to provide two of two sampled residents (Resident 85 and 34) with a homelike environment, when Residents 85 and 34 who were in the Restorative Nursing Assistant feeding program (RNA nursing intervention program that assists or promotes the residents' ability to maintain or attain her maximum potential) were assisted with eating in the rehabilitation (rehab.) therapy room during lunch meal service. 2. Failed to ensure one of two sampled residents (Resident 248) reviewed for Environmental Task was provided with a homelike environment when Resident 248's left floor mat had black particles and a tear on the top cover. These deficient practices had the potential to violate the residents' right to living in a safe, comfortable, and homelike environment. Findings: 1.a. During a review of Resident 85's Admission Record, the Admission Record indicated the facility admitted the resident on 1/2/2025 with diagnoses including dysphagia (difficulty swallowing), anemia (a condition where the body does not have enough healthy red blood cells), and generalized muscle weakness. During a review of Resident 85's Minimum Data Set (MDS-a resident assessment tool), dated 1/6/2025, the MDS indicated the resident had the ability to understand others and make self self understood. The MDS indicated the resident required supervision with eating. During a review of Resident 85's History and Physical (H&P), dated 1/9/2025, the H&P indicated the resident can make needs known but cannot make medical decisions. During a review of Resident 85's Physician Order dated 1/15/2025, the Physician Orderindicated RNA feeding program for breakfast and lunch, two times a day for 30 days, document meal percentage. 1.b. During a review of Resident 34's Admission Record, the Admission Record indicated the facility originally admitted the resident on 3/20/2024 and readmitted the resident on 10/22/2024 with diagnoses including chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and polymyalgia rheumatica (a chronic inflammatory condition that causes muscle pain and stiffness, particularly in the shoulders, neck, hips, and upper arms). During a review of Resident 34's H&P, dated 12/21/2024, the H&P indicated the resident does not have the capacity to understand and make decisions. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 34's MDS, dated [DATE], the MDS indicated the resident had the ability to understand others and make self self understood. The MDS indicated the resident required supervision with eating. During a concurrent observation and interview on 2/11/2025 at 12:28 p.m., inside the rehab therapy room, observed Residents 85 and 34 eating their lunch. Restorative Nursing Assistant 1 (RNA 1) stated they have the RNA feeding program in the rehab. therapy room. During an interview on 2/13/2025 at 8:10 a.m., RNA 1 stated there are about four to five residents who are in the RNA feeding program during lunch time. During a concurrent observation and interview on 2/13/2025 at 12:20 p.m., inside the rehab therapy room, with the Quality Assurance Nurse (QAN), observed Resident 85 eating his lunch. The QAN stated the rehab. therapy room has multiple walkers, a weighing scale, parallel bars where residents walk with physical therapy, and two electric bikes. The QAN stated they used to have the RNA feeding program in the bistro room but is currently being used as an office and as an employee lounge since around 10/2024. The QAN stated she was told it was temporary and they will move the office and employee lounge that day. During an interview on 2/14/2025 at 11:56 a.m., with the Director of Nursing (DON), the DON stated they will move the RNA feeding program to the bistro for the usual use for RNA feeding program and for other residents for fine dining. The DON stated the bed requirements provide enough space to the residents and make them feel this is their home and their privacy and comfort are met. During a review of the facility's policy and procedure titled, Homelike Environment, last reviewed on 6/27/2024, the P&P indicated residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible . The facility staff and management maximize, to the extent possible, the characteristics of the facility that reflect a personalized homelike setting. These characteristics include: a. clean safe, sanitary and orderly/clutter free environment, no excessive items and items shall be stored off the floor; .c. inviting colors and decor; d. personalized furniture and room arrangements . The facility staff and management minimize, to the extent possible, the characteristics of the facility that reflect a depersonalized, institutional setting. These characteristics include . c. institutional signage (for example, labeled storage closets and work rooms in common areas). During a review of the facility's policy and procedure titled, Space Conversion, last reviewed on 6/27/2024, the P&P indicated it is the facility's policy to provide residents with a safe, clean, comfortable, and homelike environment. The P&P indicated staff shall provide person centered care that emphasizes the residents' comfort, independence, and personal needs, and preferences . the characteristics of the facility that reflect a personalized homelike setting. These characteristics include: a. Clean, sanitary, and orderly environment . c. Inviting colors and decor; personalized furniture and room arrangements. 43988 (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a review of Resident 248's Admission Record, the Admission Record indicated the facility admitted the resident on 1/24/2025 with diagnoses including fracture (a crack or break in a bone) of shaft of right tibia (also known as shin bone the large bone located between the knee and ankle), unsteadiness on feet, and generalized muscle weakness. During a review of Resident 248's H&P dated 1/25/2025, the H&P indicated the resident can make her needs but cannot make medical decisions. During a review of Resident 248's MDS, dated [DATE], the MDS indicated the resident had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and required substantial/maximal assistance to total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a review of Resident 248's care plan (CP) on risk for falls and injuries due to shaft right tibia fracture initiated on 1/27/2025, the CP indicated landing pad on both sides and use of injury prevention device such as floor mats as a few of the interventions to prevent falls. During a concurrent observation and interview on 2/11/2025 at 11:05 a.m. inside Resident 248's room with Registered Nurse 3 (RN 3), RN 3 stated Resident 248's left floor mat had dried black particles stuck on top and a tear on the right lower side of the mat. RN 3 stated the dried black particles were dirt in the shape of dried liquid that was not wiped dry. RN 3 stated housekeeping department is responsible to clean the floor mats every day. RN 3 stated if there was a spill on the floor mat, the staff who spilled on the floor mat should have wiped the mat to maintain a safe, clean environment for Resident 248. During a concurrent observation and interview on 2/13/2025 at 1:00 p.m. inside Resident 248's room with the DON, the DON verified the tear on top of Resident 248's floor mat. The DON floor mats are cleaned ever day by the housekeeping department and the staff when they spill liquid on the top of the floor mat. The DON stated residents should be provided with a safe, clean, and homelike environment while residing in the facility. The DON stated the staff should have notified the housekeeping department to change and clean Resident 248's floor mat as the damaged and unclean floor mat do not provide a safe, clean, comfortable, and homelike environment for the resident while in the facility which can affect their well-being. During a review of the facility's P&P titled, Homelike Environment, last reviewed 6/27/2024, the P&P indicated: - Residents are provided with a safe, clean, comfortable, and homelike environment. - The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflects a personalized, homelike setting by maintaining a clean, safe, sanitary, and orderly/clutter free environment During a review of facility provided manufacturer's guideline on Floor Mat 1 (FM 1), the manufacturer's guideline indicated fall mats should be thoroughly cleaned after each patient use.

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F 0604

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 44376

Based on observation, interview, and record review, the facility failed to ensure residents were treated with respect and dignity including the right to be free from physical restraints (any manual method, physical or mechanical device, material or equipment that is attached or adjacent to the resident's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body) for four of four sampled residents (Residents 37, 63, 78, and 248) reviewed for physical restraints care area by failing to ensure:

1. Residents 37 and 63 had a physician's order, an informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered), a restraint assessment, and a care plan for restraint bed placed against the wall.

2. Residents 78 and 248 had a physician's order, a restraint assessment, obtain an informed consent (process in which residents or resident representatives are given important information, including possible risks and benefits, about a procedure or treatment), and a care plan for the use of pillows placed underneath the fitted sheet.

These deficient practices had the potential to result in the restriction of residents' freedom of movement, a decline in physical functioning, psychosocial harm, physical harm from entrapment (a state in which a person is trapped by the bed rail in a position that they cannot move from), and death of residents.

Findings:

1. During a review of Resident 37's Admission Record, the Admission Record indicated the facility admitted the resident on 3/4/2023, with diagnoses including cerebral infarction (stroke that occurs when blood flow to the brain is blocked), glaucoma (an eye condition that occurs when fluid builds up in the eye, damaging the optic nerve), and long-term use of anticoagulants (a family of medications that stop the blood from clotting too easily).

During a review of Resident 37's History and Physical (H&P), dated 12/18/2024, the H&P indicated the resident had periods of confusion and can make needs known but cannot make medical decisions.

During a review of Resident 37's Minimum Data Set (MDS, a resident assessment tool), dated 11/29/2024, the MDS indicated the resident had the ability to make self-understood and understand others and had moderate cognitive impairment (a condition that involves increased confusion and memory loss, as well as difficulty with language and completing tasks). The MDS indicated the resident had upper and lower extremity impairment and uses a wheelchair for mobility. The MDS indicated the resident was dependent to requiring substantial to maximal assistance on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily).

During a review of Resident 37's Order Summary Report, the Order Summary Report did not indicate an order for restraint bed placed against the wall.

(continued on next page)

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NAME OF PROVIDER OR SUPPLIER Santa Clarita Post-Acute Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 23801 Newhall Avenue Newhall, CA 91321	

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 37's Fall Risk Assessment, dated 11/29/2024, the Fall Risk Assessment indicated the resident was high risk for falls. During a concurrent observation and interview on 2/12/2025, at 10:51 a.m., with Licensed Vocational Nurse 1 (LVN 1), inside Resident 37's room, observed Resident 37's bed was placed against the wall on the resident's left side of the bed with 2 upper grab bars (a safety device that helps people get in and out of bed, and move around in bed) on. LVN 1 stated placing the bed against the wall is a form of a restraint because they are limiting the resident to get out only on one side of the bed. LVN 1 stated they were placing the bed against the wall because the resident was a fall risk and to make way for the resident's wheelchair. LVN 1 stated before applying a restraint on a resident there should be a physician's order, an assessment for the safe use of the restraint, an informed consent, and a care plan on the use of the restraint. LVN 1 stated as far as she knows there was no order, no assessment, no informed consent, and there was no care plan on the use of restraint bed placed against the wall on the resident. LVN 1 stated it was important to have all of the above interventions to ensure safe use of the restraint and to avoid accidents such as entrapment and to honor the resident's right to accept and refuse the planned treatment. During a concurrent interview and record review on 2/14/2025, at 9:11 a.m., with Registered Nurse 5 (RN 5), reviewed Resident 37's Order Summary Report, Assessments, Informed Consent, and Care Plans. RN 5 stated there was no physician's order, no restraint assessment, no informed consent, and there was no care plan on the use of restraint bed placed against the wall. RN 5 stated it is important to have all the requirements to ensure the restraint was safe to use and to prevent injury such as entrapment to the resident. During an interview on 2/14/2025, at 12:44 p.m., with the Director of Nursing (DON), the DON stated the staff should have obtained a physician's order, obtained an informed consent from the resident/representative, assessed the resident on the use of the restraint, and developed and implemented a care plan on the use of bed placed against the wall for Resident 37. The DON stated it was important to have all those elements to ensure safe use of the restraint bed placed against the wall on the resident to prevent injuries such as bed entrapment and to honor the resident's right to informed consent. During a review of the facility's recent policy and procedure (P&P) titled Physical Restraint Application, last reviewed on 6/27/2024, the P&P indicated physical restraints are defined by the Centers for Medicare and Medicaid Services (CMS) as any manual method or physical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Verify physician's order for the use of restraints. Review the resident's care plan to assess for any special needs of the resident. During a review of the facility's recent policy and procedure (P&P) titled Informed Consent for Psychotropic Medications and Physical Restraints, last reviewed on 6/27/2024, the P&P indicated Title 22 72528 requires that informed consents be obtained for all psychotherapeutic drugs and physical restraints. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's recent policy and procedure (P&P) titled Care Plans, Comprehensive Person-Centered, last reviewed on 6/27/2024, the P&P indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required comprehensive assessment (MDS). During a review of the facility's recent policy and procedure (P&P) titled Bed Safety, last reviewed on 6/27/2024, the P&P indicated Bed against the wall requested by the resident or representative will be honored after assessment is completed. When the bed against the wall is preventing the resident from leaving his/her bed the protocol for restraints shall be followed. 2. During a review of Resident 63's Admission Record, the Admission Record indicated the facility admitted the resident on 12/28/2023, and readmitted the resident on 6/17/2024, with diagnoses including age-related osteoporosis (bone disease that causes bones to become weak and more likely to break as people get older), unsteadiness on feet, and lack of coordination. During a review of Resident 63's H&P, dated 6/18/2024, the H&P indicated the resident can make needs known but cannot make medical decisions. During a review of Resident 63's MDS, dated [DATE], the MDS indicated the resident rarely to never had the ability to make self-understood and sometimes understand others and had highly impaired vision. The MDS indicated the resident was dependent to needing substantial to maximal assistance on mobility and activities of daily living (ADLs). During a review of Resident 63's Order Summary Report, the Order Summary Report did not indicate a physician's order for restraint bed placed against the wall. During a review of Resident 63's Fall Risk Assessment, dated 11/13/2024, the Fall Risk Assessment indicated the resident was high risk for falls. During a concurrent observation and interview on 2/12/2025, at 10:51 a.m., with LVN 1, inside Resident 63's room, observed Resident 63's bed was placed against the wall on the resident's left side of the bed with 2 upper grab bars on. LVN 1 stated placing the bed against the wall is a form of a restraint because they are limiting the resident to get out only on one side of the bed. LVN 1 stated they were placing the bed against the wall because the resident was a fall risk and to make way for the resident's wheelchair. LVN 1 stated before applying a restraint on a resident there should be a physician's order, an assessment for the safe use of the restraint, an informed consent, and a care plan on the use of the restraint. LVN 1 stated as far as she knows there was no order, no assessment, no informed consent, and there was no care plan on the use of restraint bed placed against the wall on the resident. LVN 1 stated it was important to have all of the above interventions to ensure safe use of the restraint and to avoid accidents such as entrapment and to honor the resident's right to accept and refuse the planned treatment. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 2/14/2025, at 9:05 a.m., with RN 5, reviewed Resident 63's Order Summary Report, Assessments, Informed Consent, and Care Plans. RN 5 stated there was no order, no restraint assessment, no informed consent, and there was no care plan on the use of restraint bed placed against the wall. RN 5 stated it is important to have all the requirements to ensure the restraint was safe to use and to prevent injury such as entrapment to the resident. During an interview on 2/14/2025, at 12:44 p.m., with the DON, the DON stated the staff should have obtained a physician's order, obtained an informed consent from the resident/representative, assessed the resident on the use of the restraint, and developed and implemented a care plan on the use of bed placed against the wall for Resident 63. The DON stated it was important to have all those elements to ensure safe use of the restraint bed placed against the wall on the resident to prevent injuries such as bed entrapment and to honor the resident's right to informed consent. During a review of the facility's recent policy and procedure (P&P) titled Physical Restraint Application, last reviewed on 6/27/2024, the P&P indicated physical restraints are defined by the Centers for Medicare and Medicaid Services (CMS) as any manual method or physical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Verify physician's order for the use of restraints. Review the resident's care plan to assess for any special needs of the resident. During a review of the facility's recent policy and procedure (P&P) titled Informed Consent for Psychotropic Medications and Physical Restraints, last reviewed on 6/27/2024, the P&P indicated Title 22 72528 requires that informed consents be obtained for all psychotherapeutic drugs and physical restraints. During a review of the facility's recent policy and procedure (P&P) titled Care Plans, Comprehensive Person-Centered, last reviewed on 6/27/2024, the P&P indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required comprehensive assessment (MDS). During a review of the facility's recent policy and procedure (P&P) titled Bed Safety, last reviewed on 6/27/2024, the P&P indicated Bed against the wall requested by the resident or representative will be honored after assessment is completed. When the bed against the wall is preventing the resident from leaving his/her bed the protocol for restraints shall be followed. 43988 3. During a review of Resident 78's Admission Record, the Admission Record indicated the facility admitted the resident on 10/14/2024 with diagnoses including dementia (a progressive state of decline in mental abilities), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and generalized muscle weakness. During a review of Resident 78's History and Physical (H&P) dated 10/15/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 78's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 1/17/2025, the MDS indicated the resident had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and required substantial/maximal assistance to total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS did not indicate Resident 78 had a restraint. During a review of Resident 78's care plan (CP) on risk for falls and injuries due to dementia, weakness, and depression initiated on 12/10/2024, the CP indicated to assess and anticipate resident's needs as one of the interventions to prevent falls. During a review of Resident 78's fall risk assessment dated [DATE], the fall risk assessment indicated the resident is a high risk for falls. During an observation on 2/11/2025 at 10:30 a.m., inside Resident 78's room, observed Resident 78 lying in bed with wedge pillow placed under the fitted sheet placed from the midback down to the mid leg area on the right side. Observed Resident 78 mumbling and trying to get out of the bed by dangling the legs over the wedge pillow but unsuccessful. During a concurrent observation and interview on 02/11/25 at 10:35 a.m. inside Resident 78's room with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated and verified the presence of wedge pillow placed under Resident 78's fitted sheet. CNA 1 stated Resident 78 was trying to get out of the bed but was unable to due to the wedge pillow placed under the fitted sheet. CNA 1 stated the wedge pillow is used to reposition the resident. CNA 1 stated she placed the pillow under the fitted sheet so Resident 78 would not be able to remove the pillow and prevent the resident from getting up by herself and fall. During an interview on 2/13/2025 at12:00 p.m. with the Director of Nursing (DON), the DON stated wedge pillows are supposed to be used only for repositioning of residents. The DON stated placing the wedge pillow under the fitted sheet can be considered a restraint as the residents were unable to remove the pillow. The DON stated Resident 78's wedge pillow should not have been placed under the fitted sheet as it was restricting Resident 78's freedom of movement to get out of the bed. The DON stated the staff should make frequent rounds on the residents and the wedge pillow under the fitted sheet cannot be used as an intervention to prevent Resident 78 from getting out of bed unassisted. The DON stated if there is a need for a restraint, a restraint assessment should be completed for the use of pillow, obtain a physician's order, and development and implement a care plan for the restraint use. During a review of the facility's policy and procedure (P&P) titled, Physical Restraint Application, last reviewed on 6/27/2024, the P&P indicated: - Provide safety or postural support of a resident to prevent injury to the resident or others when the resident has medical symptoms that warrant the use of restraints. - Physical restraints are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Verify physician's order for the use of restraints preview resident's care plan to assess for any special needs for the resident. During a review of the facility's P&P titled, Informed Consent for Psychotropic Medications and Physical Restraints, last reviewed on 6/27/2024, the P&P indicated: - The facility staff is responsible to assure that the consent was obtained. - The facility staff is responsible to verify that the physician has obtained consent. During a review of the facility's P&P titled, Care Plans, Comprehensive Person-Centered, last reviewed on 6/27/2024, the P&P indicated: - A comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. - The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. - The comprehensive person-centered care plan will include measurable objectives and timeframes, describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, incorporate identified problem areas, aid in preventing or reducing decline in the resident's functional status and/or functional levels. 4. During a review of Resident 248's Admission Record, the Admission Record indicated the facility admitted the resident on 1/24/2025 with diagnoses including fracture (a crack or break in a bone) of shaft of right tibia (also known as shin bone the large bone located between the knee and ankle), unsteadiness on feet, and generalized muscle weakness. During a review of Resident 248's History and Physical (H&P) dated 1/25/2025, the H&P indicated the resident can make her needs but cannot make medical decisions. During a review of Resident 248's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 1/30/2025, the MDS indicated the resident had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and required substantial/maximal assistance to total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS did not indicate Resident 248 had a restraint. During a review of Resident 248's care plan (CP) on risk for falls and injuries due to shaft right tibia fracture initiated 1/27/2025, the CP indicated to assess and anticipate resident's needs as one of the interventions to prevent falls. During a review of Resident 248's fall risk assessment dated [DATE], the fall risk assessment indicated the resident is a high risk for falls. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 2/11/2025 at 11:05 a.m., inside Resident 248's room, observed Resident 248 lying in bed with wedge pillow placed under the fitted sheet placed from the midback down to the mid leg area on the left side. During a concurrent observation and interview on 02/11/25 at 11:19 a.m. inside Resident 248's room with Certified Nursing Assistant 2 (CNA 2), CNA 2 stated and verified the presence of wedge pillow placed under Resident 248's fitted sheet. CNA 2 stated the wedge pillow is used for repositioning Resident 248. CNA 2 stated she placed the pillow under the fitted sheet so Resident 248 would not be able to remove the pillow and easier for her to reposition the resident. CNA 2 stated she should not have placed the wedge pillow under the fitted sheet as Resident 248 was unable to get out of bed freely. During a concurrent observation and interview on 2/11/2025 at 11:25 a.m. inside Resident 248's room with Registered Nurse 3 (RN 3), stated the wedge pillow was placed under Resident 248's fitted sheet. RN 3 stated wedge pillows are used for repositioning of residents and should not be placed under the fitted sheet as the residents were unable to remove the pillow. RN 3 stated CNA 2 should not have placed the wedge pillow under the fitted sheet as Resident 248 was unable to move freely. During an interview on 2/13/2025 at12:00 p.m. with the Director of Nursing (DON), the DON stated wedge pillows are supposed to be used only for repositioning of residents. The DON stated placing the wedge pillow under the fitted sheet can be considered a restraint as the residents were unable to remove the pillow. The DON stated Resident 248's wedge pillow should not have been placed under the fitted sheet as it was restricting Resident 248's freedom of movement to get out of the bed if she wants to. The DON stated the staff should make frequent rounds on the residents and the wedge pillow under the fitted sheet cannot be used as an intervention to prevent Resident 248 from getting out of bed unassisted. The DON stated if there is a need for a restraint, a restraint assessment should be completed for the use of pillow, obtain a physician's order, and development and implement a care plan for the restraint use. During a review of the facility's policy and procedure (P&P) titled, Physical Restraint Application, last reviewed on 6/27/2024, the P&P indicated: - Provide safety or postural support of a resident to prevent injury to the resident or others when the resident has medical symptoms that warrant the use of restraints. - Physical restraints are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. - Verify physician's order for the use of restraints preview resident's care plan to assess for any special needs for the resident. During a review of the facility's P&P titled, Informed Consent for Psychotropic Medications and Physical Restraints, last reviewed on 6/27/2024, the P&P indicated: - The facility staff is responsible to assure that the consent was obtained. - The facility staff is responsible to verify that the physician has obtained consent. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Care Plans, Comprehensive Person-Centered, last reviewed on 6/27/2024, the P&P indicated: - A comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. - The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. - The comprehensive person-centered care plan will include measurable objectives and timeframes, describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, incorporate identified problem areas, aid in preventing or reducing decline in the resident's functional status and/or functional levels.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38552 Based on interview and record review, the facility failed to implement its abuse reporting policy and procedure (P&P) by failing to report an allegation of injury of unknown origin to the State Survey Agency (Department of Public Health) within two hours for one of one sampled resident (Resident 93) reviewed under the Abuse care area. This deficient practice had the potential to place the resident at risk for elder abuse. Findings: During a review of Resident 93's Admission Record, the Admission Record indicated the facility originally admitted the resident on 1/15/2025, and readmitted on [DATE], with diagnoses including dislocation (an injury where the ends of two bones separate at a joint) of internal left hip prosthesis (artificial body part), fracture (bone that is broken in at least two places) of unspecified part of neck of left femur (thigh bone), dementia (a progressive state of decline in mental abilities), and generalized muscle weakness. During a review of Resident 93's Minimum Data Set (MDS - a resident assessment tool), dated 1/22/2025, the MDS indicated the resident had the ability to understand others and makes self-understood. The MDS indicated the resident had severely impaired cognition (difficulty understanding and making decisions). The MDS indicated the resident was dependent on staff for activities of daily living (ADLs - activities such as bathing, dressing and toileting a person performs daily) and with mobility, including sit to lying, lying to sitting on side of bed, chair/bed-to-chair transfer, and substantial assistance with rolling left and right on the bed. During a review of Resident 93's History and Physical (H&P) Note, dated 1/31/2025, the H&P Note indicated the resident can make needs known but cannot make medical decisions. During a review of Resident 93's Admission/Readmission Initial Assessment, dated 1/15/2025, the Admission/Readmission Initial Assessment indicated the resident was admitted from General Acute Care Hospital (GACH) 1 with diagnoses of status-post (s/p) fall, left femoral neck fracture s/p open reduction and internal fixation (ORIF - surgical procedure that involves putting pieces of bone into place using screws or rods to hold the broken bone together). During a review of Resident 93's Situation Background Assessment Request (SBAR - a communication tool used by healthcare workers when there is a change of condition among the residents), dated 1/26/2025, the SBAR indicated the resident complained of severe pain to her left hip manifested by possible hip displacement, needed more assistance with ADLs, labored or rapid breathing, left leg appeared turned inwards, and unable to move her toes, foot or leg. During a review of Resident 93's Physician Discharge Note, dated 1/26/2025, the Physician Discharge Note indicated the resident was discharged to GACH 2 due to the resident's welfare and needs cannot be met at the facility due to severe pain to left hip with possible hip displacement. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 93's Admission/Readmission Initial Assessment, dated 1/30/2025, the Admission/Readmission Initial Assessment indicated the resident was readmitted from GACH 2 with a diagnosis of s/p revision of left hemiarthroplasty (a surgical procedure that replaces the ball portion of the hip joint, leaving the socket intact) on 1/27/2025 due to dislocation of left hip arthroplasty with pain. During an interview, on 2/11/2025, at 2:50 p.m., with Resident 93, Resident 93 stated she was at the hospital, and the hospital did something to her left leg, but she does not recall what was done on her leg. Resident 93 stated her leg was hurting in the past but not right now. During a concurrent interview and record review, on 2/14/2025, at 9:29 a.m., with MDS Nurse (MDSN) 1, Resident 93's progress notes, interdisciplinary progress notes, Certified Nursing Assistant (CNA) ADLs task, dated between 1/15/2025 to 1/26/2025, were reviewed. MDSN 1 stated she did not know if Resident 93's left hip dislocation was reported to the State Survey Agency. During an interview, on 2/14/2025, at 12:02 p.m., with the DON, the DON stated on 1/26/2025, Resident 93 was noted with left hip discoloration due to left internal rotation. The DON stated the incident was not common and the facility conducted an investigation and had an interdisciplinary team meeting with the resident's family member on 2/3/2025. During an interview, on 2/14/2025, at 12:44 p.m., with the DON, the DON stated the facility did not follow their policy titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating for Resident 93's unusual occurrence. During a review of the facility's P&P titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, last reviewed on 6/27/2024, the P&P indicated All reports of resident abuse (including injuries or unknown origin), neglect, exploitation, or theft/misappropriation of resident are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. The P&P indicated the implementation of reporting allegations to the Administrator and Authorities: 1. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. 2. Incidents resulting in physical harm, notify local law enforcement immediately or as soon as possible but no later than [two] hours. Provide written notice of the incident within [two] hours to the state agency, ombudsman, and local law enforcement.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44376 Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for four (4) of six (6) residents reviewed for unnecessary medications (Resident 7, 37, 53 and 55) by failing to: 1. Develop and implement a care plan for methenamine hippurate (an antibiotic) for Resident 37. 2. Implement the Care Plan (a document outlining a detailed approach to care customized to an individual resident's need) for providing non-pharmacological (not involving medications or drugs) interventions for the use of trazodone (a psychotropic [any medication capable of affecting the mind, emotions, and behavior] used for insomnia [difficulty sleeping]) for Resident 7. As a result, Resident 7 did not have non-pharmacological interventions provided as outlined in the Care Plan between 2/1/2025 and 2/11/2025. 3. Implement the Care Plan for providing non-pharmacological interventions for the use of Haldol (a brand name for haloperidol [a psychotropic medication used to treat disorders that cause difficulty in telling the difference between things or ideas that are real and not real]) for Resident 53. As a result, Resident 53 did not have non-pharmacological interventions provided as outlined in the Care Plan between 2/1/2025 and 2/11/2025. 4. Develop a Care Plan with measurable goals and monitoring of hours slept with use of trazodone for Resident 55. As a result, Resident 55 did not have an identified goal of hours of sleep per night and was not monitored for the hours of sleep per night with the use of trazodone between 2/1/2025 and 2/12/2025. These deficient practices had the potential to cause Resident 7, 37, 53 and 55 to receive suboptimal (less than the highest standard or quality) care leading to the use of unnecessary medications causing potential side effects (unwanted, unpleasant results of a medication) and negatively impacting their physical, mental, and psychosocial well-being. Findings: a). During a review of Resident 37's Admission Record, the Admission Record indicated the facility admitted the resident on 3/4/2023, with diagnoses including thrombocytopenia (a condition that occurs when the platelet count in the blood is too low) and gastro-esophageal reflux disease (GERD, a digestive disorder that occurs when stomach acid flows back into the esophagus). During a review of Resident 37's Order Summary Report, dated 9/2/2023, the Order Summary Report indicated an order of methenamine hippurate oral tablet 1 gram (gm, a unit of weight). Give 1 tablet by mouth two times a day for urinary tract infection (UTI, a bacterial infection in the urinary system, which includes the bladder, kidneys, ureters, and urethra) prophylaxis (an attempt to prevent disease). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Santa Clarita Post-Acute Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 23801 Newhall Avenue Newhall, CA 91321	

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 37's MDS dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had moderate cognitive impairment (a condition that involves increased confusion and memory loss, as well as difficulty with language and completing tasks.) The MDS indicated the resident was on a high-risk drug class antibiotic. During a review of Resident 37's History and Physical (H&P), dated 12/18/2024, the H&P indicated the resident had periods of confusion and can make needs known but cannot make medical decisions. 43455 b). During a review of Resident 7's Admission Record (a document containing demographic and diagnostic information,) dated 2/12/2025, the Admission Record indicated Resident 7 was originally admitted to the facility on [DATE] with diagnosis including depression (a health condition that causes constant feeling of sadness and loss of interest in activities that one would normally enjoy,) and insomnia. During a review of Resident 7's Order Summary Report, dated 2/12/2025, the report indicated Resident 7 was prescribed trazodone 50 milligram ([mg] - a unit of measure of mass) to give one tablet by mouth at bedtime for depression manifested by inability to sleep, starting 1/15/2025. During a review of Resident 7's Minimum Data Set ([MDS] - a resident assessment tool), dated 1/17/2025, the MDS indicated the resident had mild cognitive impairment and had trouble falling or staying asleep or sleeping too much. During a review of Resident 7's Care Plan, initiated on 1/17/2025, the Care Plan indicated that the resident uses trazodone for depression manifested by inability to sleep. The Care Plan included to provide non-pharmacological interventions such as: therapeutic interventions; environmental/equipment interventions; environmental changes or modifications (reducing light & noise); positive staff interactions, distraction, positioning, music therapy, praise for positive attitude, activity program or other alternative. During a review of Resident 7's Medication Administration Record ([MAR] - a record of medication and therapies administered to residents,) for February 2025, the MAR indicated Resident 7 was prescribed trazodone 50 milligram ([mg] - a unit of measure of mass) to give one tablet by mouth at bedtime for depression manifested by inability to sleep, at 9 p.m. The MAR did not contain documentation for non-pharmacological interventions provided for Resident 7's inability to sleep between 2/1/2025 and 2/11/2025. c). During a review of Resident 53's Admission Record (a document containing demographic and diagnostic information,) dated 2/12/2025, the Admission Record indicated Resident 53 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including schizoaffective disorder (a mental health problem with psychosis and mood symptoms,) depression and anxiety. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 53's Care Plan, initiated 1/2/2025, the Care Plan indicated that the resident uses Haldol related to behavior management, disease process, paranoia manifested by thinking that people are out to get her. The listed interventions included to provide non-pharmacological interventions such as: therapeutic interventions; environmental/equipment interventions; environmental changes or modifications (reducing light & noise); positive staff interactions, distraction, positioning, music therapy, praise for positive attitude, activity program or other alternative. During a review of Resident 53's MDS dated [DATE], the MDS indicated the resident was cognitively intact, and had verbal behavioral symptoms directed towards others. d). During a review of Resident 53's Order Summary Report, dated 2/12/2025, the report indicated Resident 53 was prescribed haloperidol 5 mg to give one (1) tablet by mouth every 12 hours for schizophrenia manifested by verbal outbursts and paranoid thoughts, starting 1/24/2025. During a review of Resident 53's Medication Administration Record ([MAR] - a record of mediations administered to residents,) for February 2025, the MAR indicated Resident 53 was prescribed haloperidol 5 mg to give one tablet by mouth every 12 hours for schizophrenia manifested by verbal outbursts and paranoid thoughts, at 9 a.m. and 9 p.m. The MAR did not contain documentation for non-pharmacological interventions provided for verbal outbursts and paranoid thoughts between 2/1/2025 and 2/11/2025. e). During a review of Resident 55's Admission Record dated 2/12/2025, the Admission Record indicated Resident 55 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including depression and anxiety. During a review of Resident 55's MDS dated [DATE], the MDS indicated the resident was cognitively intact or mildly impaired, and was feeling down, depressed or hopeless. During a review of Resident 55's Order Summary Report, dated 2/12/2025, the report indicated Resident 55 was prescribed trazodone 50 mg to give 0.5 tablet = 25 mg by mouth at bedtime for major depressive disorder manifested by inability to sleep, starting 7/2/2024. During a review of Resident 55's Care Plan, initiated 7/2/2024, the Care Plan indicated that the resident uses trazodone related to depression manifested by inability to sleep. The Care Plan did not indicate a goal for the hours of sleep per night and did not indicate to monitor the hours of sleep per night. During a review of Resident 55's MAR for February 2025, the MAR indicated Resident 55 was prescribed trazodone 50 mg to give 0.5 tablet = 25 mg by mouth at bedtime for major depressive disorder manifested by inability to sleep, starting 7/2/2024. The MAR did not contain documentation for the hours of sleep per night between 1/1/2025 and 1/30/2025. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent record review and interview on 2/12/2025 at 10:40 a.m., with Registered Nurse (RN) 1, RN 1 reviewed Resident 7's Care Plan dated 1/17/2025 and February 2025 MAR, and Resident 53's Care plan dated 1/2/2025 and February 2025 MAR. RN 1 stated the Care Plan indicated Resident 7 uses trazodone for depression manifested by inability to sleep, and to provide non-pharmacological interventions. RN 1 stated the Care Plan indicated Resident 53 uses Haldol related to behavior management, disease process, paranoia manifested by thinking that people are out to get her and to provide non-pharmacological interventions. RN 1 stated non-pharmacological interventions would be documented on the MAR. RN 1 stated the February 2025 MARs for Residents 7 and 53 did not include documentation for non-pharmacological interventions indicating non-pharmacological interventions were not provided as outlined in the Care Plan. RN 1 stated without providing non-pharmacological interventions, no one would know if they would be effective in reducing episodes of inability to sleep and that trazodone may be used unnecessarily for Resident 7. RN 1 stated without documenting number of episodes no one would know if the Haldol was effective in reducing episodes of paranoia and that Haldol may be used unnecessarily for Resident 53. During a concurrent record review and interview on 2/12/2025 with RN 1, RN 1 reviewed Resident 55's February 2025 MAR and stated Resident 55 was prescribed trazodone for major depressive disorder manifested by inability to sleep. RN 1 stated RN 1 was unable to locate documentation for monitoring the number of hours of sleep between 2/1/2025 and 2/11/2025. RN 1 stated without monitoring hours of sleep it was unknown if trazodone was effective in reducing episodes of inability to sleep, therefore preventing the ability make changes to the medication such as lowering the dose or discontinuing, potentially leading to the use of unnecessary psychotropic medication for Resident 55. RN 1 stated the facility failed to monitor hours of sleep for Resident 55. During a concurrent record review and interview on 2/12/2025 at 12:47 p.m., with the Director of Nursing (DON,) the DON stated that Resident 7's Care Plan dated 1/17/2025 indicated the resident uses trazodone for depression manifested by inability to sleep and to provide non-pharmacological interventions, and Resident 53's Care Plan dated 1/2/2025 indicated the resident uses Haldol for paranoia manifested by thinking that people are out to get her and to provide non-pharmacological interventions. The DON stated Resident 7's and 53's Care Plan were not implemented as the DON was unable to locate documentation for providing non-pharmacological interventions for inability to sleep and for paranoia in the MAR between 2/1/2025 and 2/11/2025. The DON stated the facility failed to implement the Care Plans to accurately reflect the needs of Residents 7 and 53 and ensure to maintain the highest level of functionality and quality of life and limit the use of psychotropic medications. The DON stated that the Care Plans and MAR documentation will be immediately implemented for Resident 7 and 53. During a concurrent record review and interview on 2/12/2025 at 12:47 p.m., with the DON, the DON stated that Resident 55's Care Plan dated 7/2/2024 indicated the resident uses trazodone related to depression manifested by inability to sleep. The DON stated the Care Plan did not indicate a goal for the hours of sleep per night and did not indicate to monitor the hours of sleep per night with the use of trazodone. The DON stated it was important to identify measurable goals with the use of psychotropic medications to provide person-centered care and identify when to taper the medication, while maintaining the highest level of functionality and quality of life to Resident 55. The DON stated the facility failed to develop a Care Plan for hours of sleep for Resident 55. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 2/14/2025, at 9:28 a.m., with RN 5, Resident 37's Order Summary Report and Care Plans were reviewed. RN 5 stated there was no care plan on Resident 37's medical chart for methenamine hippurate oral tablet. RN 5 stated it is important to develop and implement a care plan for the use of methenamine hippurate, an antibiotic to ensure its safe to use and to prevent antibiotic resistance (happens when bacteria change and are no longer killed by antibiotics) in Resident 37. During an interview on 2/14/2025, at 12:50 a.m., with the Director of Nursing (DON), the DON stated the staff should have created a care plan for Resident 37 for the use of Methenamine Hippurate, an antibiotic to prevent its prolonged use to prevent antibiotic resistance in Resident 37. During a review of the facility's Policy & Procedures (P&P,) titled Care Plans, Comprehensive Person Centered, last reviewed on 6/27/2024, the P&P indicated A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The comprehensive, person-centered care plan will: a. Include measurable objectives and timeframes. b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable, physical, mental, and psychosocial well-being. e. Include the resident's stated goals upon admission and desired outcomes. g. Incorporate identified problem areas. d. Reflect treatment goals, timetables and objectives in measurable outcomes. f. Aid in preventing or reducing decline in the resident's functional status and/or functional levels. h. Reflect on currently recognized standards of practice for problem areas and conditions. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required comprehensive assessment (MDS).

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 38552 Based on interview and record review, the facility failed to revise one of two sampled residents (Resident 6) care plans to reflect the updated interventions provided to Resident 6 reviewed for Nutrition care area. This deficient practice had the potential to place the resident at risk for a delay in necessary interventions. Findings: During a review of Resident 6's Admission Record, the Admission Record indicated the facility admitted the resident on 3/22/2017 with diagnoses including type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion) of right and left hands, and both eyes visual loss. During a review of Resident 6's History and Physical (H&P), dated 11/21/2024, the H&P indicated the resident did not have the capacity to understand and make medical decisions. During a review of Resident 6's Minimum Data Set (MDS-a resident assessment tool), dated 11/28/2024, the MDS indicated the resident had no speech (absence of spoken words) with severely impaired vision, rarely/never had the ability to make self understood and rarely/never had the ability understood others. The MDS indicated the resident was dependent on staff with eating (the ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident). During a review of Resident 6's Nutrition Assessment, dated 2/6/2025, the Nutrition Assessment indicated the resident had a 17-pound (lbs.-a unit of measurement) weight loss of 15 percent loss (%-a unit of measurement) in 180 days and indicated recommendations to give Liquacel 30 ml daily for 30 days. During a review of Resident 6's Order Summary Report, the Order Summary Report indicated to administer LiquaCel (protein supplement) oral liquid (Amino Acids) 30 milliliters (ml-a unit of measurement) by mouth one time a day for 30 days, dated 2/12/2025. During a concurrent interview and record review on 2/13/2025 at 2:27 p.m. with Registered Nurse (RN) 1, Resident 6's Care Plan Report, last revised 2/7/2025 was reviewed. RN 1 stated the care plan addressing the resident's unplanned/unexpected weight loss did not indicate the Liquacel intervention for the resident. RN 1 stated the care plan drives the care for what the resident needs and ensure interventions are updated and are being implemented. RN 1 stated the resident could potentially continue to lose weight when interventions are not revised. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/14/2025 at 11:58 a.m., with the Director of Nursing (DON), the DON stated they missed updating Resident 6's care plan for the updated intervention of the Liquacel order. The DON stated the licensed nurse who carried out the order should have updated the care to reflect the current interventions. The DON stated the purpose of revising the interventions is for all staff to be aware of the updated interventions. The DON stated they could potentially miss providing it to the resident. During a review of the facility's policy and procedure titled, Care Plans, Comprehensive Person-Centered, last reviewed on 6/27/2024, the P&P indicated the care plan includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident . Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.

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F 0658

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Ensure services provided by the nursing facility meet professional standards of quality.

43988

Based on interview and record review, the facility's licensed nursing staff failed to provide care in accordance with professional standards by failing to:

1. Rotate (a method to ensure repeated injections are not administered in the same area) the insulin administration site (subcutaneous (beneath the skin) for one (1) out of one sampled resident (Resident 73) reviewed for insulin (a hormone that lowers the level of glucose [a type of sugar] in the blood).

2. Rotate subcutaneous insulin medication administration sites for one of five (5) sampled residents (Resident 63) investigated under unnecessary medications.

These deficient practices had the potential to result in adverse effect (unwanted, unintended result) of same site subcutaneous administration of insulin such as excessive bruising, lipodystrophy (abnormal distribution of fat) and cutaneous amyloidosis (is a condition in which clumps of abnormal proteins called amyloids build up in the skin).

Cross Reference F760

Findings:

a. During a review of Resident 73's Admission Record, the Admission Record indicated the facility originally admitted the resident on 11/23/2023 and readmitted the resident in the facility on 8/14/2024, with diagnoses including type 2 diabetes mellitus (a chronic disease that occurs when the body does not produce enough insulin or does not use it properly) without complications, congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), and unsteadiness on feet.

During a re view of Resident 73's History and Physical (H&P) dated 5/22/2024, the H&P indicated the resident had the capacity to understand and make decisions.

During a review of Resident 73's Minimum Data Set (MDS, a resident assessment tool), dated 11/28/2024, the MDS indicated the resident had an intact cognition (having the ability to think, learn, and remember clearly). The MDS indicated Resident 73 required set up or clean-up assistance with eating and oral hygiene; partial/moderate assistance with upper body dressing; substantial/maximal assistance with personal hygiene and bed mobility; total assistance with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 73 had a diagnosis of DM 2 and received insulin.

During a review of Resident 73's Order Summary Report, the Order Summary Report indicated the following physician's orders:

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 5/21/2024 to 1/17/2025: Insulin Lispro Injection Solution (a short-acting insulin) 100 unit per milliliter (unit/ml - a unit of measurement). Inject as per sliding scale (increasing administration of the pre?meal insulin dose based on the blood sugar level before the meal): if 0 - 149 = 0 units;150 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; 401 or more = 12 units. If blood sugar (BS) is above 400, give the dose and call provider., subcutaneously before meals and at bedtime for DM 2. Notify physician (MD) if BS less than (< - a unit of measurement) 80. Rotate site. - 1/17/2025: Insulin Lispro Injection Solution 100 unit/ml. Inject as per sliding scale: if 0 - 149 = 0 units;150 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; 401 or more = 12 units. If BS is above 400, give the dose and call provider., subcutaneously before meals and at bedtime for DM 2. Rotate site, notify MD if BS < 80. Give within 15 minutes prior to a meal or immediately after a meal. - 12/15/2024 to 12/23/2024: Lantus subcutaneous solution (a long-acting insulin) 100 unit/ml (insulin glargine). Inject ten (10) units subcutaneously at bedtime related to DM 2. Rotate site. - 12/23/2024 to 2/11/2025: Lantus subcutaneous solution 100 unit/ml (insulin glargine). Inject 12 units subcutaneously at bedtime related to DM 2. Rotate sites. - 2/11/2025: Lantus Subcutaneous Solution 100 unit/ml (insulin glargine). Inject 12 units subcutaneously at bedtime related to DM 2. Rotate site. Hold for BS < 80. During a concurrent interview and record review on 2/13/2025 at 11:45 a.m., Resident 73's Order Summary Report, Medication Administration Record (MAR - a daily documentation records used by a licensed nurse to document medications and treatments given to a resident) Location of Administration Report from 11/2024 to 1/2025 was reviewed with Minimum Data Set Nurse 1 (MDSN 1), MDSN 1 verified Resident 73 had a physician's order for Lantus and insulin lispro and were administered as follows: - Lantus subcutaneous solution 100 unit/ml: 12/22/24 8:24 p.m. subcutaneously Abdomen - right lower quadrant (RLQ) 12/23/24 8:07 p.m. subcutaneously Abdomen - RLQ 1/10/25 8:56 p.m. subcutaneously Abdomen - right upper quadrant (RUQ) 1/11/25 8:10 p.m. subcutaneously Abdomen - RUQ - Insulin lispro injection solution 100 unit/ml: 11/16/24 6:01 a.m. subcutaneously Abdomen - left upper quadrant (LUQ) 11/16/24 12:29 p.m. subcutaneously Abdomen - LUQ 12/06/24 4:58 p.m. subcutaneously Abdomen - left lower quadrant (LLQ) 12/07/24 5:14 p.m. subcutaneously Abdomen - LLQ (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	MDSN 1 stated insulin administration sites should be rotated per standards of practice, manufacturer's guidelines, and according to physician's orders. MDSN 1 stated Resident 73's MAR indicated the insulin administration sites were not rotated and that there was a physician's order to rotate injection sites. MDSN 1 stated Resident 73' s insulin administration sites should have been rotated as ordered by the physician to prevent pain, redness, irritation, bruising, lipodystrophy, and denting of the resident's skin. During an interview on 2/13/2025, at 12 p.m. with the Director of Nursing (DON), the DON stated the administration sites of insulin should be rotated as indicated in the manufacturer's guideline, according to MD orders, and standards of practice. The DON stated the licensed staff can see in the MAR the previous administration sites for the insulin and there was a physician's order to rotate administration sites. The DON stated Resident 73's insulin administration sites should have been rotated per MD order, manufacturer's guideline and standards of practice to prevent complications such as bruising, pain, redness, and lipodystrophy on the administration site. During a review of the facility provided undated manufacturer's guideline for Lantus, undated, the manufacturer's guideline indicated: - Always rotate your injection sites as instructed by the doctor. - Choose an injection site. The three possible injection sites are the abdomen, thighs, and upper arms. These areas have more fat and fewer nerve endings and may feel less discomfort in these areas. - Choose a new injection spot each time. - Change (rotate) the injection sites within the area with each dose to reduce the risk of getting lipodystrophy (pitted or thickened skin) and localized cutaneous amyloidosis (skin with lumps) at the injection sites. Do not use the same spot for each injection or inject where the skin is pitted, thickened, lumpy, tender, bruised, scaly, hard, scarred or damaged. During a review of the facility provided undated manufacturer's guideline on insulin lispro, undated, the manufacturer's guideline indicated: - Change (rotate) the injection sites within the area chosen with each dose to reduce the risk of getting lipodystrophy (pitted or thickened skin) and localized cutaneous amyloidosis (skin with lumps) at the injection sites. - Do not use the same spot for each injection or inject where the skin is pitted, thickened, lumpy, tender, bruised, scaly, hard, scarred or damaged. During a review of the facility's policy and procedure (P&P) titled, Insulin Administration, last reviewed on 6/27/2024, the P&P indicated its purpose is to provide guidelines for the safe administration of insulin to residents with diabetes. The P&P further indicated: - The type of insulin, dosage requirements, strength, and method of administration must be verified before administration, to assure that it corresponds with the order on the medication sheet and the physician's order. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The nursing staff will have access to specific instructions (from the manufacturer if appropriate on all forms of insulin delivery system prior to their use. - Select an injection site: a. Insulin may be injected into the SQ tissue of the upper arm, and the anterior or lateral areas of the thighs and abdomen. Avoid the area approximately 2 inches around the navel area. b. Injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm). 44376 b. During a review of Resident 63's Admission Record, the Admission Record indicated the facility admitted the resident on 12/28/2023, and readmitted the resident on 6/17/2024, with diagnoses including type 2 diabetes mellitus (a disease that occurs when your blood glucose, also called blood sugar, is too high), dementia (a progressive state of decline in mental abilities), and Alzheimer's disease (a disease characterized by a progressive decline in mental abilities). During a review of Resident 63's History and Physical (H&P), dated 6/18/2024, the H&P indicated the resident can make needs known but cannot make medical decisions. During a review of Resident 63's Minimum Data Set (MDS, a resident assessment tool), dated 11/13/2024, the MDS indicated the resident rarely to never had the ability to make self-understood and sometimes had the ability to understand others. The MDS indicated the resident had highly impaired vision and was on a high-risk drug class hypoglycemic medication (drugs that lower blood sugar levels) insulin. During a review of Resident 63's Order Summary Report, the Order Summary Report indicated an order for: 8/19/2024 Insulin Glargine-yfgn Subcutaneous Solution Pen-Injector 100 unit per milliliter (unit/ml, one unit of insulin equals 0.01 ml) (Insulin Glargine-yfgn). Inject 25 unit subcutaneously at bedtime for diabetes mellitus (DM). 1/17/2025 Insulin Lispro Injection Solution (Insulin Lispro). Inject 4 unit subcutaneously before meals related to type 2 diabetes mellitus with unspecified complications (Hold for blood sugar [BS] less than [<] 110 milligrams per deciliter [mg/dl, a unit of measurement used to report the concentration of a substance in a fluid]; rotate site). Give within 15 mins. prior to a meal or immediately after a meal. 1/17/2025 Insulin Lispro Injection Solution 100 unit/ml (Insulin Lispro). Inject as per sliding scale (the increasing administration of the pre?meal insulin dose based on the blood sugar level before the meal): if 0 - 149 = 0 units; 150 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; 401+ = 12 units. If blood glucose (BG) above 400 give dose and call provider, subcutaneously before meals related to type 2 diabetes mellitus with unspecified complications. Rotate site. Notify MD for BS <80 and start if needed (PRN) hypoglycemia (low blood sugar) interventions. Give within 15 mins. prior to a meal or immediately after a meal. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 63's Care Plan (CP) titled The resident has diabetes mellitus, last revised on 2/16/2024, the CP indicated an intervention of insulin Lispro Injection Solution (Insulin Lispro). Inject 4 unit subcutaneously before meals related to type 2 diabetes mellitus with unspecified complications. Hold for BS <110 mg/dl; rotate site). During a review of Resident 63's Location of Administration Report of Insulin for 11/2024 to 1/2025, the Location of Administration Report for Insulin indicated Insulin Lispro Injection Solution 100 unit/ml was administered subcutaneously on: 11/05/2024 at 11:36 a.m. on the Abdomen - Left Lower Quadrant (LLQ) 11/06/2024 at 11:59 a.m. on the Abdomen - LLQ 12/21/2024 at 11:47 a.m. on the Abdomen - Right Lower Quadrant (RLQ) 12/22/2024 at 12:11 p.m. on the Abdomen - RLQ 01/21/2025 at 12:02 p.m. on the Abdomen - Left Upper Quadrant (LUQ) 01/22/2025 at 11:43 a.m. on the Abdomen - LUQ During a concurrent interview and record review on 2/12/2025, at 11:21 a.m., with Registered Nurse 2 (RN 2), Resident 63's Order Summary Report, Location of Administration for Insulin, and Care Plan were reviewed. RN 2 stated there were multiple instances that the licensed staff did not rotate the insulin administration sites of Resident 63. RN 2 stated the staff should have rotated the insulin administration sites of Resident 63 to prevent bruising and lipodystrophy. During an interview on 2/14/2025, at 12:52 p.m., with the Director of Nursing (DON), the DON stated the licensed staff should have rotated the insulin administration sites of Resident 63 to prevent skin irritation, lipodystrophy, and cutaneous amyloidosis on Resident 63. The DON added the licensed staff should check on Point Click Care (PCC, a cloud-based software platform that helps long-term care providers manage patient records, care planning, and medication) of where the last administration of insulin before administering the medication to prevent repetition of administration sites. During a review of the facility's recent policy and procedure (P&P) titled Insulin Administration, last reviewed on 6/27/2024, the P&P indicated to select an injection site. a. Insulin may be injected into the subcutaneous tissue of the upper arm, and the anterior or lateral areas of the thighs and abdomen. Avoid the area approximately 2 inches around the navel. b. Injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm). During a review of the facility-provided undated Instructions for Use of Insulin Lispro Kwikpen injection, for subcutaneous use 3 ml single-patient use pen (100 units per mL), the instructions indicated to change (rotate) your injection sites within the area you choose for each dose to reduce your risk of getting lipodystrophy (pits in skin or thickened skin) and localized cutaneous amyloidosis (skin with lumps) at the injection sites.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44376 Based on observation, interview, and record review, the facility failed to ensure residents received care consistent with professional standards of practice to prevent pressure ulcers/injury (the breakdown of skin integrity due to pressure) for one (1) of 1 sampled resident (Resident 12) reviewed for pressure injury by failing to ensure: 1. The resident was turned every two (2) hours. 2. The staff documented the position the resident was placed every time they turned the resident. 3. Licensed Vocational Nurse (LVN) 1 and Certified Nursing Assistant (CNA) 6 documented the reason when the resident refused to turn on 2/12/2025. These deficient practices had the potential for development and worsening of pressure ulcers/injuries to residents. Findings: During a review of Resident 12's Admission Record, the Admission Record indicated the facility admitted the resident on 10/29/2019, and readmitted the resident on 10/28/2024, with diagnoses including pressure ulcer of sacral region stage four (4) (full thickness tissue loss with exposed bone, tendon, or muscle), Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), and dementia (a progressive state of decline in mental abilities). During a review of Resident 12's History and Physical (H&P), dated 10/30/2024, the H&P indicated the resident had a pre-existing sacral ulcer with visible bone and the resident can make needs known but cannot make medical decisions. During a review of Resident 12's Minimum Data Set (MDS - a resident assessment tool), dated 1/21/2025, the MDS indicated the resident had the ability to make self-understood and understand others and had moderate cognitive impairment (a condition that involves increased confusion and memory loss, as well as difficulty with language and completing tasks). The MDS indicated the resident was dependent to needing substantial to maximal assistance on mobility and activities of daily living (ADLs - activities such as bathing, dressing and toileting a person performs daily). The MDS indicated the resident was at risk for developing pressure injuries, had one unhealed stage 4 pressure injury, and was on turning/repositioning program. During a review of Resident 12's Braden Risk Scale (a validated risk assessment tool used in medical settings to identify patients who are at high risk for developing pressure ulcers), dated 1/21/2025, the Braden Risk Scale indicated the resident was at risk for developing pressure injuries. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 12's Care Plan (CP) titled, Sacro coccyx (the last bone at the bottom [base] of the spine) extending to right buttock stage 4 pressure ulcer, last revised on 5/30/2024, the CP indicated an intervention to assist and encourage resident to turn and reposition with turning schedule to redistribute weight and reduce the risk of skin breakdown and turn and reposition every 2 hours and if needed (PRN). During a review of Resident 12's Order Summary Report, dated 2/1/2025, the Order Summary Report indicated an order for Sacro-coccyx stage 4 pressure ulcer (PU). The Order Summary Report indicated to cleanse with normal saline (a mixture of water and salt with a 0.9% concentration of sodium chloride), pat dry, apply Santyl (a topical enzyme medication used to remove damaged or burned skin) followed by collagen (a protein in the body), and cover with dry dressing (a dressing made of dry material, like gauze or cotton, that doesn't appear damp) every day shift for 21 days. During a review of the facility-provided turning schedule, undated, the turning schedule indicated: 12:00 to 2:00 a.m. or p.m. reposition on back; 2:00 to 4:00 a.m. or p.m. reposition on right side; 4:00 to 6:00 a.m. or p.m. reposition on left side; 6:00 to 8:00 a.m. or p.m. reposition on back; 8:00 to 10:00 a.m. or p.m. reposition on right side; 10:00 to 12:00 a.m. or p.m. reposition on left side. During a review of Resident 12's Turn and Reposition Log, dated between 1/31/2025 to 2/13/2025, the Turn and Reposition Log indicated the following: On 1/31/2025: 12:24 a.m. turned, no position indicated; 3:37 a.m. turned, no position indicated; 3:38 a.m. turned, no position indicated; 7:00 a.m. turned, no position indicated; 9:23 p.m. 4 times turned; no position indicated. On 2/1/2025: 1:42 a.m. with entry of not applicable and also turned; 2:27 a.m. with entry of not applicable; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5:00 a.m. turned, no position indicated; 2:35 p.m. turned, no position indicated; 2:36 p.m. turned, no position indicated; and with 2 entries of not applicable; On 2/2/2025: 2:53 a.m. turned, no position indicated; entered twice; 2:54 a.m. turned, no position indicated; 5:00 a.m. turned, no position indicated; 9:12 a.m. turned, no position indicated; entered twice; 12:28 p.m. turned, no position indicated; entered twice; 3:58 p.m. turned, no position indicated. During an observation, on 2/11/2025, at 9:08 a.m., Resident 12 laid in bed and faced her left side. The turning schedule posted on Resident 12's wall indicated the resident should be facing right side. During a concurrent observation and interview, on 2/12/2025, at 11:04 a.m., Resident 12 laid on her back and the turning schedule posted on the resident's wall indicated the resident should be facing her left side. Resident 12 confirmed and stated she was on her back, and she cannot remember the last time she was turned by the staff. During a concurrent interview and record review, on 2/12/2025, at 2:45 p.m., with LVN 1, CNA 6, and Resident 12, inside Resident 12's room, LVN 1 confirmed the resident was on her back, and stated she does not know why the resident was not on her left as indicated on the turning schedule posted on the resident's wall. CNA 6 stated she was in the resident's room [ROOM NUMBER] minutes ago but there was no entry on the Turning and Repositioning Log of Resident 12 close to that time. CNA 6 stated the resident refused, however when asked in the presence of LVN 1 and CNA 6, Resident 12 stated she did not refuse to turn. LVN 1 stated it was important to turn the resident every 2 hours to help in the healing of Resident 12's stage 4 pressure injury in the coccyx. During a concurrent observation and interview, on 2/12/2025, at 4:29 p.m., with Restorative Nursing Assistant (RNA) 1, inside Resident 12's room, Resident 12 did not have a wedge pillow (a triangular shaped pillow made from foam which allows positioning the body on an incline for comfortable sleeping) on her side. RNA 1 confirmed a wedge pillow was on top of Resident 23's drawer. RNA 1 stated the facility should not use an ordinary pillow to turn the resident on her sides as it is not turning the resident properly and it is not relieving the pressure on her buttocks. During an observation, on 2/13/2025, at 8:00 a.m., Resident 12 laid on her back and the turning schedule posted on the wall indicated the resident should be on her right side. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review, on 2/13/2025, at 8:25 a.m., with CNA 6 and CNA 7, Resident 12's Turn and Reposition Log, dated between 1/31/2025 to 2/13/2025, was reviewed. CNA 6 stated she did not document Resident 12's refusal to turn on 2/12/2025, around 2:00 p.m. CNA 6 stated she did not explain to the resident why she needed to turn every 2 hours. CNA 6 stated she reported Resident 12's refusal to turn to LVN 1. CNA 6 and CNA 7 reviewed Resident 12's Turn and Reposition Log and stated the log indicated the resident is not being turned every 2 hours per documentation and the position was not indicated on the document. CNA 6 and CNA 7 stated it was important to document the refusal and turning of the resident accurately to prevent the worsening of pressure ulcer on the resident. During a concurrent interview and record review, on 2/13/2025, at 8:37 a.m., with LVN 1, Resident 12's Turn and Reposition Log, dated between 1/31/2025 to 2/13/2025, was reviewed. LVN 1 stated she remembered CNA 6 reporting to her Resident 12's refusal to turn on 2/12/2025, at around 2:00 p.m., but she did not document the incident on the resident's medical chart. LVN 1 reviewed Resident 12's Turn and Reposition Log and stated the logs did not indicate the resident has been turned every 2 hours. LVN 1 stated it was important to document a resident's refusal to turn and the turning every 2 hours to prevent Resident 12's pressure injury from worsening. During a concurrent interview and record review, on 2/13/2025, at 9:51 a.m., with Treatment Nurse (TX) 2, Resident 12's Turn and Reposition Log, dated between 1/31/2025 to 2/13/2025, was reviewed and TX 2 stated the resident was not being turned every 2 hours per the documentation record. TX 2 stated it was important to turn and document every 2 hours to prevent Resident 12's pressure injury from worsening. During an interview, on 2/14/2025, at 12:54 p.m., with the Director of Nursing (DON), the DON stated the staff should have turned Resident 12 every 2 hours because the resident was at risk for worsening of pressure injury at her Sacro coccyx. The DON stated the staff should have followed the care plan to turn and reposition every 2 hours and document the position to ensure the resident was not laying in the same position for a long time. The DON stated if the resident refuses to turn, the staff should document the reason and explain to the resident the risk of refusal to turn. During a review of the facility's recent policy and procedure (P&P) titled, Repositioning, last reviewed on 6/27/2024, the P&P indicated residents who are in bed should be on at least an every two-hour (q2 hour) repositioning schedule. For residents with a Stage 1 or above pressure ulcer, an every two-hour (q2 hour) repositioning schedule is inadequate. The P&P indicated to review the resident's care plan to evaluate for any special needs of the resident, check the care plan, assignment sheet or the communication system to determine resident's specific positioning needs including special equipment, resident level of participation and the number of staff required to complete the procedure. The P&P indicated the following information should be recorded in the resident's medical record: Documentation 1. The position in which the resident was placed. This may be on flow sheet . 5. If the resident refused the care and the reason(s) why. Reporting (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Notify the supervisor if the resident refuses the procedure.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44376 Based on observation, interview, and record review, the facility failed to ensure the resident environment was free of accident hazards for two of four (4) sampled residents (Resident 19 and 66)) reviewed for accidents by failing to ensure: 1. Resident 19's bilateral fall mat (a cushioned mat that reduces the risk of injury from a fall) did not have furniture or equipment on top of them. 2. To accurately complete Resident 66's risk for falls after a fall incident on 10/11/2024. 3. Conduct an interdisciplinary team (IDT - a collaboration of healthcare professionals who work together to plan and coordinate patient care) meeting after Resident 66 fell on [DATE] and 11/13/2024. These deficient practices had the potential to increase the risk of injury to the resident, if the resident slips, trips, and falls by hitting the hard surface of the equipment or furniture that is on top of the fall mat. Findings: 1) During a review of Resident 19's Admission Record, the Admission Record indicated the facility admitted the resident on 5/22/2021, with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness or the inability to move on one side of the body, making it hard to perform everyday activities like eating or dressing), unsteadiness on feet, and age-related osteoporosis (a bone disease that causes bones to become weak and more likely to break as people get older) with current pathological fracture (broken bones in an area already weakened by another disease, not by an injury) of left hand. During a review of Resident 19's Care Plan (CP), initiated on 9/18/2024, the CP indicated a goal for the resident's risk for falls/injuries to be reduced through implementation of safety devices and other interventions. During a review of Resident 19's Minimum Data Set (MDS, a resident assessment tool), dated 11/28/2024, the MDS indicated the resident had the ability to make self-understood and understand others and had moderately impaired vision. The MDS indicated the resident had moderate cognitive impairment (when someone has significant difficulty with memory, learning, and completing tasks) and the resident required substantial to partial assistance in mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). The MDS indicated the resident had history of two or more falls on admission or reentry prior to assessment without injury. During a review of Resident 19's Fall Risk Assessment, dated 11/28/2024, the Fall Risk Assessment indicated the resident was high risk for falls. During a review of Resident 19's History and Physical, dated 1/28/2025, the H&P indicated the resident had the capacity to understand and make decisions. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 2/12/2025, at 11:27 a.m., with Registered Nurse 2 (RN 2), while inside Resident 19's room, Resident 19's bilateral fall mat had a drawer on top of the upper part of the fall mat. The Fall mat at the right side of the bed was not placed near the exit side of the bed. It had a gap where the resident can directly fall to the ground. RN 2 stated the fall mat of Resident 19 should be placed directly on the exit side of the right side of the resident's bed to prevent the resident from landing on the floor. RN 2 also stated the drawers should not be on top of the fall mat because when the resident falls on either side of the bed, the resident could hit their head on them causing a major injury such as fractures or lacerations. During an interview and record review on 2/14/2025, at 1 p.m., with the Director of Nursing (DON), the photograph of the placement of Resident 19's fall mat on 2/12/2025 was reviewed. The DON stated the fall mat at the right side of the bed was placed improperly. The DON stated there was a gap between the bed and the fall mat where the resident can land on the floor. The DON stated the fall mats on both sides of the resident had a drawer on top of them and when the resident falls on either side, Resident 19 can hit his head and sustain an injury. The DON also stated the furniture on top of the fall mat can alter the integrity of the mat by causing a permanent dent on them leaving the mattress less capable of lessening the fall impact on the resident. During a review of the facility's recent policy and procedure (P&P) titled Safety and Supervision of Residents last reviewed on 6/27/2024, the P&P indicated safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes; QAPI reviews of safety and incident/accident data; and facility-wide commitment to safety. During a review of the facility's recent policy and procedure (P&P) titled Homelike Environment, last reviewed on 6/27/2024, the P&P indicated the facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. Clean, safe, sanitary and orderly/clutter free environment, no excessive items and items shall be stored off the floor. During a review of the undated facility-provided User Instructions titled Fall Mat 1 (FM 1), , the User Instructions indicated in addition to low height beds that have been found to help reduce the incidence of falls; impact reduction fall mats placed alongside the bed have become a cost-effective means to help reduce the incidence of patient trauma and severity of injury by providing a cushioned, slide resistant surface. 43988 2) During a review of Resident 66's Admission Record, the Admission Record indicated the facility originally admitted the resident on 3/15/2024 and readmitted the resident in the facility on 1/15/2025 with diagnoses including dementia (a progressive state of decline in mental abilities), unsteadiness on feet, and generalized muscle weakness. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 66's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 1/20/2025, the MDS indicated the resident had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and required supervision with oral hygiene; substantial/maximal assistance with bed mobility and transfers; total assistance with bathing and shower transfers; partial/moderate assistance with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 66 had history of falls in the last six months. During a review of Resident 66's History and Physical (H&P) dated 2/6/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 66's care plan (CP) for risk for falls and injuries related to balance problem and gait abnormality initiated 12/21/2024 and last revised on 1/8/2025, the CP included interventions to perform frequent observations when in the room and remind to call for assistance if need to go to the bathroom to reduce Resident 66's risk for fall or injuries. During a review of Resident 66's fall risk assessments after a fall incident, the fall risk assessments indicated the following: - 10/11/2024: Score is 4 - 11/13/2024: Score is 9 - 12/5/2024: Score is 10 (High Risk) - 12/6/2024: Score is 6 - 1/7/2024: Score is 8 During a concurrent interview and record review, on 2/13/2025 at 9:40 a.m., Resident 66's fall risk assessments, care plans, SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents), and IDT meeting notes were reviewed, after a fall incident, with the Minimum Data Set Nurse 1 (MDSN 1). MDSN 1 stated fall risk assessments are completed upon admission, readmission, quarterly, and after a fall incident. MDSN 1 stated the IDT meeting is conducted after each fall incident to determine what may have caused the incident. MDSN 1 stated the fall risk assessment dated [DATE] was not completed accurately as the score should be higher than 4 due to a recent fall incident. MDSN 1 stated the fall risk assessment did not indicate Resident 66 had a history of 1 to two (2) falls in the last six (6) months. MDSN 1 stated she was unable to find in Resident 66's medical record that an IDT meeting was conducted on 10/11/2024 and 11/13/2024 after the fall. MDSN 1 stated Resident 66's fall risk assessment on 10/11/2024 should have indicated Resident 66 had 1-2 falls in the last six months to provide an accurate fall risk score and the IDT meeting should have been conducted after the fall incidents to identify the possible cause leading to the fall and to implement the appropriate interventions for Resident 66 to prevent falls and/or injuries. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 2/13/2025 at 11 a.m., Resident 66's IDT meeting notes were reviewed with the Director of Nursing (DON). The DON stated IDT meetings are conducted after each incident of a fall to determine the factors that caused the fall incident and identify interventions appropriate for the resident. The DON stated she was unable to find the IDT meeting notes after Resident 66's fall incident on 10/11/2024 and 11/13/2024. The DON stated the IDT meeting should have been conducted to determine the factors that caused the falls and ensure appropriate interventions are being implemented placing Resident 66 at risk for further falls which may lead to injuries. During a review of the facility's policy and procedure (P&P) titled, Falls - Clinical Protocol, last reviewed on 6/27/2025, the P&P indicated: - The staff will document risk factors for falling in the resident's record and discuss the resident's fall risk. - For an individual who has fallen, staff will attempt to define possible causes within 24-72 hours of the fall. - Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling. - If the individual continues to fall, the staff will evaluate the situation and consider other possible reasons for the resident's falling.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 43988 Based on observation, interview, and record review, the facility failed to ensure residents with a urinary catheter (also known as an indwelling catheter, a hollow tube inserted into the bladder to drain or collect urine) received appropriate care and services to prevent urinary tract infections (UTI - an infection in the bladder/urinary tract) for one (1) out of 1 sampled resident (Resident 249) reviewed for urinary catheter or UTI care area when the facility failed to ensure Residents 249's urinary catheter tubing did not have a loop while hanging on the side the bed. This deficient practice had the potential for the resident's urine not to flow freely which may lead to development of UTI. Findings: During a review of Resident 249's Admission Record, the Admission Record indicated the facility admitted Resident 249 on 2/5/2025 with diagnoses including UTI, unsteadiness on feet, and generalized muscle weakness. During a review of Resident 249's Admission/Readmission Initial Assessment, dated 2/5/2025, the Admission/Readmission Initial Assessment form indicated Resident 249 was able to understand others and make her needs known. The Admission/Readmission Initial Assessment form indicated Resident 249 had an indwelling catheter for urine retention. The Admission/Readmission Initial Assessment form further indicated Resident 249 required partial/moderate assistance to total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a review of Resident 249's History and Physical (H&P), dated 2/7/2025, the H&P indicated Resident 249 had the capacity to understand and make decisions. During a review of Resident 249's Order Summary Report, dated 2/5/2025, the Order Summary Report indicated the following physician's orders: - Indwelling catheter to straight drainage. Size: (16) Bulb: ten (10) every shift. - Provide urinary catheter care daily: Cleanse with NS then pat dry every day shift. - Monitor indwelling catheter for presence of sediment and cloudy urine. Notify MD if noted every shift. Document if present: Y for present N for not present. - Monitor for signs and symptoms of UTI every shift and notify physician (MD) if present every shift for indwelling catheter use. Document: (Y) If present (N) = If absent. - Change indwelling catheter. Size: (16) Bulb: (10) if plugged, leaking, or pulled out as needed. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Indwelling Catheter: ensure urinary catheter securement device is in place to prevent movement and urethral traction every day shift and as needed. During an observation, on 2/11/2025, at 10:07 a.m., inside Resident 249's room, Resident 249 laid in bed asleep with a urinary catheter drainage bag hanging on the side of the bed with a loop on the catheter tubing. During a concurrent observation and interview, on 2/11/2025, at 10:15 a.m., inside Resident 249's room with the Quality Assurance Nurse (QAN), the QAN verified Resident 249's urinary catheter tubing had a loop, and the loop had urine inside. The QAN stated urinary catheter tubing should not have a loop as the urine will not flow freely or back up into the bladder and cause a UTI. The QAN stated Resident 249's urinary catheter tubing should have no loop as it placed Resident 240 at risk for acquiring UTI when the urine in the tubing cannot flow freely and possibly back up into the bladder. During an interview, on 2/11/2025, at 12:00 p.m., with the Director of Nursing (DON), the DON stated urinary catheter tubing should be positioned properly on the side of the bed to prevent loops or kinks as the urine will not flow freely and back up into the bladder and the staff should check every time they go to the resident's room. The DON stated Resident 249's urinary catheter tubing should have been placed properly on the side of the bed to prevent kinks or loops as the urine will not flow freely and back up into the bladder which may lead to UTI. During a review of the facility's policy and procedure (P&P) titled, Catheter Care, Urinary, last reviewed on 6/27/2024, the P&P indicated a purpose to prevent catheter-associated urinary tract infections. The P&P further indicated: - Check the resident frequently to be sure he or she is not lying on the catheter and to keep the catheter and tubing free of kinks. - Check drainage tubing and bag to ensure that that the catheter is draining properly.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 44376 Based on observation, interview, and record review, the facility failed to ensure the staff providing care and services to the resident who has a feeding tube (are soft plastic tubes through which liquid nutrition travels through the gastrointestinal tract [the series of organs that food and liquids pass through as they are digested, absorbed, and leave the body as feces]) are aware of, competent in, and utilize facility protocols regarding feeding tube nutrition and care for one of one sampled resident (Resident 22) reviewed for tube feeding by failing to ensure the water flush bag was labeled with the name, room number, and the rate of the water flush. This deficient practice had the potential to result in altered nutritional status that can lead to over or under hydration, gastrointestinal infection to the resident. Findings: During a review of Resident 22's Admission Record, the Admission Record indicated the facility admitted the resident on 8/28/2023, and readmitted the resident on 12/29/2024, with diagnoses including gastrostomy (a surgical procedure used to insert a tube, often referred to as a G-tube, through the abdomen and into the stomach), acute kidney failure (is a sudden condition where the kidneys stop working properly), and dysphagia (swallowing difficulties). During a review of Resident 22's History and Physical (H&P), dated 12/12/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 22's Minimum Data Set (MDS, a resident assessment tool), dated 1/2/2025, the MDS indicated the resident sometimes had the ability to make self-understood and sometimes had the ability to understand others. The MDS indicated the resident had highly impaired vision and had severe cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS indicated the resident had a feeding tube. During a review of Resident 22's Order Summary Report, dated 12/31/2024, the Order Summary Report indicated an enteral feed order every shift continuous water via g-tube. Administer 50 milliliters (ml, a unit of volume)/ hour (hr., a unit of time) times (X) 20 hrs. using enteral pump for a total of 1000 ml X 20 hrs. while feeding is on. On at 1200, Off at 0800 or until total volume is complete. During a concurrent observation and interview on 2/12/2025, at 11:13 a.m., with Registered Nurse 2 (RN 2), inside Resident 22's room, observed Resident 22's water flush feeding bag labeled with the date 2/11/2025 at 5:30 a.m., without the resident's name, and the rate it should be run via pump. RN 2 stated the label should also contain the resident's name, room number, and the rate it needed to be infused. RN 2 stated it was important to have the name, room number, and the rate of the infusion of the water flush to ensure accurate administration of the flush to prevent over or under hydration of the resident and to ensure the water flush bag was for the right resident. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/14/2025 at 1:03 p.m., with the Director of Nursing (DON), reviewed the picture of Resident 22's water flush bag taken on 2/12/2025, labeled with only the date and time it was hung. The DON stated the water flush bag should also be labeled with the name, room number, and the rate of infusion to ensure accurate water flushes to avoid over and under hydration and to ensure the water flush bag is for the right patient. During a review of the facility's recent policy and procedure (P&P) titled Enteral Feedings- Safety Precautions, last reviewed on 6/27/2024, the P&P indicated water flush: a. Label water flush bag and change following closed system hang time of 24-48 hours. Preventing errors in administration: -Check the enteral nutrition label against the order before administration. Check the following: a. Resident name, ID, and room number; b. Type of formula; c. Date and time of formula was prepared; d. Route of delivery; e. Access site; f. Method (pump, gravity, syringe); and g. Rate of administration (ml/hour)

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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. 44376 Based on observation, interview, and record review, the facility failed to ensure respiratory care provided to residents were consistent with professional standards of practice for two of two sampled residents (Residents 22 and 346) reviewed for respiratory care by failing to ensure: 1. Resident 22's suction canister (a temporary storage container for secretions or fluids removed from the body) was labeled with the date it was last changed. 2. Resident 346's oxygen tubing (a flexible, clear tube used to deliver oxygen from a source like a tank or concentrator to a patient's nose or mouth) was labeled with the date it was last changed and was off the floor. 3. Resident 346's nebulizer (a small machine that turns liquid medicine into a mist that can be easily inhaled) mask and tubing (this allows the medicine to enter the lungs directly) were kept in a plastic bag with the name of the resident and the date it was provided. The deficient practices had a potential for residents to develop complications such as respiratory infections of using a nebulizer and oxygen tubing caused by improper handling of the mask and tubing. Findings: 1. During a review of Resident 22's Admission Record, the Admission Record indicated the facility admitted the resident on 8/28/2023, and readmitted the resident on 12/29/2024, with diagnoses including acute respiratory failure (a condition where the respiratory system is unable to function properly, which can lead to a failure of gas exchange), asthma (a chronic lung disease that makes it difficult to breathe), and choric obstructive pulmonary disease (COPD, a lung disease that makes it hard to breathe). During a review of Resident 22's History and Physical (H&P), dated 12/12/2024, the H&P indicated the resident did not have the capacity to understand and make medical decisions. During a review of Resident 22's Minimum Data Set (MDS, a resident assessment tool), dated 1/2/2025, the MDS indicated the resident sometimes had the ability to make self-understood, sometimes had the ability to understand others, and had severe cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS indicated the resident was on continuous oxygen therapy (a treatment that supplies oxygen at higher levels than normal room air). During a review of Resident 22's Order Summary Report, dated 12/30/2024, the Order Summary Report indicated an order to suction resident for increased secretion three times a day (TID) as needed. (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 observation and interview on 2/11/2025 at 9:40 a.m., with Licensed Vocational Nurse 3 (LVN 3), inside Resident 22's room, observed Resident 22's suction set-up with the suction canister not labeled with the date it was provided/changed. LVN 3 stated the suction canister of Resident 22 should be dated with the date it was provided or changed to ensure the canister was not used for a longer period of time to prevent growth of microorganisms inside the canister that can cause respiratory infection to Resident 22. During an interview on 2/14/2025, at 1:04 p.m., with the Director of Nursing (DON), the DON stated the staff should label the suction canister with the date it was provided or changed to prevent growth of bacteria in the canister when used for a longer period of time. The DON stated the suction canister should be changed every seven days and if needed (prn). During a review of the facility's recent policy and procedure (P&P) titled Respiratory Therapy- Prevention of Infection, last reviewed on 6/27/2024, the P&P indicated to label oxygen cannula and change the oxygen cannula and tubing every seven (7) days, or as needed. Change nebulizer tubing and mask every seven days. Label suction canister and change every 7 days or as needed. 2. During a review of Resident 346's Admission Record, the Admission Record indicated the facility admitted the resident on 2/4/2025, with diagnoses including chronic obstructive pulmonary disease with exacerbation (a worsening or flare-up of a disease or its symptoms, making a condition that was already bad become even worse) and asthma. During a review of Resident 346's H&P, dated 2/6/2025, the H&P indicated the resident had the capacity to understand and make medical decisions. During a review of Resident 346's Order Summary Report, the Order Summary Report indicated the following physician's orders: 2/7/2025 (date of order): Administer oxygen at 2 liters per minute (L/min, a unit of measurement that indicates how many liters of a liquid or gas move in one minute) via nasal cannula (device that delivers extra oxygen through a tube and into your nose) every shift related to chronic obstructive pulmonary disease with (acute) exacerbation. 2/6/2025 (date of order): Ipratropium-Albuterol Solution 0.5-2.5 (3) milligrams (mg, a unit of weight)/3 milliliters (ml, a unit of volume). Inhale orally via nebulizer four times a day related to chronic obstructive pulmonary disease with (acute) exacerbation for 14 days. Document duration of administration in minutes. During a review of Resident 346's Care Plan (CP) titled The resident has oxygen therapy related to (r/t) COPD, last revised on 2/7/2025, the CP indicated an intervention to change and date oxygen tubing weekly or as needed. Place oxygen in a labeled bag and when not in use. (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 observation and interview on 2/11/2025 at 9:27 a.m., with Certified Nursing Assistant 3 (CNA 3) and Licensed Vocational Nurse 1 (LVN 1), observed Resident 346's oxygen via nasal cannula dated 2/14/2025 and was touching the floor. Also observed a nebulizer mask and tubing not placed inside a plastic bag with the name of the resident and the date it was provided or last changed, and the tubing was inside the trash can. LVN 1 and CNA 3 both stated the tubing should be labeled with the date it was last changed and the nebulizer mask should be inside a plastic bag with the name of the resident and the date it was last changed to prevent using the tubing from being used for a longer period of time as microorganisms grow on them that can make the residents sick. LVN 1 also stated the tubing should not be touching the floor nor the trash to prevent infection. During an interview on 2/14/2025 at 1:04 p.m., with the DON, the DON stated the staff should label the oxygen tubing and the nebulizer masks and tubing with the date it was provided or changed to prevent growth of bacteria in the tubing when used for a longer period. The DON stated both tubing should be changed every seven days and if needed (prn) and the nebulizer mask and tubing should be placed inside a plastic bag with the name of the resident with the date it was changed or provided. The DON also stated the tubing should not be touching the floor or trash can, if observed by staff, it should be replaced immediately to prevent infection. During a review of the facility's recent policy and procedure (P&P) titled Respiratory Therapy- Prevention of Infection, last reviewed on 6/27/2024, the P&P indicated to label oxygen cannula and change the oxygen cannula and tubing every seven (7) days, or as needed. Change nebulizer tubing and mask every seven days. Label suction canister and change every 7 days or as needed.

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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.

43455

Based on observation, interview, and record review the facility failed to:

1. Reconcile (the process of comparing transactions and activity to supporting documentation) one medication emergency kit ([ekit] - storage container for emergency use medications) containing controlled substances ([CS] -drugs which have a potential for abuse and may also lead to physical or psychological dependence,) in one (1) of one (1) inspected medication carts (Medication Cart Station 1).

2. Include the verifying signatures of either the Director of Nursing (DON) or a Registered Nurse (RN) along with Licensed Vocational Nurse (LVN) on the Medication Count Sheet accountability logs for four (4) of four (4) sampled CS records awaiting disposal (removal, destroying) stored inside a locked cabinet.

As a result, control and accountability of controlled substances and those awaiting final disposition (process of returning and/or destroying unused medications) did not follow state and federal regulations and facility policy and procedures.

These deficient practices increased the opportunity for controlled substances diversion (the transfer of a controlled medication or other medication from a lawful to an unlawful channel of distribution or use) and increased the risk that residents in the facility could have accidental exposure to harmful medications possibly leading to physical and psychosocial harm, and hospitalization .

Findings:

During a concurrent observation of Medication Cart 1 and interview with Licensed Vocational Nurse 4 (LVN 4), on 2/12/2025 at 2:10 p.m., there was one (1) medication ekit containing controlled substances that was not reconciled as part of the CS inventory at every shift change. LVN 4 stated that all controlled substances should be reconciled at every shift. LVN 4 stated that the medication ekit containing controlled substances in Medication Cart 1 was not reconciled at every shift, and it was important to account for all controlled substances to ensure accountability, prevent CS diversion and accidental exposure of harmful substances to residents.

During a concurrent observation and interview with the Director of Nursing (DON), on 2/12/2025 at 2:55 p.m., four (4) Medication Count Sheet accountability logs for controlled substances awaiting final disposition in a locked cabinet, did not contain verifying signatures. The DON stated the DON was unable to locate the verifying signatures of Registered Nurse (RN)/DON on the four (4) Medication Count Sheet accountability logs. The DON stated the DON and the LVNs failed to sign the Medication Count Sheet accountability logs upon receipt of the controlled substances from the LVNs. The DON stated the DON counts the controlled substances with the LVN upon receipt of the accountability log; however, they overlooked to sign & date the four (4) logs. The DON stated the DON understood the importance of controlled substance accountability to ensure each controlled substance dose was accounted for until disposed throughout the process of controlled substance accountability. The DON stated it was important to verify and sign these logs to prevent medication diversions and accidental exposure of harmful substances to residents.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/13/2025 at 12:47 p.m., with the DON, the DON stated the medication ekit containing controlled substances were not being counted and reconciled at every shift change for Medication Cart Station 1. The DON stated that all controlled substances should be reconciled at every shift change to ensure accountability and prevent controlled substances diversion. During a review of the facility's policies and procedures (P&P) titled Controlled Substances, last reviewed 6/27/2024, the P&P indicated the facility shall comply with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of Schedule II and other controlled substances. 9. Nursing staff must count controlled medications (substances) at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. They must document and report any discrepancies to the DON Services. During a review of the facility's P&P titled Discarding and Destroying Medications, last reviewed 6/27/2024, the P&P indicated Medications will be disposed of in accordance with federal, state and local regulations governing management of .CSs. 10. The medication disposition record will contain the following information: h. Signature of witnesses. During a review of the P&P titled Emergency Kit (E-Kit) Use, [undated,] the P&P indicated: 10.the controlled drugs (if any) will be counted each shift for accountability.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 44376 Based on interview and record review, the facility failed to ensure the licensed pharmacist during drug regimen review provided a recommendation on the use of an antibiotic as a prophylaxis for UTI to one of two sampled residents (Resident 37) reviewed for antibiotic use by failing to: 1. Ensure the use of methenamine hippurate as a prophylaxis (an attempt to prevent disease) for urinary tract infection (UTI, a bacterial infection in the urinary system, which includes the kidneys, ureters, bladder, and urethra), an antibiotic (medicines that fight bacterial infections in people and animals) had an order for monitoring for signs and symptoms of UTI to evaluate its effectiveness. 2. Follow-up with the attending physician the reason for prolonged use of methenamine hippurate as a prophylaxis for UTI, as it was ordered since 9/2/2023. This deficient practice created the risk for Resident 37 to receive excessive dosages of methenamine hippurate which may cause adverse effects (an undesired effect of a drug or other type of treatment, such as surgery) and can result in overdosage or hospitalization . Cross Reference F757 Findings: During a review of Resident 37's Admission Record, the Admission Record indicated the facility admitted the resident on 3/4/2023, with diagnoses including thrombocytopenia (a condition that occurs when the platelet count in the blood is too low), gastro-esophageal reflux disease (GERD, a digestive disorder that occurs when stomach acid flows back into the esophagus), and cerebral infarction (a stroke that occurs when blood flow to the brain is blocked). During a review of Resident 37's History and Physical (H&P), dated 12/18/2024, the H&P indicated the resident had periods of confusion and can make needs known but cannot make medical decisions. During a review of Resident 37's Minimum Data Set (MDS, a resident assessment tool), dated 11/29/2024, the MDS indicated the resident had the ability to make self-understood and understand others and had moderate cognitive impairment (a stage of dementia where a person has clear signs of memory loss and difficulty completing tasks). The MDS indicated the resident was on a high-risk drug class antibiotic. During a review of Resident 37's Order Summary Report, dated 9/1/2023, the Order Summary Report indicated an order of methenamine hippurate oral tablet 1gram (gm, a unit of weight). Give 1 tablet by mouth two times a day for UTI prophylaxis. The order summary did not indicate any monitoring for signs and symptoms of UTI. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Santa Clarita Post-Acute Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 23801 Newhall Avenue Newhall, CA 91321	

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 2/12/2025 at 11 p.m., with the Infection Preventionist (IP), the IP stated methenamine hippurate oral tablet is not an antibiotic. The IP stated the medication was antibacterial (a substance that kills bacteria or stops them from growing and causing disease). The IP stated they did not do any monitoring for signs and symptoms of UTI and there was no end date on the use of this antibiotic as it was antibacterial. During an interview on 2/12/2025 at 12:51 p.m., with the Consultant Pharmacist (PHARM), the PHARM stated methenamine hippurate is an antibiotic. The PHARM stated there should be renal function (a term used to describe how well the kidneys work) monitoring at least yearly for residents without kidney issues and weekly to monthly monitoring for residents with compromised kidneys. The PHARM stated there should be monitoring for signs and symptoms of UTI to ensure the antibiotic is working as a prophylaxis to UTI. The PHARM stated the possible side effects of prolonged use of methenamine hippurate are skin rash, nausea, vomiting etc. The PHARM stated the staff should have monitored for signs and symptoms of UTI and followed up with the physician regarding the prolonged use of the antibiotic to reduce the adverse effects related to prolonged use and to improve resident outcomes to treatment. During an interview on 2/13/2025, at 10:08 a.m., with the IP, the IP stated that her Director of Nursing (DON) and herself had spoken to the PHARM and they decided moving forward they will also screen residents on methenamine hippurate as a prophylaxis for UTI for antibiotic stewardship program (a healthcare initiative that aims to ensure antibiotics are used appropriately and only when necessary). The IP stated they will start monitoring for signs and symptoms of UTI when the resident is using them. The IP stated they will screen residents of methenamine hippurate for antibiotic appropriateness of use and if there's no monitoring for signs and symptoms of UTI, they will obtain an order and if urine culture (a lab test that checks for bacteria, yeast, or other germs in a urine sample) is done, they will relay the results to the doctor and ask the doctor if they still want the medication continued, if they do, they will prompt the doctor to do a note to explain its continued use. The IP stated it is important to screen Resident 37's use of antibiotic methenamine hippurate to ensure the resident does not develop antibiotic resistance (when bacteria change and are no longer killed by antibiotics). During an interview on 2/14/2025 at 1:08 p.m., with the DON, the DON stated the staff should have monitored for signs and symptoms of UTI on Resident 37 while using methenamine hippurate to know if the medication is effective or not. The DON stated if there was no order for monitoring the staff should have called the doctor for an order. The DON also stated the staff should have followed up with the doctor during the relay of the urine culture results if they wanted the medication continued or not since the resident had been taking them since 9/2023. During a review of the facility's recent policy and procedure (P&P) titled Antibiotic Stewardship, last reviewed on 6/27/2024, the P&P indicated the consultant pharmacist will included in the monthly medication regimen review medication safety criteria (i.e. pertinent drug-drug and drug-disease interactions, durations of therapy, appropriate doses, etc. where appropriate).

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 44376 Based on interview and record review, the facility failed to ensure resident's drug regimen was free from unnecessary drugs to one of two sampled residents (Resident 37) reviewed for antibiotic (medicines that fight bacterial infections in people and animals) use by failing to ensure Resident 37's methenamine hippurate used as a prophylaxis (an attempt to prevent disease) for urinary tract infection (UTI, a bacterial infection in the urinary system, which includes the kidneys, ureters, bladder, and urethra) was not used for excessive duration and without adequate monitoring for signs and symptoms of UTI. This deficient practice had the potential to cause adverse effects (an undesired effect of a drug or other type of treatment, such as surgery) from the continued use of this medication. Cross Reference F756 Findings: During a review of Resident 37's Admission Record, the Admission Record indicated the facility admitted the resident on 3/4/2023, with diagnoses including thrombocytopenia (a condition that occurs when the platelet count in the blood is too low), gastro-esophageal reflux disease (GERD, a digestive disorder that occurs when stomach acid flows back into the esophagus), and cerebral infarction (a stroke that occurs when blood flow to the brain is blocked). During a review of Resident 37's History and Physical (H&P), dated 12/18/2024, the H&P indicated the resident had periods of confusion and can make needs known but cannot make medical decisions. During a review of Resident 37's Minimum Data Set (MDS, a resident assessment tool), dated 11/29/2024, the MDS indicated the resident had the ability to make self-understood and understand others and had moderate cognitive impairment (a stage of dementia where a person has clear signs of memory loss and difficulty completing tasks). The MDS indicated the resident was on a high-risk drug class antibiotic. During a review of Resident 37's Order Summary Report, dated 9/1/2023, the Order Summary Report indicated an order of methenamine hippurate oral tablet 1 gram (gm, a unit of weight). Give 1 tablet by mouth two times a day for UTI prophylaxis. The order summary did not indicate any monitoring for signs and symptoms of UTI. During a concurrent interview and record review on 2/12/2025 at 11 p.m., with the Infection Preventionist (IP), the IP stated methenamine hippurate oral tablet is not an antibiotic. The IP stated the medication was antibacterial (a substance that kills bacteria or stops them from growing and causing disease). The IP stated they did not do any monitoring for signs and symptoms of UTI and there was no end date on the use of this antibiotic as it was antibacterial. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/12/2025, at 12:51 p.m., with the Consultant Pharmacist (PHARM), the PHARM stated methenamine hippurate is an antibiotic. The PHARM stated there should be renal function (a term used to describe how well the kidneys work) monitoring at least yearly for residents without kidney issues and weekly to monthly monitoring for residents with compromised kidneys. The PHARM stated there should be monitoring for signs and symptoms of UTI to ensure the antibiotic is working as a prophylaxis to UTI. The PHARM stated the possible side effects of prolonged use of methenamine Hippurate are skin rash, nausea, vomiting etc. The PHARM stated the staff should have monitored for signs and symptoms of UTI and followed up with the physician regarding the prolonged use of the antibiotic to reduce the adverse effects related to prolonged use and to improve resident outcomes to treatment. During an interview on 2/13/2025 at 10:08 a.m., with the IP, the IP stated that her Director of Nursing (DON) and herself had spoken to the PHARM and they decided moving forward they will also screen residents on methenamine hippurate as a prophylaxis for UTI for antibiotic stewardship program (a healthcare initiative that aims to ensure antibiotics are used appropriately and only when necessary). The IP stated they will start monitoring for signs and symptoms of UTI when the resident is using them. The IP stated they will screen residents of methenamine hippurate for antibiotic appropriateness of use and if there's no monitoring for signs and symptoms of UTI, they will obtain a physician's order. The IP stated if urine culture (a lab test that checks for bacteria, yeast, or other germs in a urine sample) is done, they will relay the results to the doctor and ask the doctor if they still want the medication continued. If they do, they will prompt the doctor to do a note to explain its continued use. The IP stated it is important to screen Resident 37's use of antibiotic methenamine hippurate to ensure the resident does not develop antibiotic resistance (when bacteria change and are no longer killed by antibiotics). During an interview on 2/14/2025, at 1:08 p.m. with the DON, the DON stated the staff should have monitored for signs and symptoms of UTI on Resident 37 while using methenamine hippurate to know if the medication is effective or not. The DON stated if there was no order for monitoring the staff should have called the doctor for an order. The DON also stated the staff should have followed up with the doctor during the relay of the urine culture results if they wanted the medication continued or not since the resident had been taking them since 9/2023. During a review of the facility's recent policy and procedure (P&P) titled Antibiotic Stewardship, last reviewed on 6/27/2024, the P&P indicated the facility will implement an antibiotic stewardship program to promote appropriate use of antibiotics optimizing the treatment of infection, reducing the threat of antibiotic resistance, reducing adverse events associated with antibiotic use and improve outcomes for residents.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44376 Based on interview and record review, the facility failed to ensure five (5) of six (6) sampled residents (Resident 5, 7, 53, 55 and 71) drug regimen was free from unnecessary medications (any medication in excessive dose, excessive duration, without adequate monitoring) in accordance with the facility policy and procedure by failing to: 1. Limit the use of lorazepam (generic name for Ativan) as needed order to fourteen days or specify a duration or provide a stop date for Resident 71. 2. Limit the use of Ativan (a psychotropic medication used for anxiety [a feeling of fear, dread, and uneasiness]) as needed order to fourteen days or specify a duration or provide a stop date for Resident 5. 3. Provide non-pharmacological (that do not involve medications or drugs) interventions (therapies) for insomnia [difficulty sleeping]) with the use of trazodone (a psychotropic [any medication capable of affecting the mind, emotions, and behavior] used for insomnia) between 2/1/2025 and 2/11/2025 for Resident 7. 4. Provide non-pharmacological interventions for paranoia with the use of Haldol (a brand name for haloperidol [a psychotropic medication for used to treat disorders that cause difficulty in telling the difference between things or ideas that are real and not real]) between 2/1/2025 and 2/11/2025 for Resident 53. 5. Monitor for the number of occurrences of paranoia with the use of Haldol between 2/1/2025 and 2/12/2025 for Resident 53. 6. Monitor the hours of sleep with the use of trazodone between 2/1/2025 and 2/12/2025 for Resident 55. These deficient practices had the potential to place Resident 5, 7, 53, 55, and 71 at risk for significant adverse effects (unwanted, unpleasant results of a medication) from the use of unnecessary psychotropic drugs, resulting in the impairment or decline of residents' mental, physical condition, functional, and psychosocial status. Findings: a) During a review of Resident 71's Admission Record, the Admission Record indicated the facility admitted the resident on 10/12/2023, and readmitted the resident on 4/30/2024, with diagnoses including depression (a mental health condition that can cause persistent feelings of sadness, hopelessness, and loss of interest in activities), dementia (a progressive state of decline in mental abilities), and anxiety (a feeling of fear, dread, and uneasiness) disorder. (continued on next page)

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F 0758

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

During a review of Resident 71's Order Summary Report, dated 9/6/2024, the Order Summary Report indicated an order of Lorazepam Oral Concentrate 2 milligram per milliliter (mg/ml, a metric measure of weight per unit of volume) (Lorazepam). Give 0.5 ml (ml, a unit of weight) sublingually (something that exists or is placed underneath the tongue) every 2 hours as needed for anxiety monitor for behavior (m/b) hyperventilation (breathing too quickly and deeply) leading to shortness of breath (SOB) (0.5 ml= 1 mg).

During a review of Resident 71's MDS, dated [DATE], the MDS indicated the resident rarely to never had the ability to make self-understood and understand others and had severely impaired cognitive skills (problems with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS indicated the resident was on high-risk drug class antianxiety (a drug or intervention that helps relieve anxiety) and antidepressant (prescription medicines to treat depression) medications.

During a review of Resident 71's History and Physical (H&P), dated 1/26/2025, the H&P indicated the resident can make needs known but cannot make medical decisions.

During a concurrent interview and record review on 2/12/2025, at 12:31 p.m., with RN 3, Resident 71's Order Summary Report was reviewed. RN 3 stated there was an order for Lorazepam Oral Concentrate 2 mg/ml (Lorazepam). Give 0.5 ml sublingually every 2 hours as needed for anxiety m/b hyperventilation leading to SOB (0.5 ml= 1 mg) on 9/6/2024 and there was no stop date after 14 days because the resident was on hospice (a program that gives special care to people who are near the end of life and have stopped treatment to cure or control their disease). RN 3 stated there should be a stop date on psychotropic medications to ensure the residents were not getting unnecessary medications. RN 3 stated licensed nurses are responsible to make sure if needed (PRN) psychotropic medications have 14 days stop date.

43455

b) A review of Resident 5's Admission Record dated 2/11/2025, indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with a diagnosis including hemiplegia (partial or complete paralysis on one side of the body) and hemiparesis (partial paralysis or weakness on one side of the body,) bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration, making it difficult to carry out day-to-day tasks,) depression (a health condition that causes constant feeling of sadness and loss of interest in activities that one would normally enjoy,) and anxiety.

A review of Resident 5's Minimum Data Set ([MDS] - a resident assessment tool) dated 12/9/2024, indicated the resident was cognitively intact.

During a review of Resident 5's Order Summary Report, dated 2/12/2025, the report indicated Resident 5 was prescribed Ativan 0.5 milligram ([mg] - a unit of measure of mass) to give one (1) tablet by mouth every eight (8) hours a needed for anxiety manifested verbalization of being anxious, starting 10/15/2023. The physician order did not indicate the specific duration of use for the Ativan order.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 5's Medication Administration Record ([MAR] - a record of medication and therapies administered to residents,) for February 2025, the MAR indicated the resident received Ativan 0.5 mg orally eight (8) times between 2/2/2025 and 2/9/2025. The MAR indicated the Ativan as needed order did not have a specific duration or stop date. During a review of Resident 5's clinical record it indicated that the facility did not indicate a specific duration or stop date for the Ativan as needed order. c) During a review of Resident 7's Admission Record dated 2/12/2025, the Admission Record indicated Resident 7 was originally admitted to the facility on [DATE] with diagnosis including depression (a health condition that causes constant feeling of sadness and loss of interest in activities that one would normally enjoy,) and insomnia. During a review of Resident 7's Order Summary Report, dated 2/12/2025, the report indicated Resident 7 was prescribed trazodone 50 mg to give one (1) tablet by mouth at bedtime for depression manifested by inability to sleep, starting 1/15/2025. During a review of Resident 7's MDS dated [DATE], indicated the resident had mild cognitive impairment and had trouble falling or staying asleep or sleeping too much. During a review of Resident 7's Care Plan, initiated 1/17/2025, the Care Plan indicated that the resident uses trazodone for depression manifested by inability to sleep. Provide non-pharmacological interventions such as: therapeutic interventions; environmental/equipment interventions; environmental changes or modifications (reducing light & noise); positive staff interactions, distraction, positioning, music therapy, praise for positive attitude, activity program or other alternative. During a review of Resident 7's MAR for February 2025, the MAR indicated Resident 7 was prescribed trazodone 50 mg to give one (1) tablet by mouth at bedtime for depression manifested by inability to sleep, at 9 p.m. The MAR did not contain documentation for non-pharmacological interventions provided for inability to sleep between 2/1/2025 and 2/11/2025. d) During a review of Resident 53's admitted d 2/12/2025, the Admission Record indicated Resident 53 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including schizoaffective disorder (a mental health problem with psychosis and mood symptoms,) depression and anxiety. During a review of Resident 53's Care Plan, initiated 1/2/2025, the Care Plan indicated that the resident uses Haldol related to behavior management, disease process, paranoia manifested by that people are out to get her. Provide non-pharmacological interventions such as: therapeutic interventions; environmental/equipment interventions; environmental changes or modifications (reducing light & noise); positive staff interactions, distraction, positioning, music therapy, praise for positive attitude, activity program or other alternative. During a review of Resident 53's MDS dated [DATE], indicated the resident was cognitively intact, and had verbal behavioral symptoms directed towards others. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 53's Order Summary Report, dated 2/12/2025, the report indicated Resident 53 was prescribed haloperidol 5 mg to give one (1) tablet by mouth every 12 hours for schizophrenia manifested by verbal outbursts and paranoid thoughts, starting 1/24/2025. During a review of Resident 53's MAR for February 2025, the MAR indicated Resident 53 was prescribed haloperidol 5 mg to give one tablet by mouth every 12 hours for schizophrenia manifested by verbal outbursts and paranoid thoughts, at 9 a.m. and 9 p.m., and to monitor episodes of schizophrenia manifested by verbal outburst and paranoid thoughts every shift tally by number of episodes. The February 2025 MAR did not contain documentation for non-pharmacological interventions provided and the tally of number of episodes for verbal outbursts and paranoid thoughts between 2/1/2025 and 2/11/2025. e) During a review of Resident 55's Admission Record, the Admission Record indicated Resident 55 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including depression and anxiety. During a review of Resident 55's Care Plan, initiated 7/2/2024, the Care Plan indicated that the resident uses trazodone related to depression manifested by inability to sleep. The Care Plan did not indicate a goal for the hours of sleep per night and did not indicate to monitor the hours of sleep per night. During a review of Resident 55's Order Summary Report, the report indicated Resident 55 was prescribed trazodone 50 mg to give 0.5 tablet = 25 mg by mouth at bedtime for major depressive disorder manifested by inability to sleep, starting 7/2/2024. During a review of Resident 55's MDS dated [DATE], indicated the resident was cognitively intact or mildly impaired, and was fell ing down, depressed or hopeless. During a review of Resident 55's MAR for February 2025, the MAR indicated Resident 55 was prescribed trazodone 50 mg to give 0.5 tablet = 25 mg by mouth at bedtime for major depressive disorder manifested by inability to sleep, starting 7/2/2024. The MAR did not contain documentation for the hours of sleep per night between 1/1/2025 and 1/30/2025. During a concurrent record review and interview on 2/12/2025 at 10:40 a.m., with Registered Nurse (RN) 1, RN 1 reviewed Resident 7's Care Plan dated 1/17/2025 and February 2025 MAR, and Resident 53's Care plan dated 1/2/2025 and February 2025 MAR. RN 1 stated the Care Plan indicated Resident 7 uses trazodone for depression manifested by inability to sleep, and to provide non-pharmacological interventions. RN 1 stated the Care Plan indicated Resident 53 uses Haldol related to behavior management, disease process, paranoia manifested by that people are out to get her and to provide non-pharmacological interventions. RN 1 stated non-pharmacological interventions would be documented on the MAR. RN 1 stated the February 2025 MARs did not include documentation for non-pharmacological interventions indicating non-pharmacological interventions were not provided as outlined in the Care Plan for Residents 7 and 53. RN 1 stated the February 2025 MAR for Resident 53 did not contain documentation for the tally of number of episodes for verbal outburst and paranoid thoughts. RN 1 stated without providing non-pharmacological interventions no one would know if they would be effective in reducing episodes of inability to sleep and that trazodone may be used unnecessarily for Resident 7. RN 1 stated without documenting number of episodes no one would know if the Haldol was effective in reducing episodes of paranoia and that Haldol may be used unnecessarily for Resident 53. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent record review and interview on 2/12/2025 at 12:11 p.m., with RN 1, RN 1 reviewed Resident 55's February 2025 MAR and stated Resident 55 was prescribed trazodone for major depressive disorder manifested by inability to sleep. RN 1 stated RN 1 was unable to locate documentation for monitoring the number of hours of sleep for Resident 55 between 2/1/2025 and 2/11/2025. RN 1 stated without monitoring hours of sleep it was unknown if trazodone was effective in reducing episodes of inability to sleep, therefore preventing the ability make changes to the medication such as lowering the dose or discontinuing, potentially leading to the use of unnecessary psychotropic medication for Resident 55. RN 1 stated the facility failed to monitor hours of sleep for Resident 55. During an interview on 2/12/2025 at 12:30 p.m., with Licensed Vocational Nurse (LVN) 4, LVN 4 stated residents on medications for inability to sleep should be monitored for hours of sleep and have documentation for the hours of sleep for each night/evening. During a concurrent record review and interview on 2/12/2025 at 12:47 p.m., with the Director of Nursing (DON,) the DON stated that Resident 7's Care Plan dated 1/17/2025 indicated the resident uses trazodone for depression manifested by inability to sleep and to provide non-pharmacological interventions, and Resident 53's Care Plan dated 1/2/2025 indicated the resident uses Haldol for paranoia manifested by thinking that people are out to get her and to provide non-pharmacological interventions. The DON stated Resident 7's and 53's Care Plan were not implemented, and the DON was unable to locate documentation for providing non-pharmacological interventions for inability to sleep and for paranoia in the MAR between 2/1/2025 and 2/11/2025. The DON stated the DON was not able to locate documentation for the tally of number of episodes of verbal outburst and paranoid thoughts for Resident 53. The DON stated the facility failed to implement the Care Plans to accurately reflect the needs of Residents 7 and 53 and ensure to maintain the highest level of functionality and quality of life and limit the use of unnecessary psychotropic medications. The DON stated that the Care Plans and MAR documentation will be immediately implemented for Resident 7 and 53. During an interview on 2/13/2025 at 12:23 p.m., with LVN 6, LVN 6 confirmed that LVN 6 was unable to locate a specific duration or stop date for the Ativan as needed order in the clinical record for Resident 5. LVN 6 stated that per facility policy psychotropic medications used for as needed basis needed to have a stop date of 14 days or a specific duration if needed longer, to ensure that the medications were not causing more harm than good. LVN 6 stated that the licensed staff failed to include the duration for the Ativan as needed order for Resident 5. During a concurrent record review and interview on 2/13/2025 at 12:47 p.m., with the DON, the DON stated that it was important to have a stop date and specific duration for psychotropic medications to ensure they do not cause significant adverse effects that can diminish a resident's quality of life such as drowsiness and dizziness. The DON stated that the facility failed to add a stop date or duration to Resident 5's Ativan as needed order. The DON stated the DON will call the physician to obtain a stop date for the Ativan order for Resident 5. During the same interview, the DON stated that Resident 55's Care Plan dated 7/2/2024 indicated the resident uses trazodone related to depression manifested by inability to sleep. The DON stated the Care Plan did not indicate a goal for the hours of sleep per night and did not indicate to monitor the hours of sleep per night with the use of trazodone. The DON stated it was important to identify measurable goals with the use of psychotropic medications to provide person-centered care and identify when to taper the medication, while maintaining the highest level of functionality and quality of life to Resident 55. The DON stated the facility failed to monitor hours of sleep per night for Resident 55 leading to the potential unnecessary use of trazodone. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Santa Clarita Post-Acute Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 23801 Newhall Avenue Newhall, CA 91321	

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/14/2025, at 1:09 p.m., with the DON, the DON stated there should be a 14 day stop date on the use of lorazepam PRN to ensure the resident was not taking any unnecessary medications and to ensure the physicians are evaluating its use to avoid the adverse reactions of the medications. During a review of the facility's recent policy and procedure (P&P) titled Psychotropic/Antipsychotic Medication Use/PRN, last reviewed on 6/27/2024, the P&P indicated Psychotropic/Antipsychotic medications will be prescribed at the lowest possible dosage for the shortest period of time and are subject to gradual dose reduction and re-review. 14. The need to continue PRN orders for psychotropic medications beyond 14 days requires that the practitioner document the rationale for the extended order. The duration of the PRN order will be indicated in the order. 15. PRN orders for antipsychotic medications will not be renewed beyond 14 days or given routinely unless the healthcare practitioner has evaluated the resident for the appropriateness of that medication. During a review of the facility's P&P titled Psychotropic/Antipsychotic Medications and Gradual Drug Dose Reduction, last reviewed on 6/27/2024, the P&P indicated After psychotropic medications are ordered for a resident, the staff and practitioner shall seek an appropriate dose and duration for each medication that also minimizes the risk of adverse consequences. 2. The Attending physician and staff will identify target symptoms for which a resident is receiving various mediations. The staff will monitor for improvement in those target symptoms and provide the physician with that information. 4. The staff and practitioner will consider tapering .when: c. Non-pharmacological interventions .have been effective in reducing symptoms. During a review of the facility's P&P titled Behavioral Assessment, Management, Psychoactive Medications and Monitoring, last reviewed on 6/27/2024, the P&P indicated: 7. Interventions will be individualized and part of an overall care environment that supports, physical, functional and psychosocial needs. 8. Non-pharmacological approaches will be utilized .to avoid or reduce the use of antipsychotic medications to manage behavioral symptoms.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43455 Based on observation, interview, and record review, the facility failed to ensure that its medication error rate was less than five (5) percent (%). Two (2) medication errors out of 29 total opportunities contributed to an overall medication error rate of 6.9% affecting one (1) of three (3) residents observed for medication administration (Resident 196.) The medication errors were as follows: 1. Resident 196 received metoprolol (a medication used to for hypertension [HTN - a condition in which the blood vessels have persistently raised pressure]) and aspirin (a medication used to prevent cerebrovascular accident [CVA] - stroke] from having atrial fibrillation [irregular, fast heart rate]), at a different time than ordered by Resident 196's physician. These failures had the potential to result in Resident 196 to experience medication adverse effects (unwanted, uncomfortable, or dangerous effects that a medication may have) and the potential to result in Residents 196's health and well-being to be negatively impacted. Findings: During an observation on 2/11/2025 at 9:39 a.m., of Medication Cart 2, Licensed Vocational Nurse 5 (LVN 5) was observed administering aspirin 81 milligram ([mg]-a unit of measure of mass) chewable tablet and metoprolol 12.5 mg tablet to Resident 196. Resident 196 was observed swallowing the aspirin tablet with a glass of water. During an interview on 2/11/2025 at 1:20 p.m., with LVN 5, LVN 5 stated that LVN 5 administered aspirin 81 mg chewable tablet and metoprolol 12.5 mg tablet during the morning medication administration at 9:39 a.m. to Resident 196. LVN 5 acknowledged the physician's order specified to administer aspirin and metoprolol at 7:30 a.m. with food. LVN 5 stated, per facility policy, there was a 60-minute window for medication administration and LVN 5 administered the aspirin and metoprolol later than that timeframe. LVN 5 stated these were considered medication errors, and that there was a risk of stomach irritation to Resident 196 when not given with food at 7:30 a.m. During an interview on 2/13/2025 12:47 p.m., with the Director of Nursing (DON), the DON stated that LVN 5 failed to administer aspirin 81 mg and metoprolol 12.5 mg tablets to Resident 196 according to physician orders at 7:30 a.m. with food on 2/11/2025. The DON stated these were considered medication errors. The DON stated that licensed nurses should follow facility medication administration guidelines to ensure physician orders are followed and the medications are administered at the right time to residents. The DON stated Resident 196 may be at risk for developing stomach irritation from receiving aspirin 81 mg and metoprolol 12.5 mg tablet at 9:39 a.m. without a meal. During a review of Resident 196's Admission Record (a document containing demographic and diagnostic information,) dated 2/11/2025, the Admission Record indicated the resident was originally admitted to the facility on [DATE] with diagnoses including hypertension and atrial fibrillation. During a review of Resident 196's Order Summary Report, dated 2/11/2025, the Order Summary Report indicated Resident 196 was prescribed aspirin 81 mg twice a a day for CVA prophylaxis ([PPX] - prevention) give with food and metoprolol 12.5 mg twice a day for HTN give with food, starting 2/1/2025. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 196's Medication Administration Record ([MAR] - a record of mediations administered to residents), for February 2025, the MAR indicated Resident 196 was prescribed aspirin 81 mg to be given twice a day orally for CVA PPX give with food at 7:30 a.m. and 5 p.m., and metoprolol 12.5 mg to be given twice a day orally for HTN give with food at 7:30 a.m. and 5 p.m. During a review of the facility's policy and procedures (P&P), titled Administering Medications, last reviewed 6/27/2024, the P&P indicated Medications shall be administered in a safe and timely manner, and as prescribed. - Medications must be administered in accordance with the orders, including any required time frame. - Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). - The individual administering the medication must check the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. During a review of the facility's P&P, titled Medication Errors, last reviewed 6/27/2024, the P&P indicated: - An 'adverse consequence' is defined as an unpleasant symptom or event that is due to or associated with a medication, such as an impairment or decline in an individual's mental or physical condition or functional or psychosocial status. An adverse consequence may include: adverse drug/medication reaction; side effect An adverse drug reaction (ADR), a form of adverse consequence, is defined as a secondary and usually undesirable effect of a drug and is different from the therapeutic and helpful effects of the drug. An ADR is any noxious and unintended response to a drug and occurs in doses for prophylaxis, diagnosis or therapy. - The staff and practitioner shall strive to minimize adverse consequences by: o Following relevant clinical guideline and manufacturer's specifications for use, dose, administration, duration, and monitoring of the medication. - A medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders. Examples of medication errors include: o wrong time.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. 43988 Based on interview and record review, the facility failed to ensure residents were free of any significant medication errors (means the observed or identified preparation or administration of medications or biologicals which is not in accordance with the prescriber's order, manufacturer's specifications, and accepted professional standards): 1. For one (1) out of one sampled resident (Resident 73) reviewed for insulin (a hormone that lowers the level of glucose [a type of sugar] in the blood) care area by failing to rotate (a method to ensure repeated injections are not administered in the same area) the subcutaneous (beneath the skin) insulin administration sites. 2. For 1 of five (5) sampled residents (Resident 63) reviewed under unnecessary medications by failing to rotate (a method to ensure repeated injections are not administered in the same area) subcutaneous (beneath the skin) insulin medications (a hormone that lowers the level of glucose [a type of sugar] in the blood) administration sites. These deficient practices had the potential for adverse effect (unwanted, unintended result) of same site subcutaneous administration of insulin such as excessive bruising, lipodystrophy (abnormal distribution of fat) and cutaneous amyloidosis (is a condition in which clumps of abnormal proteins called amyloids build up in the skin). Findings: a. During a review of Resident 73's Admission Record, the Admission Record indicated the facility originally admitted the resident on 11/23/2023 and readmitted the resident in the facility on 8/14/2024, with diagnoses including type 2 diabetes mellitus (a chronic disease that occurs when the body does not produce enough insulin or does not use it properly) without complications, congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), and unsteadiness on feet. During a review of Resident 73's Minimum Data Set (MDS, a resident assessment tool), dated 11/28/2024, the MDS indicated the resident had an intact cognition (having the ability to think, learn, and remember clearly). The MDS indicated Resident 73 required set up or clean-up assistance with eating and oral hygiene; partial/moderate assistance with upper body dressing; substantial/maximal assistance with personal hygiene and bed mobility; total assistance with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 73had a diagnosis of DM 2 and received insulin. During a review of Resident 73's History and Physical (H&P) dated 5/22/2024, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 73's Order Summary Report, the Order Summary Report indicated the following physician's orders: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 5/21/2024 to 1/17/2025: Insulin Lispro Injection Solution (a short-acting insulin) 100 unit per milliliter (unit/ml - a unit of measurement). Inject as per sliding scale (increasing administration of the pre?meal insulin dose based on the blood sugar level before the meal): if 0 - 149 = 0 units;150 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; 401 or more = 12 units. If blood sugar (BS) is above 400, give the dose and call provider., subcutaneously before meals and at bedtime for DM 2. Notify physician (MD) if BS less than (< - a unit of measurement) 80. Rotate site. - 1/17/2025: Insulin Lispro Injection Solution 100 unit/ml. Inject as per sliding scale: if 0 - 149 = 0 units;150 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; 401 or more = 12 units. If BS is above 400, give the dose and call provider., subcutaneously before meals and at bedtime for DM 2. Rotate site, notify MD if BS < 80. Give within 15 minutes prior to a meal or immediately after a meal. - 12/15/2024 to 12/23/2024: Lantus subcutaneous solution (a long-acting insulin) 100 unit/ml (insulin glargine). Inject ten (10) units subcutaneously at bedtime related to DM 2. Rotate site. - 12/23/2024 to 2/11/2025: Lantus subcutaneous solution 100 unit/ml (insulin glargine). Inject 12 units subcutaneously at bedtime related to DM 2. Rotate sites. - 2/11/2025: Lantus Subcutaneous Solution 100 unit/ml (insulin glargine). Inject 12 units subcutaneously at bedtime related to DM 2. Rotate site. Hold for BS < 80. During a concurrent interview and record review on 2/13/2025 at 11:45 a.m., reviewed Resident 73's Order Summary Report, Medication Administration Record (MAR - a daily documentation records used by a licensed nurse to document medications and treatments given to a resident) Location of Administration Report from 11/2024 to 1/2025 with Minimum Data Set Nurse 1 (MDSN 1), MDSN 1 verified Resident 73 had a physician's order for Lantus and insulin lispro and were administered as follows: - Lantus subcutaneous solution 100 unit/ml: 12/22/24 8:24 p.m. subcutaneously Abdomen - right lower quadrant (RLQ) 12/23/24 8:07 p.m. subcutaneously Abdomen - RLQ 1/10/25 8:56 p.m. subcutaneously Abdomen - right upper quadrant (RUQ) 1/11/25 8:10 p.m. subcutaneously Abdomen - RUQ - Insulin lispro injection solution 100 unit/ml: 11/16/24 6:01 a.m. subcutaneously Abdomen - left upper quadrant (LUQ) 11/16/24 12:29 p.m. subcutaneously Abdomen - LUQ 12/06/24 4:58 p.m. subcutaneously Abdomen - left lower quadrant (LLQ) 12/07/24 5:14 p.m. subcutaneously Abdomen - LLQ (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	MDSN 1 stated insulin administration sites should be rotated per standards of practice, manufacturer's guidelines, and according to physician's orders. MDSN 1 stated Resident 73's MAR indicated the insulin administration sites were not rotated and that there was a physician's order to rotate injection sites. MDSN 1 stated Resident 73' insulin administration sites should have been rotated as ordered by the physician to prevent pain, redness, irritation, bruising, lipodystrophy, and denting of the resident's skin. MDSN 1 stated not following manufacturer's guidelines, physician's orders, and standards of practice can be considered a medication error. During an interview on 2/13/2025, at 12:00 p.m. with the Director of Nursing (DON), the DON stated the administration sites of insulin should be rotated as indicated in the manufacturer's guideline, according to MD orders, and standards of practice. The DON stated the licensed staff can see in the MAR the previous administration sites for the insulin and there was a physician's order to rotate administration sites. The DON stated Resident 73's insulin administration sites should have been rotated per MD order, manufacturer's guideline and standards of practice to prevent complications such as bruising, pain, redness, and lipodystrophy on the administration site. The DON stated not following manufacturer's guidelines, physician's orders, and standards of practice can be considered a medication error. During a review of the facility provided manufacturer's guideline for Lantus, undated, the manufacturer's guideline indicated: - Always rotate your injection sites as instructed by the doctor. - Choose and injection site. The three possible injection sites are the abdomen, thighs, and upper arms. These areas have more fat and fewer nerve endings and may feel less discomfort in these areas. - Choose a new injection spot each time. - Change (rotate) the injection sites within the area with each dose to reduce the risk of getting lipodystrophy (pitted or thickened skin) and localized cutaneous amyloidosis (skin with lumps) at the injection sites. Do not use the same spot for each injection or inject where the skin is pitted, thickened, lumpy, tender, bruised, scaly, hard, scarred or damaged. During a review of the facility provided manufacturer's guideline on insulin lispro, undated, the manufacturer's guideline indicated: - The type of insulin, dosage requirements, strength, and method of administration must be verified before administration, to assure that it corresponds with the order on the medication sheet and the physician's order. - The nursing staff will have access to specific instructions (from the manufacturer if appropriate_ on all forms of insulin delivery system prior to their use. - Select an injection site: a. Insulin may be injected into the SQ tissue of the upper arm, and the anterior or lateral areas of the thighs and abdomen. avoid the area approximately 2 inches around the navel area. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm). During a review of the facility's P&P titled, Medication Errors, last reviewed on 6/27/2024, the P&P indicated: - A medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's order, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services. - Failure to follow manufacturer instructions and/or accepted professional standards. 44376 b. During a review of Resident 63's Admission Record, the Admission Record indicated the facility admitted the resident on 12/28/2023, and readmitted the resident on 6/17/2024, with diagnoses including type 2 diabetes mellitus (a disease that occurs when your blood glucose, also called blood sugar, is too high), dementia (a progressive state of decline in mental abilities), and Alzheimer's disease (a disease characterized by a progressive decline in mental abilities). During a review of Resident 63's History and Physical (H&P), dated 6/18/2024, the H&P indicated the resident can make needs known but cannot make medical decisions. During a review of Resident 63's Minimum Data Set (MDS, a resident assessment tool), dated 11/13/2024, the MDS indicated the resident rarely to never had the ability to make self-understood and sometimes had the ability to understand others. The MDS indicated the resident had highly impaired vision and was on a high-risk drug class hypoglycemic medication (drugs that lower blood sugar levels) insulin. During a review of Resident 63's Order Summary Report, the Order Summary Report indicated an order for: 8/19/2024 Insulin Glargine-yfgn Subcutaneous Solution Pen-Injector 100 unit per milliliter (unit/ml, one unit of insulin equals 0.01 ml) (Insulin Glargine-yfgn). Inject 25 unit subcutaneously at bedtime for diabetes mellitus (DM). 1/17/2025 Insulin Lispro Injection Solution (Insulin Lispro). Inject 4 unit subcutaneously before meals related to type 2 diabetes mellitus with unspecified complications (Hold for blood sugar [BS] less than [<] 110 milligrams per deciliter [mg/dl, a unit of measurement used to report the concentration of a substance in a fluid]; rotate site). Give within 15 mins. prior to a meal or immediately after a meal. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1/17/2025 Insulin Lispro Injection Solution 100 unit/ml (Insulin Lispro). Inject as per sliding scale (the increasing administration of the pre?meal insulin dose based on the blood sugar level before the meal): if 0 - 149 = 0 units; 150 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; 401+ = 12 units. If blood glucose (BG) above 400 give dose and call provider., subcutaneously before meals related to type 2 diabetes mellitus with unspecified complications. Rotate site. Notify MD for BS <80 and start if needed (PRN) hypoglycemia (low blood sugar) interventions. Give within 15 mins. prior to a meal or immediately after a meal. During a review of Resident 63's Care Plan (CP) titled The resident has Diabetes Mellitus, last revised on 2/16/2024, the CP indicated an intervention of insulin Lispro Injection Solution (Insulin Lispro). Inject 4 unit subcutaneously before meals related to type 2 diabetes mellitus with unspecified complications. Hold for BS <110 mg/dl; rotate site). During a review of Resident 63's Location of Administration Report of Insulin for 11/2024 to 1/2025, the Location of Administration Report for Insulin indicated Insulin Lispro Injection Solution 100 unit/ml was administered subcutaneously on: 11/05/2024 at 11:36 a.m. on the Abdomen - (Left Lower Quadrant (LLQ) 11/06/2024 at 11:59 a.m. on the Abdomen - LLQ 12/21/2024 at 11:47 a.m. on the Abdomen - Right Lower Quadrant (RLQ) 12/22/2024 at 12:11 p.m. on the Abdomen - RLQ 01/21/2025 at 12:02 p.m. on the Abdomen - Left Upper Quadrant (LUQ) 01/22/2025 at 11:43 a.m. on the Abdomen - LUQ During a concurrent interview and record review on 2/12/2025, at 11:21 a.m., with Registered Nurse 2 (RN 2), reviewed Resident 63's Order Summary Report, Location of Administration for Insulin, and Care Plan. RN 2 stated there were multiple instances that the licensed staff did not rotate the insulin administration sites of Resident 63. RN 2 stated the staff should have rotated the insulin administration sites of Resident 63 to prevent bruising and lipodystrophy. RN 2 stated not rotating insulin administration sites is a medication error. During an interview on 2/14/2025, at 12:52 p.m., with the Director of Nursing (DON), the DON stated the licensed staff should have rotated the insulin administration sites of Resident 63 to prevent skin irritation, lipodystrophy, and cutaneous amyloidosis on Resident 63. The DON added the licensed staff should check on Point Click Care (PCC, a cloud-based software platform that helps long-term care providers manage patient records, care planning, and medication) of where the last administration of insulin before administering the medication to prevent repetition of administration sites. The DON stated not rotating insulin administration sites is considered as a medication error. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's recent policy and procedure (P&P) titled Medication Errors, last reviewed on 6/27/2024, the P&P indicated a medication error is defined as the preparation or administration of drugs or biological which is not in accordance with the physician's orders, manufacturer's specifications, or accepted professional standards and principles of the professional(s) providing services. During a review of the facility's recent policy and procedure (P&P) titled Insulin Administration, last reviewed on 6/27/2024, the P&P indicated to select an injection site. a. Insulin may be injected into the subcutaneous tissue of the upper arm, and the anterior or lateral areas of the thighs and abdomen. Avoid the area approximately 2 inches around the navel. b. Injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm). During a review of the facility-provided Instructions for Use of Insulin Lispro Kwikpen injection, for subcutaneous use 3 ml single-patient use pen (100 units per mL), undated, the instruction indicated to change (rotate) your injection sites within the area you choose for each dose to reduce your risk of getting lipodystrophy (pits in skin or thickened skin) and localized cutaneous amyloidosis (skin with lumps) at the injection sites.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055728	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/14/2025
NAME OF PROVIDER OR SUPPLIER: Santa Clarita Post-Acute Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 23801 Newhall Avenue, Newhall, CA 91321	

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44244 Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices in the kitchen reviewed during the kitchen facility task by failing to: 1. Ensure food items in the walk-in refrigerator were labeled according to facility policy. 2. Ensure used cloths and towels were stored per facility policy. 3. Ensure the walk-in freezer temperature was maintained per facility policy and procedure. These deficient practices had the potential to result in harmful bacterial growth and cross contamination (the process by which bacteria or other microorganisms are unintentionally transferred from one substance or object to another, with harmful effect) that could lead to foodborne illness (a disease caused by consuming food or drinks that are contaminated by germs or chemicals) in 89 of 93 medically compromised residents who received food from the kitchen. Findings: a. During an initial kitchen observation tour on [DATE] at 7:50 a.m., observed the walk-in refrigerator with the Dietary Supervisor (DS). In the walk-in refrigerator, the DS stated there was a tray containing various food items that would be served to residents that day. The DS stated the facility process is all items that are removed from the original packaging are labeled with the item contents, the date prepared, and the date of expiration. The DS stated foods are labeled in order to ensure that staff knows exactly what they are serving to residents and to ensure expired foods are not served. The DS noted the following on the tray: - There was an unlabeled white bag that the DS stated contained a cookie. The DS stated the bag should have been labeled with the type of cookie, the date prepared, and the date of expiration, but it was not. The DS stated it was important for staff to know the type of cookie to prevent any residents from receiving a food that may cause an allergic reaction. - There was an unlabeled small bowl of grapes. The DS stated the bowl should have been labeled with the date of preparation and the dated of expiration, but it was not. During a concurrent interview and record review on [DATE] at 2:23 p.m., the DS reviewed the facility policy and procedure (P&P) regarding food storage and labeling. The DS stated the kitchen staff did not follow the facility policy when they did not label the cookie and the bowl of grapes. The DS stated the food items would be discarded. During an interview on [DATE] at 10 a.m., with the Director of Nursing (DON), the DON stated every food item removed from its original packaging should be labeled to ensure resident were served items that were fresh and maintained their nutritional value, did not pose a risk for food borne illness, and would not cause an allergic reaction in the resident. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility P&P titled, Refrigerators and Freezers, last reviewed [DATE], the P&P indicated the facility will ensure safe refrigerator and freezer maintenance, temperatures, and sanitation, and will observe food expiration guidelines. All food should be appropriately dated to ensure proper rotation by expiration dates. Received dates (date of delivery) will be marked on cases and on individual items removed from cases for storage. Use by dates will be completed with expiration dates on all prepared food in refrigerators. Expiration dates on unopened food will be observed and Use by dates indicated once food is opened. During a review of the facility P&P titled, Storage and Food Supplies, last reviewed [DATE], the P&P indicated food, and supplies will be stored properly and in a safe manner. Labels should be visible, and the arrangement should permit rotation of supplies so that oldest items will be used first. All food will be dated - month, day, year. During a review of the facility procedure titled, Procedure for Refrigerated Storage, last reviewed [DATE], the procedure indicated prepared perishables such as desserts should be stored in the refrigerator. Food items should be arranged so that older items will be used first. Leftovers will be covered, labeled, and dated. Individual packages of refrigerated food taken from the original packing box, need to be labeled and dated. During a review of the undated facility-provided guide titled, Refrigerated Storage Guide, the guide indicated the maximum refrigeration time for prepared desserts was three days. During a review of the undated facility-provided guideline titled, Produce Storage Guidelines, the guideline indicated to refrigerate grapes for five to seven days. b. During an initial kitchen observation tour on [DATE] at 7:50 a.m., with the DS, the DS stated the facility used white towels with sanitizer to disinfect kitchen surfaces. The DS stated clean dry towels are stored away from the kitchen area and when towels are in use they are stored in the red sanitization bucket under the sink. In the kitchen prep area, the DS noted there were two dry white towels placed on top of the meat slicer. The DS stated one of the towels had a dry brown substance on it and it appeared to be used. The DS stated the towels should not have been left on the meat slicer because there was a risk of contaminating the slicer with whatever was on the towels. The DS stated a contaminated slicer may cause illness in residents when it is used to prepare food for meals. During a concurrent interview and record review on [DATE] at 2:23 p.m., the DS reviewed the facility P&P regarding kitchen sanitization and stated the policy was not followed when staff left the towels on the meat slicer. During an interview on [DATE] at 10 a.m., with the DON, the DON stated towels in the kitchen that were not stored in the proper manner was an infection control issue. The DON stated dirty towels placed on the meat slicer may cause cross contamination (the process by which bacteria or other microorganisms are unintentionally transferred from one substance or object to another, with harmful effect) from the towels to the resident's food and cause illness in residents. During a review of the facility P&P titled, Sanitation, last reviewed [DATE], the P&P indicated the food service area shall be maintained in a clean and sanitary manner. Between uses, cloths and towels used to wipe kitchen surfaces will be soaked in containers filled with approved sanitizing solution. Washed / Unused cleaning / sanitizing cloths and towels will be stored in designated area. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. During a follow-up kitchen observation tour on [DATE] at 11:55 a.m., observed the walk-in freezer with the DS. The DS stated the freezer was old, but it still was in working condition. The DS stated the freezer temperature should be maintained to keep items from thawing and refreezing to ensure the quality of the food is maintained. The DS stated the walk-in freezer stored frozen meat. The DS opened the freezer door and noted there was a build up of ice around the gasket of the freezer door and there was a build-up of ice on the ceiling of the freezer. The DS stated the build up of ice was not normal and should have been reported by kitchen staff, but he was not made aware of any issues. The DS stated the build-up of ice indicated the freezer temperature was not always maintained because there was condensation and moisture that dripped and then froze on the ceiling. The DS stated the door to the freezer was difficult to close and may have been left open causing the thawing and ice buildup. During a concurrent interview and record review on [DATE] at 10:24 a.m., the DS reviewed the facility P&P regarding the kitchen freezer. The DS stated the facility policy was not followed when the freezer temperature was not maintained and could have potentially resulted in affecting the quality of meat served to residents. The DS stated the freezer should not have signs of defrosting, but it did. During a review of the facility P&P titled, Refrigerators and Freezers, last reviewed [DATE], the P&P indicated the facility will ensure safe refrigerator and freezer maintenance, temperatures, and sanitation, and will observe food expiration guidelines. Acceptable temperatures for freezers is less than zero degrees for freezers. During a review of the facility P&P titled, Freezer Storage, last reviewed [DATE], the P&P indicated the freezer should be maintained at a temperature of zero degrees or lower. Freezer doors are to close tightly and should be opened as little as possible to prevent storage temperature fluctuations.

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F 0814

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Dispose of garbage and refuse properly.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 44244

Based on observation, interview, and record review, the facility failed to dispose of garbage and refuse properly reviewed during the kitchen facility task by failing to ensure the surrounding area of the dumpster (large trash container designed to be emptied into a truck) did not have three tied clear bags of trash and one open trash bag containing items including disposable gloves, dirty rags, a Styrofoam (brand of plastic) cup, and a food wrapper.

This failure had a potential to attract birds, flies, insects, and rodents resulting in the transmission and spread of infection to 89 of 93 facility residents.

Findings:

During an observation on 2/11/2025 at 3:16 p.m., observed multiple large dumpsters outside the facility at the end of the parking lot. Observed on the ground behind the dumpsters an open trash bag containing items including disposable gloves, dirty rags, a Styrofoam cup, and a food wrapper. No staff were present.

During a follow-up observation on 2/12/2025 at 7:45 a.m., observed on the ground behind the dumpsters an open trash bag containing items including disposable gloves, dirty rags, a Styrofoam cup, and a food wrapper. Observed three bags of trash placed on the wall next to the dumpster. No staff were present.

During a concurrent observation and interview on 2/12/2025 at 7:50 a.m., with Janitor 1 ([NAME] 1), [NAME] 1 stated the three bags of trash were placed on the wall outside the dumpsters because the dumpsters were full. Observed inside the dumpsters and the dumpsters were empty. [NAME] 1 stated the trash was picked up at 6 a.m. and the bags of trash should have been placed inside the dumpsters. [NAME] 1 stated he did not previously see the open trash bag behind the dumpsters, but it should not be there. [NAME] 1 stated any staff that brings trash to the dumpster area should look around and place all trash in the surrounding area into the dumpster, but they did not do that. [NAME] 1 stated when trash is left outside the dumpsters there was the potential that it would cause contamination issues and attract pests.

During an interview on 2/12/2025 at 10:14 a.m., with the Infection Preventionist (IP), the IP stated any staff member that takes trash to the dumpster should know to place the trash in the receptacles. The IP stated if trash is left in the surrounding area of the dumpsters, there was a potential that it would invite critters that would leave droppings behind and possibly cause the spread of infection to residents.

During an interview on 2/12/2025 at 10:50 a.m., with the Maintenance Supervisor (MS), the MS stated waste should always be inside the dumpsters because it was important to keep animals out of the trash to prevent the spread of infections. The MS stated the there was trash outside of the dumpsters and it should not have been.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/13/2025 at 10 a.m., with the Director of Nursing (DON), the DON stated all facility trash should be kept inside a closed container because trash attracts insects, rodents, and flies that could potentially cause illness in residents like maggots (fly larvae that develop in decaying organic matter) in resident wounds. During a review of the facility policy and procedure (P&P) titled, Garbage and Refuse Disposal, last reviewed 6/27/2024, the P&P indicated garbage and refuse are disposed of in accordance with current state laws. All waste shall be kept in containers. Garbage and refuse containing food wastes will be stored in a manner that is inaccessible to pests. Outside dumpsters provided by garbage pickup services will be kept closed and free of surrounding litter. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 5-501.116 Cleaning Receptacles. Proper storage and disposal of garbage and refused are necessary to minimize the development of odors, prevent such waste from becoming an attractant and harborage of breeding place for insects and rodents . Storage areas for garbage and refuse containers must be constructed so that they can be thoroughly cleaned in order to avoid creating an attractant or harborage for insects or rodents. In addition, such storage areas must be large enough to accommodate all the containers necessitated by the operation in order to prevent scattering of the garbage and refuse .Outside receptacles must be constructed with tight-fitting lids or covers to prevent the scattering of the garbage or refuse by birds, the breeding of flies, or the entry of rodents.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38552 Based on interview, and record review, the facility failed to ensure necessary care was provided consistently for a resident who was receiving hospice service (a program designed to provide a caring environment for meeting the physical and emotional needs of the terminally ill) for one of one sampled residents (Resident 30) reviewed for Hospice and End of Life care area by, failing to ensure the hospice aide (HA) visited according to the hospice plan of care for Resident 30. This deficient practice had the potential to negatively affect the resident's physical comfort, psychosocial well-being, and had the potential to result in a delay or a lack of necessary care and services. Findings: During a review of Resident 30's Admission Record, the Admission Record indicated the facility originally admitted the resident on 8/14/2024 and readmitted on [DATE] with diagnoses including malignant neoplasm (an abnormal growth of cells that invade and spread to other parts of the body) of colon (tube-like organ of the digestive system which processes and eliminate waste products from the body), acute and chronic respiratory failure (a serious condition that makes it difficult to breathe on your own) with hypercapnia (a condition where there is an excessive amount of carbon dioxide in the blood), and type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 30's History and Physical (H&)), dated 11/9/2024, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 30's Order Summary Report, the Order Summary Report indicated Admit to [Hospice Provider (HP) 1] under routine level of care ., dated 12/6/2024. During a review of Resident 30's Minimum Data Set (MDS-a resident assessment), dated 12/13/2024, the MDS indicated the resident had clear speech, minimal hearing difficulty, had the ability to understand others and had the ability to make self-understand. The MDS indicated the resident required substantial/maximal assistance from staff with activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily) including shower/bathe self, toileting hygiene, lower body dressing, and personal hygiene. The MDS indicated the resident required substantial/maximal assistance with sit to stand, chair/bed-to-chair transfer, and toilet transfer. During a review of Resident 30's Care Plan Report for Comfort care/Hospice care, last revised 12/8/2024, the Care Plan indicated a goal to honor resident's choice for desired level of care which included interventions of Integrate with hospice. During a review of Resident 30's HP 1's Certification of Terminal Illness, dated 12/6/2024, the Certification of Terminal Illness indicated the effective date of certification was from 12/6/2024 to 3/5/2025. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 30's HP 1's Plan of Care (POC) Summary, dated 1/11/2025, indicated the resident with HA visits 0 week 1 then 2 times a week for effective and safe personal care. During a concurrent interview and record review on 2/12/2025 at 4:35 p.m. with Registered Nurse 4, Resident 30's HA visit notes and hospice visit calendar, dated 1/2025 was reviewed. RN 4 stated the HA visit should have been twice per week. RN 4 stated for the week of 1/19/2025 to 1/25/2025 the HA visited only once on 1/22/2025. RN 4 stated the next visit was 1/28/2025. During a concurrent interview and record review on 2/14/2025 at 3 p.m., with Registered Nurse 1 (RN) 1, of Resident 30's nursing progress notes, dated 1/2025 were reviewed. RN 1 stated when the HA is unable to make a visit that week, the HP 1 would call their facility and let them know. RN 1 stated there were no nursing progress notes of why there was only one HA visit for the week of 1/19/2025. RN 1 stated the HA visits are to provide supplementary care to the resident and when they miss a visit, they would not be able to provide that supplementary care to the resident. During an interview on 2/14/2025 at 11:52 a.m., with the Director of Nursing (DON), the DON stated hospice missed one day for the HA visit. The DON stated the resident could potentially be affected with their choice for care not being followed. The DON stated this could potentially affect the resident's mental and psychosocial well-being. During a review of the facility's policy and procedure titled, Hospice Program, last reviewed on 6/27/2024, the P&P indicated Hospice services are available to residents at the end of life . Coordinated care plans for residents receiving hospice services will include the most recent hospice plan of care as well as the care and services provided by our facility (including the responsible provider and discipline assigned to specific tasks) in order to maintain the resident's highest practicable physical, mental and psychosocial well-being. The coordinated care plan will reflect the resident's goals and wishes, as stated in his or her advance directives and during ongoing communication with the resident or representative, including: a Palliative goals and objectives; b. Palliative interventions .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 44376 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections by failing to ensure: 1. Resident 20's urinal bottle (a container for collecting urine that is used by people who are unable to use a bathroom toilet) was labeled with the name and room number for one of 24 sampled residents (Resident 20) during an initial pool screening. 2. Clean linens, clean clothing, and clean curtains were not placed on the ground in the Clean Linen Folding area during a review of the Infection Control task The deficient practices had a potential to spread infections and illnesses among residents. Findings: 1. During a review of Resident 20's Admission Record, the Admission Record indicated the facility admitted the resident on 10/29/2012, and readmitted the resident on 12/28/2021, with diagnoses that included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), hemiparesis (weakness or the inability to move on one side of the body, making it hard to perform everyday activities like eating or dressing), and type 2 diabetes mellitus (a disease that occurs when your blood glucose, also called blood sugar, is too high). During a review of Resident 20's History and Physical (H&P), dated 8/30/2024, the H&P indicated Resident 20 had the capacity to make needs known but could not make medical decisions. During a review of Resident 20's Minimum Data Set (MDS, a resident assessment tool), dated 1/17/2025, the MDS indicated Resident 20 had the ability to make self-understood and to understand others and had intact cognition (a person's mental abilities, like thinking, remembering, understanding, and reasoning, are fully functional and working normally, with no significant decline or impairment). During a concurrent observation and interview on 2/11/2025, at 9:50 a.m., with Treatment Nurse 2 (TX 2), while inside resident 20's room, Resident 20's urinal was observed hanging on the left upper side rail without a label with the name and room number of the resident. TX 2 stated the urinal should be labeled with the name and room number of the resident to prevent switching of urinals with other residents causing cross contamination among residents that can make them sick. During an interview on 2/14/2025, at 1:12 p.m., with the Director of Nursing (DON), the DON stated the staff should have labeled the urinal of Resident 20 with the name and room number of the resident to prevent switching of urinals with other residents that can cause cross contamination (the transfer of harmful bacteria to food from other foods, cutting boards, and utensils and it happens when they are not handled properly) of infection among residents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's recent policy and procedure (P&P) titled Infection Prevention Quality Control Plan last reviewed on 6/27/2024, the P&P indicated prior to having direct-care responsibilities for residents, staff must have appropriate in-service training on managing infections in residents including: b. Methods of preventing their spread. During a review of the facility's recent policy and procedure (P&P) titled Cleaning and Disinfection of Resident-Care Items and Equipment, last reviewed on 6/27/2024, the P&P indicated reusable items are cleaned and disinfected or sterilized between residents (e.g., stethoscopes, durable medical equipment). a. Single resident-use items are cleaned and/disinfected between uses by a single resident and disposed of afterwards (e.g., bedpans, urinals). These items will be labeled with resident name. 44244 2. During a Laundry Area tour on 2/11/2025 at 3:10 a.m., with Laundry Attendant 1 (LA 1) and the Maintenance Supervisor (MS), of the Clean Linen Folding Area. The MS stated all the clean linens, even if placed inside a plastic bag or bin, should be off the floor. LA 1 observed the following in the Clean Linen Folding Area: - one clear plastic bin of clean donation clothing was placed on the floor with a clean white sheet draped over the top and touching the floor. - Four plastic bags containing clean resident room curtains were placed on the floor, one bag was split open. - Four open cardboard boxes were placed on the floor that were overflowing with clean donation clothing, some clothing was touching the floor. During a continued interview with MS, MS stated the linens should have been placed off the floor in bins, but they were not. The MS stated clean linens should never be placed on the ground because there was a potential for the dirt from the ground to contaminate the linens and the contaminated linens then being used for residents. The MS stated when dirty linens are used for residents, bacteria could transfer to the residents and make them ill. The MS stated it was the facility's policy to keep clean linens off the floor and the policy was not followed. During an interview on 2/12/2025 at 10:14 a.m., with the Infection Preventionist (IP), the IP stated clean linens should not be placed on the ground because they may become soiled from any germs or bacteria on the ground and then used for residents. The IP stated contaminated linens could cause rashes in residents. During an interview on 2/13/2025 at 10 a.m., with the Director of Nursing (DON), the DON stated clean linen on the floor is a potential infection control issue. The DON stated the dirty linens could cross contaminate (the process by which bacteria or other microorganisms are unintentionally transferred from one substance or object to another, with harmful effect) from the floor to the resident causing illness. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility procedure titled, Clean Linen, last reviewed 6/27/2024, the P&P indicated the purpose of this procedure is to provide a process for the safe and aseptic handling, washing, and storage of linen. Clean linen will remain hygienically clean (free of pathogens in sufficient numbers to cause human illness) through measures designed to protect it from environmental contamination. Clean linen shall be stored and handled in a way that precludes cross-contamination. Store clean linens in an orderly manner, neatly folded and stacked.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. 38552 Based on observation, interview, and record review, the facility failed to meet the required room size of 80 square feet (sq ft-a unit of measurement) per resident in multiple bedrooms for 35 out of 38 resident rooms (rooms 1, 2, 3, 4, 5, 7, 8, 9, 10, 11, 12, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 36, 37, 38, and 39). This deficient practice had the potential to result in inadequate space for resident care and mobility. Findings: During observations from 2/11/2025 to 2/14/2025, observed a sufficient amount of space for residents to move freely inside the rooms with an application for room variance. There was adequate room for the operation and use of wheelchairs, walkers, or canes. The room variance did not affect the care and services provided by nursing staff for the residents. During a review of the facility Room Waiver Request Letter for 35 resident rooms submitted by the Administrator, dated 2/12/2025, the Room Waiver Request Letter indicated that these rooms did not meet the 80 sq ft per resident requirement per federal regulation. The room waiver request indicated the following: Room Beds Room Size Sq Ft per resident 1 3 209.35 69.78 2 3 209.35 69.78 3 3 209.35 69.78 4 3 209.25 69.75 5 3 209.25 69.75 7 3 209.25 69.75 8 3 209.25 69.75 9 2 143.55 71.77 10 3 209.25 69.75 11 2 144.25 72.12 12 3 209.25 69.75 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055728	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/14/2025
NAME OF PROVIDER OR SUPPLIER Santa Clarita Post-Acute Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 23801 Newhall Avenue Newhall, CA 91321	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	14 2 145.5 72.75 15 3 209.16 69.72 16 2 143.33 71.66 17 3 209.35 69.75 18 2 143.75 71.87 19 3 209.35 69.78 20 3 209.4 69.8 21 3 214.5 71.5 22 3 209.2 69.73 23 3 209.16 69.72 25 3 209.25 69.75 26 3 209.25 69.75 27 3 209.25 69.75 28 2 143.2 71.6 29 3 209.2 69.67 30 2 143.55 71.77 31 3 209.16 69.72 32 2 143.25 71.62 33 3 209.16 69.72 34 2 143.16 71.58 36 2 143.38 71.69 37 3 209.21 69.73 38 2 143.33 71.66 39 3 209.35 69.78 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055728	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Santa Clarita Post-Acute Care Center	23801 Newhall Avenue Newhall, CA 91321

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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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Each room listed on the attached 'Client Accommodation Analysis' has no projections or other obstructions, which may interfere with free movement of wheelchairs and/or sitting devices. There is enough space to provide for each resident's care, dignity, and privacy, and that the rooms are in accordance with the special needs of the residents and would not have an adverse effect on the resident health and safety or impede the ability of any resident in the rooms to attain his or her highest practicable well-being. All measures will be taken to assure the comfort of each resident. The granting of the variance will not adversely affect the resident's health and safety and will be in accordance with any special needs of each resident. During an interview on 2/11/2025 at 11:58 a.m., with Resident 30 in a room measuring 69.73 sq ft per person, the resident stated he did not have an issue with the size of the room. The resident stated there was enough space for the nurses to provide care. During an interview on 2/12/2025 at 4:06 p.m. with Certified Nursing Assistant 4 (CNA 4), CNA 4 stated the rooms in the facility have adequate space to provide care to residents. CNA 4 stated he can freely move wheelchairs in the rooms and there is no need to move furniture or place the beds against the wall to provide care. During an interview on 2/14/2025 at 11:56 a.m., with the Director of Nursing (DON), the DON stated the bed requirements provide enough space to the residents and make them feel this is their home and their privacy and comfort are met. During a review of the facility's policy and procedure (P&P) titled, Bedrooms, last reviewed on 6/27/2024, the P&P indicated all residents are provided with clean, comfortable and safe bedrooms that meet federal and state requirements. The P&P indicated bedrooms measure at least 80 square feet of space per resident in double rooms, and at least 100 square feet of space in single rooms.