STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055870	A. Building B. Wing	11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunray Healthcare Center	3210 W Pico Blvd Los Angeles, CA 90019

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49130 Based on observation, interview, and record review, the facility failed to maintain dignity and privacy for one of three sampled residents (Resident 63) by failing to close the bedside curtain during medication administration. This failure had the potential to cause psychosocial harm to Resident 63, violated the resident's right to privacy and the right to be treated with dignity. Findings: A review of Resident 63's Admission Record indicated the resident was originally admitted to the facility on [DATE] with diagnoses including Type II Diabetes Mellitus without complications and unspecified anemia (a condition where the body does not have enough healthy red blood cells). A review of Resident 63's History and Physical (H&P), dated 4/24/2024 indicated Resident 63 had the capacity to understand and make decisions. A review of Resident 63's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 8/23/2024, indicated Resident 63's had intact cognition (able to understand and make decisions), required supervision or touching assistance for eating and was dependent or required moderate assistance for personal hygiene. During an observation on 10/29/2024 at 11:06 AM, the Director of Nursing (DON) instructed Licensed Vocational Nurse (LVN) 4 to help LVN 3 with medication pass. LVN 4 assisted LVN 3 in preparing 12 medications for Resident 63. LVN 3 entered Resident 63's room with the prepared medications to administer to Resident 63. LVN 3 did not close Resident 63's bedside curtain while administering medications. During an interview on 10/30/2024 at 12:59 PM, the DON stated it was important to close the bedside curtain to provide privacy while providing care to residents and to prevent violation of residents' rights to dignity and privacy. During an interview on 10/31/2024 at 1:57 PM, LVN 4 stated she would knock before entering resident's room, verify resident's name and close the bedside curtain to provide privacy to the residents. LVN 4 stated LVN 3 was not available for interview. LVN 4 stated LVN 3 did not close curtains while administering medications for Resident 63. (continued on next page)

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	A review of the facility's policy and procedure titled, Dignity, reviewed 8/2024, indicated residents were treated with dignity and respect at all times. Staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50296 Based on interview and record review, the facility failed to ensure one of eleven residents (Resident 66) had legal documentation indicating the resident's family member was the resident's representative. This failure had the potential to result in Resident 66 receiving delayed care. Findings: A review of Residents 66's admission record indicated the resident was admitted to the facility on [DATE], with diagnoses including unspecified mental disorder due to known physiological condition and essential primary hypertension (high blood pressure). A review of the facility's letter of agreement with the home health facility supervising the care of Resident 66, dated 6/27/2024, indicated the resident's Family Member 1 passed away and therefore the resident's Family Member 2 would be able to make decisions for the resident. A review of Resident 66's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 8/27/2024, indicated the resident was not able to report the correct year, month, or day of the week. A review of Resident 66's electronic record on 10/30/2024 with the Social Services Director (SSD) indicated the Physician's Orders for Life-Sustaining Treatment was not signed. A review of Resident 66's admission record, dated 10/31/24, indicated the resident's family member was identified as the responsible party, financial representative, and emergency contact. During an interview on 11/1/2024 at 1:31 p.m., the Director of Nursing (DON) stated during admission to the facility, the admission nurse should identify if a resident could represent themselves. If the resident cannot represent themselves the facility must explore if a responsible party was available. The DON stated if there was not a responsible party, during the initial care conference, the ombudsman or conservatorship was contacted. The DON stated the impact to the resident, without a legal resident representation, could be a delay in care. A review of Resident 66's electronic chart in the progress notes and assessment indicated there was no legal documentation indicating Family Member 2 would be the resident's representative. A review of the facility's policy and procedure titled, Resident Representative, dated 8/30/24, indicated, the director of nursing or a designee obtains documentation designating the representative as the delegated authority making decision on behave of the resident.

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43851 Based on observation, interview, and record review, the facility failed to ensure two of six sampled residents (Resident 48 and Resident 77), who required assistance from staff with activities of daily living (ADLs - essential and routine activities include eating, dressing, getting into or out of a bed or chair, taking a bath or shower, and using the toilet) were free from neglect (failure of the facility, its employees or service providers to provide services to a resident that were necessary to avoid pain, mental anguish or emotional distress). The facility failed to: -Provide Resident 77, who required substantial / maximal assistance (helper does more than half the effort, helper lifts or holds trunk or limbs) with personal hygiene. Resident 77 was observed lying in bed calling out for help for over 45 minutes, stating, Can somebody change my diaper (incontinence brief)? -Provide Resident 48, who required substantial / maximal assistance, with eye care. Resident 48 was observed with a dry flaky substance around the right eye, which remained from the night prior. These deficient practices resulted in Resident 77 remaining in her soiled incontinence brief with urine and feces for 45 minutes without being helped. Resident 77 stated she felt dirty, unimportant, and frustrated. Resident 48 had the potential to develop an eye infection. Cross Reference F725 Findings: a. A review of Resident 77's Admission Record indicated the facility admitted the resident on 8/13/2024 with diagnoses including chronic osteomyelitis (a bone infection that lasts longer than 30 days, usually with pain) of the left ankle and foot, Type II diabetes (a disease that results in high levels of sugar in the blood), cirrhosis of the liver (a condition that occurs when healthy liver tissue is replaced by scar tissue), abnormalities of gait and mobility, need for assistance with personal care, congestive heart failure (a serious condition that occurs when the heart can't pump enough blood to meet the body's needs). A review of Resident 77's care plan initiated on 8/14/2024, indicated the resident had an Activities of Daily Living (ADLs) self-care performance deficit related to impaired balance, limited mobility, limited range of motion (ROM), and pain. The care plan indicated a goal for Resident 77 was to improve their current level of function in bed mobility, transfers, eating, dressing, toilet use, personal hygiene, and ADL score. The interventions indicated Resident 77 required staff participation to use the toilet, required assistance with washing their hands, adjusting clothing, cleaning themselves, transferring onto the toilet, transferring off the toilet, and using the toilet. The care plan further indicated Resident 77 required total assistance with transfers. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 77's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 8/19/2024, indicated the resident had moderately impaired cognition (ability to remember understand and make decisions), required set up or clean up assistance with eating, and required supervision or touching assistance with oral hygiene. The MDS indicated Resident 77 required substantial / maximal assistance with personal hygiene and was always incontinent (unable to control) of urine and bowel. During an observation on 10/28/2024 at 11 AM. Resident 77 was observed lying in bed calling out for help stating, Can somebody change my diaper? During an observation on 10/28/2024 at 11:20 AM, a Certified Nursing Assistant (CNA) was observed passing by Resident 77's room. Resident 77 was observed again calling out for help stating, Can you change my diaper? The CNA was observed stating to resident, Give me one moment. During an observation on 10/28/2024 at 11:25 AM, Licensed Vocational Nurse (LVN) 3 was observed standing across from Resident 77's room. Resident 77 was observed calling out for help stating, Can you change my diaper? LVN 3 did not respond to Resident 77. During a concurrent observation and interview on 10/28/2024 at 11:35 AM, in Resident 77's room, Resident 77 stated she needed to have her incontinence brief changed. Resident 77 stated she had gone both number 1 (urine) and number 2 (feces) and had been sitting in her soiled incontinence brief for 45 minutes. Resident 77 stated she had been asking nurses for help, but no one had come in to help her. Resident 77 stated no one comes to check on her and it made her feel unimportant. Everyone keeps telling me they're coming but don't come. Resident 77 stated she felt frustrated and uncomfortable because she felt dirty. Resident 77 stated, It shouldn't be that hard. During an interview on 10/28/2024 at 11:39 AM, LVN 3 stated the CNA assigned to Resident 77 was at lunch and was not available to help Resident 77. LVN 3 stated they would try to find someone to help Resident 77 clean up. LVN 3 was observed trying to locate staff to assist Resident 77. During an interview on 10/28/2024 at 11:50 AM, CNA 5 stated they were assigned to take care of Resident 77 and that when they were at lunch or on break, there was another CNA that would cover for them and help their residents if needed. CNA 5 stated they did not know who was covering for them during lunch. CNA 5 was then observed assisting Resident 77 clean up. During an interview on 11/1/2024 at 12:05 PM, the Director of Staff Development (DSD) stated when a resident was calling out for help staff should not ignore the resident. The DSD stated when someone was on break, whoever was not scheduled for break should be responsible in answering the resident's needs. The DSD stated if a resident sat in a soiled incontinent brief for a long period of time, 30 minutes or more, there was a potential for skin breakdown. The DSD stated it was uncomfortable for the resident to sit in a soiled incontinent brief. b. A review of Resident 48's Admission Record indicated the facility readmitted the resident on 6/11/2024 with diagnoses including hemiplegia (severe or complete loss / paralysis of one side of the body) and hemiparesis (slight muscle weakness or partial paralysis of one side of the body), glaucoma (a group of eye conditions that cause blindness), need for assistance with personal care, and contracture (permanent or temporary tightening of muscles, tendons, skin, and nearby tissues that limits the normal movement of a joint or body part) of the muscle of the right hand. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 48's MDS dated [DATE], indicated the resident was cognitively intact (ability to think, remember, express thoughts and make decisions), required substantial / maximal assistance with eating and was dependent on help for personal hygiene. A review of Resident 48's care plan initiated 10/28/2024, indicated the resident was at risk for injury related to impaired visual function. The care plan indicated Resident 48 followed / tracked moving objects and had a diagnosis of glaucoma. The care plan indicated a goal for Resident 48 was to show no eye redness, scratching, or tearing. The care plan interventions included to clean Resident 48's eyes every day during morning care. During an observation on 10/28/2024 at 9:45 AM, Resident 48 was observed lying in bed with the right eye closed and the left eye open. Resident 48 was observed with dry flaky fluid around the right eye. During a concurrent interview, Resident 48 stated, Can you ask someone to clean my eye. Resident 48 stated there was too much water in his right eye and some of it was dry in the eye. Resident 48 stated his eye had been like that overnight and had not been cleaned since last night. Resident 48 stated it bothered him. During a concurrent observation and interview on 10/28/2024 at 9:56 AM, Resident 48's right eye was observed with the Certified Nursing Assistant (CNA). CNA 7 stated Resident 48 was blind and could not see. CNA 7 stated Resident 48 was total care and needed assistance with cleaning. CNA 7 stated Resident 48's right eye was closed and had dried stuff around it. CNA 7 stated Resident 48's right eye needed to be cleaned so they could open their eyes. During an interview on 11/1/2024 at 1:52 PM, the Director of Nursing (DON) stated Resident 48 was dependent on others for ADLs and was visually impaired. The DON stated it was the expectation of the staff to assist Resident 48 in cleaning their eyes and ensuring their needs were being met. The DON stated there was a potential for Resident 48 to develop an eye infection if the resident was not assisted in having their eyes cleaned. A review of the facility's policy and procedure titled, Activities of Daily Living (ADLs), Supporting, reviewed 8/30/2024, indicated residents would be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who were unable to carry out activities of daily living independently would receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. Appropriate care and services would be provided for residents who were unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: hygiene (bathing, dressing, grooming, and oral care); mobility (transfer and ambulation, including walking); elimination (toileting); dining (meals and snacks); and communication (speech, language, and any functional communication systems). A review of the facility's policy and procedure titled, Abuse and Neglect - Clinical Protocol, dated 3/2018, indicated along with staff and management, the physician would help identify situations that might constitute or could be construed as neglect; for example recurrent failure to provide incontinence care. The policy indicated the facility management and staff would institute measures to address the needs of residents and minimize the possibility of neglect. The physician would advise the facility and help review and address neglect issues as part of the quality assurance process.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49836 Based on observation, interview, and record review, the facility failed to implement a comprehensive person-centered care plan for one of three sampled residents (Resident 6) by failing to implement Resident 6's 'At Risk for Falls' care plan to provide floor mats. This deficient practice increased the risk for further falls and injury of Resident 6. Findings: A review of the admission record indicated Resident 6 was readmitted to the facility on [DATE], with diagnoses including cerebral infarction (when blood flow to the brain is blocked, causing brain tissue to die) and dementia (loss of cognitive functioning - thinking, remembering, and reasoning, to such an extent that the loss interferes with a person's daily life and activities). A review of the facility's Fall Risk assessment dated [DATE] indicated Resident 6 had a history of falls and was a high fall risk. A review of the history and physical report completed on 5/24/2024, indicated Resident 6 did not have the capacity to make decision or make needs known. A review of Resident 6's At Risk for Fall and Injury care plan dated 5/30/2024 indicated the goal was to minimize falls and injuries for Resident 6. The care plan interventions indicated to place Resident 6's bed in the lowest position and to have floor mats bilaterally (on both sides). A review of the Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 7/15/2024, indicated Resident 6 had severe cognitive impairment (problems with the ability to think, remember, and make decisions) and needed maximum assistance with all the activities of daily living (ADL). During an observation on 10/28/2024 at 9:22 AM in Resident 6's room, Resident 6 was asleep in bed. The bed was in lowest position and no floor mats were observed on either side of Resident 6's bed. During an interview on 10/28/2024 at 10:04 AM with Resident 6's Responsible Party (RP 1), RP 1 stated that Resident 6 had multiple falls in the facility but no injuries. During an observation on 10/29/2024 at 2:47 PM in Resident 6's room, Resident 6 was lying in bed awake, nonverbal, and unable to make their needs known. Resident 6's bed was in the lowest position and there were no floor mats observed on either side of Resident 6's bed. During a concurrent interview, Resident 6's Certified Nursing Assistant (CNA 1) was asked if Resident 6 should have floor mats on either side of the bed and CNA 1 stated she was not sure. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 10/30/2024 at 6:45 AM, Resident 6 was asleep in bed, there were no floor mats observed on either side of Resident 6's bed. During a concurrent interview, Resident 6's CNA (CNA 2) was asked if Resident 6 should have floor mats on either side of the bed and CNA 2 stated yes, the resident should have floor mats, but CNA 2 stated she was not sure why Resident 6 did not have any floor mats in place. CNA 2 stated that not having the floor mats next to the Resident 6's bed put Resident 6 at risk injury. During a concurrent interview and record review on 11/1/2024 at 11:50 AM, the Director of Staff Development (DSD) stated that if a resident had a history of falls or was a high or moderate risk for falls as indicated on the facilities Fall Assessment one of the interventions that was included in the care plan was to place floor mats next to the resident. After review of the At Risk for Falls care plan for Resident 6 with the DSD, the DSD stated Resident 6 should have floor mats on both sides of the bed and that by not placing floor mats next to Resident 6 increased the resident at risk for further falls and injury. A review of the facility's policy and procedure reviewed 8/30/2024 and titled, Care Plans, Comprehensive Person-Centered, indicated that a person-centered care plan that included measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs was developed and implemented for each resident.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49836 Based on interview and record review, the facility failed to revise the fall care plan for one of three sampled resident (Resident 6), who sustained a fall on 10/27/2024. This deficient practice caused an increased risk in for injury and recurrent falls for Resident 6. Findings: A review of the admission record indicated Resident 6 was readmitted to the facility on [DATE], with diagnoses including cerebral infarction (when blood flow to the brain in blocked, causing brain tissue to die) and dementia (loss of cognitive functioning, thinking, remembering, and reasoning, to such an extent that the loss interferes with a person's daily life and activities). A review of the facility's Fall Risk assessment dated [DATE], indicated Resident 6 had a history of falls and was a high fall risk. A review of the history and physical report completed on 5/24/2024, indicated Resident 6 did not have the capacity to make decisions or make needs known. A review of Resident 6's care plan did not indicate a care plan was created or revised after Resident 6's fall on 10/27/2024. A review of the Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 7/15/2024, indicated Resident 6 had severe cognitive impairment (problems with a person's ability to think, remember, use judgement, and make decisions) and needed maximum assistance with all activities of daily living (ADL). A review of Resident 6's Progress Notes dated 10/27/2024 at 11:29 PM, indicated Resident 6 was found on the floor in their room and was yelling. A full body assessment was done by the nursing staff and no injuries or complaints of pain were noted at the time. Resident 6's physician (MD) and family were notified of the incident. No new orders were received from Resident 6's MD. During an interview on 10/31/2024 at 9:03 AM, Licensed Vocational Nurse (LVN) 1 stated Resident 6 had a history of falls and had a fall on 10/27/2024. LVN 1 stated Resident 6's care plan for falls should have been updated because it was considered a change of condition. During an interview on 11/1/2024 at 11:50 AM, the Director of Staff Development (DSD) stated that if a resident had a fall, the care plan should always be updated. During a concurrent review the care plan for Resident 6 with the DSD, the DSD stated Resident 6's fall care plan should have been updated to address Resident 6's most recent fall on 10/27/2024. A review of the facility's policy and procedure reviewed 8/30/2024 and titled, Care Plans, Comprehensive Person-Centered, indicated the interdisciplinary team (IDT) reviewed and updated the care plan when there was a significant change in the resident's condition or when the desired outcome was not met.

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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** 49836 Based on observation, interview, and record review, the nursing staff failed to ensure two of nine sampled residents (Resident 6 and Resident 63) were provided with interventions to prevent accidents as evidenced by: -Failing to provide floor mats for Resident 6 who had a history of falls. -Failing to provide padded bedside rails for Resident 63, who had a history of epilepsy (a brain disorder that causes seizures, which are episodes of abnormal electrical activity in the brain). This deficient practice had the potential to place Resident 6 and Resident 63 at further risk for injury due to falls or seizures. Findings: a. A review of the admission record indicated Resident 6 was readmitted to the facility on [DATE], with diagnoses including cerebral infarction (when blood flow to the brain in blocked, causing brain tissue to die) and dementia (loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that the loss interferes with a person's daily life and activities). A review of the facility's Fall Risk assessment dated [DATE] indicated Resident 6 had a history of falls and was a high fall risk. A review of the history and physical report completed on 5/24/2024, indicated Resident 6 did not have the capacity to make decisions or make needs known. A review of Resident 6's At Risk for Fall and Injury care plan revised on 10/13/2024 indicated the goal was to minimize falls and injuries for Resident 6. The care plan interventions indicated to place Resident 6's bed in the lowest position and to have floor mats bilaterally (on both sides). A review of the Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 7/15/2024, indicated Resident 6 had severe cognitive impairment and needed maximum assistance with all their activities of daily living (ADL). During an observation on 10/28/2024 at 9:22 AM in Resident 6's room, Resident 6 was asleep in bed. Resident 6's bed was in lowest position and no floor mats were observed on either side of Resident 6's bed. During an interview on 10/28/2024 at 10:04 AM with Resident 6's Representative (RP 1), RP 1 stated that Resident 6 had multiple falls in the facility but no injuries. RP 1 stated Resident 6 was to have pads on the floor next to the bed so Resident 6 did not get injured. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 10/29/2024 at 2:47 PM in Resident 6's room, Resident 6 was lying in bed awake, nonverbal, and unable to make their needs known. Resident 6's bed was in the lowest position and no floor mats were observed on either side of Resident 6's bed. During a concurrent interview, Resident 6's Certified Nursing Assistant (CNA 1) was asked if Resident 6 should have floor mats on either side of the bed and CNA 1 stated she was not sure. During an observation on 10/30/2024 at 6:45 AM, Resident 6 was asleep in bed. No floor mats were observed on either side of Resident 6's bed. During a concurrent interview, Resident 6's CNA (CNA 2) was asked if Resident 6 should have floor mats on either side of the bed and CNA 2 stated yes, the resident should have floor mats, but CNA 2 stated she was not sure why Resident 6 did not have any floor mats in place. CNA 2 stated that not having the floor mats next to the Resident 6's bed placed Resident 6 at risk of injury. During an interview on 11/1/2024 at 11:50 AM, the Director of Staff Development (DSD) stated that if a resident had a history of falls or was a high or moderate risk for falls as indicated on the facilities Fall Assessment, one of the interventions that was included in the care plan was to place floor mats next to the resident. During a concurrent record review with the DSD of Resident 6's care plan, the DSD stated that Resident 6 should have floor mats on both sides of their bed. The DSD stated that by not placing floor mats next to Resident 6 placed the resident at risk for further falls and injury. A review of the facility's policy and procedure (P&P) dated 8/24/2024 and titled, Falls-Clinical Protocol, indicated the staff and physician would identify pertinent interventions to try to prevent subsequent falls and staff would try various relevant interventions, based on assessment of the nature of falling until falling reduces or stops. b. A review of Resident 63's Admission Record indicated the facility readmitted the resident on 4/24/2024 with diagnoses including epilepsy, hemiplegia (severe or complete loss of strength or paralysis on one side of the body) and hemiparesis (mild or partial weakness or loss of strength on one side of the body). A review of the Physician's Order dated 4/26/2024 indicated Resident 63 was to have bilateral (pertaining to both sides) 1/3 padded side rails for seizure diagnosis. A review of Resident 63's Side Rail Utilization assessment dated [DATE], indicated to apply bilateral upper 1/3 side rails up for turn and repositioning. The utilization assessment indicated Resident 63 had a history of active seizure disorder or active movement disorder. A review of Resident 63's MDS dated [DATE], indicated the resident was cognitively intact (ability to think, remember, express thoughts and make decisions), had impairment on both sides of their upper and lower extremities, and was dependent on help for personal hygiene. A review of Resident 63's Care Plan revised 9/11/2024, indicated the resident needed to have bilateral upper 1/3 side rails for a diagnosis of seizure. The care plan indicated a goal for Resident 63 to minimize the risk for falls by the next review date. The care plan further indicated interventions that included to make sure padded side rails were up while in bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 10/31/2024 at 11:25 AM, Resident 63 was observed lying in bed. Resident 63's bilateral side rails were both observed up. The bilateral side rails were observed without padding. During a concurrent observation and interview on 10/31/2024 at 1:13 PM, Resident 63 was observed lying in bed with Treatment Nurse (TN) 1. TN 1 confirmed Resident 63's bed side rails were not padded. TN 1 stated Resident 63 had physician orders that indicate the residents was to have padded side rails. TN 1 stated Resident 63 had a history of seizures. TN 1 stated padded side rails are used to prevent the resident from hitting and injuring their head. TN 1 stated there was a potential for Resident 63 to injure themselves because there was no padding to the resident's side rails. During a concurrent interview and record review on 11/1/2024 at 1:52 PM, Resident 63's physician order dated 4/26/2024 was reviewed with the Director of Nursing (DON). The DON stated Resident 63 had physician's orders for padded side rails. The DON stated Resident 63 had a history of seizures. The DON stated Resident 63 should have padded side rails for the prevention of injury. The DON stated there was a potential for Resident 63 to be injured if they had a seizure and no padded side rails. A review of the facility's policy and procedure titled, Bed Safety and Bed Rails, reviewed 8/30/2024, indicated The resident's sleeping environment is evaluated by the interdisciplinary team. Consideration is given to the resident's safety, medical conditions, comfort, and freedom of movement, as well as input from the resident and family regarding previous sleeping habits and bed environment. Bed frames, mattresses and bed rails were checked for compatibility and size prior to use. Bed rails were properly installed and used according to the manufacturer's instructions, specifications, and other pertinent safety guidance to ensure proper fit. Additional safety measures are implemented for residents who have been identified as having a higher than usual risk for injury including bed entrapment. The policy indicated the use of bed rails or side rails (including temporarily raising the side rails for episodic use during care) was prohibited unless the criteria for use of bed rails have been met, including attempts to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent. If attempted alternative do not adequately meet the resident's needs the resident may be evaluated for the use of bed rails. This interdisciplinary evaluation includes: an evaluation of .input from the resident and/or representative; and consultation with the attending physician. Before using bed rails for any reason, the staff shall inform the resident or representative about the benefits and potential hazards associated with bed rails and obtain informed consent. The following information will be included in the consent: the assessed medical needs that will be addressed with the use of bed rails.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43851 Based on interview and record review, the facility failed to perform a quarterly nutritional assessment for one of six sampled residents (Resident 78). This deficient practice had the potential for Resident 78 to not have their nutritional needs met. Findings: A review of Resident 78's Admission Record indicated the facility admitted the resident on 5/25/2024 with diagnoses including Type II diabetes (a disease that result in too much sugar in the blood), dysphagia (difficulty swallowing), hyperlipidemia (high levels of cholesterol in the blood), end stage renal disease (ESRD, loss of kidney function in which the kidneys no long work to meet the body's needs), and dependence on renal dialysis (the process of removing waste products and excess fluid from the body using a machine when the kidneys are not able to do so). A review of Resident 78's nutritional assessment dated [DATE], indicated the resident was at risk for significant weight change related to the resident's admitting diagnoses. The nutritional assessment indicated Resident 78 had expected weight fluctuations related to ESRD and hemodialysis three times a week. The nutritional assessment indicated Resident 78 had fair to good intake by mouth and consumed 50% - 100% of meals. There were no nutritional assessments documented after 5/28/2024. A review of Resident 78's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 8/29/2024, indicated the resident had severely impaired cognition (loss in ability to think, remember, express thoughts and make decisions). The MDS indicated Resident 78 required set up or clean up assistance with eating, partial/moderate assistance for oral hygiene and was on a therapeutic diet (a meal plan that's tailored to a person's nutritional needs and is part of a treatment plan for a medical condition). During a concurrent telephone interview and record review on 10/31/2024 at 2:55 PM, Resident 78's nutritional assessment dated [DATE] was reviewed with the Registered Dietitian (RD). The RD stated she reviewed Resident 78's chart and stated the resident's last nutritional assessment was done on 5/28/2024. The RD stated nutritional assessments were completed by the RD when a resident was initially admitted to the facility, quarterly, and annually. The RD stated Resident 78 should have had a nutritional assessment completed on 8/28/2024 to check the resident's appetite, usual body weight, if they had any weight loss, and review their likes and dislikes. The RD further stated because Resident 78 missed their quarterly nutritional assessment, the resident could have potential weight loss, and nutritional interventions which could have severely affected the resident's health. During a concurrent interview and record review on 11/1/2024 at 10:39 AM, Resident 78's nutritional assessment dated [DATE] was reviewed with the Dietary Supervisor (DS). The DS stated Resident 78 should have had a nutritional assessment done in 8/2024. The DS further stated nutritional assessments were done on admission, quarterly, annually, and as needed. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 11/1/2024 at 1:52 PM, Resident 78's nutritional assessment dated [DATE] was reviewed with the DON. The DON stated the RD performs nutritional assessments. The DON stated Resident 78's nutritional assessment was last done on 5/28/2024. The DON further stated there was a potential for Resident 78 to not have their nutritional needs met if a nutritional assessment is not done quarterly. A review of the facility's policy and procedure titled, Food and Nutrition Services, reviewed 8/30/2024, indicated The multidisciplinary staff, including nursing staff, the attending physician and the dietitian will assess each resident's nutritional needs, food likes, dislikes, and eating habits, as well as physical, functional, and psychosocial factors that affect eating and nutritional intake and utilization. A resident-centered diet and nutrition plan will be based on this assessment.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49836 Based on observation, interview, and record review, the facility failed to change the dressing of a peripherally inserted central catheter (PICC, a thin, flexible tube inserted into an arm vein and threaded to a large vein near the heart, used for administering fluids, medications, and other treatments) in seven days, per facility policy and professional standards of practice for one of three sampled residents (Resident 49). This deficient practice had the potential to result in Resident 49's PICC line to develop an infection. Findings: A review of the admission record indicated Resident 49 was admitted to the facility on [DATE], with diagnoses including right middle finger fracture (broken bone), cellulitis (bacterial infection that affects the deep layers of the skin and underlying tissue) of the finger, and bacteremia (bacteria in the blood). A review of Resident 49's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 8/22/2024, indicated the resident had moderately impaired cognition (problems with a person's ability to think, remember, and make decisions) and required maximum assistance with all activities of daily living (ADLs). The MDS indicated Resident 49 had intravenous (IV) access (giving medicines or fluids through a needle or tube inserted into a vein) while at the facility. A review of the Physician's Orders dated 10/24/2024, indicated to administer to Resident 49 Vancomycin (an antibiotic used to treat and prevent various bacterial infections) intravenous solution 500 milligrams (mg - unit of measurement) / 100 milliliters (ml) intravenously every 12 hours for right 3rd finger osteomyelitis (serious bone infection that occurs when bacteria or fungi spread to the bone) until 10/29/2024. During an observation on 10/28/2024 at 9:42 AM in Resident 49's room, Resident 49 was awake and alert. Resident 49 revealed the right upper arm (RUA) PICC line with a dressing dated 10/19/2024 (nine days prior). There were no signs of swelling or redness noted at PICC line site. During an interview on 10/28/2024 at 10:09 AM, Registered Nurse (RN) 1 stated PICC line dressing changes were done every seven days or as needed. During a concurrent observation of Resident 49's PICC line dressing and the last date of change was 10/19/2024, RN 1 stated this resident's dressing should have been changed on Saturday 10/26/2024. RN 1 stated she was not sure why it was not changed and would change the PICC line dressing today. RN 1 stated Resident 49 had the potential risk for getting an infection. During an interview on 10/29/2024 at 12:52 PM, the Director of Nursing (DON) stated the PICC line dressing changes should be changed every seven days or as needed. The DON stated that by not changing the PICC line dressing every seven days the resident was at risk for infection and other complications. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure reviewed 8/30/2024 and titled, Central Venous Catheter Care and Dressing Changes, indicated to maintain sterile dressings for all central vascular access devices (a thin, flexible tube inserted into a vein to deliver fluids, nutrients, medication, or blood products to the bloodstream) and to change the dressing at least every seven days with a TSM (transparent semi-permeable membrane) dressing.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 49836 Based on observation, interview, and record review, the facility failed provide adequate and sufficient nursing staff to meet the needs of two sampled residents (Resident 77 and Resident 39). Both residents had to wait for available assistance to be cleaned and changed. In addition, on 10/30/2024, Certified Nursing Assistants (CNA 2 and CNA 6) stated they each had over 15 residents assigned to them to provide care, including dressing, toilet use, personal hygiene, bathing, assist getting them out of bed, repositioning, and answer their calls for help. CNA 2 and CNA 6 stated with that workload it was impossible to provide quality care to the residents. This repeated deficient practice resulted in inadequate availability of nursing services to assure resident safety and attainment of the highest practicable physical, mental, and psychosocial well-being of each resident. Cross Reference F600 Findings: a. A review of Resident 77's Admission Record indicated the facility admitted the resident on 8/13/2024 with diagnoses including chronic osteomyelitis (a bone infection that lasts longer than 30 days causing severe pain) of the left ankle and foot, abnormalities of gait and mobility, need for assistance with personal care, congestive heart failure (a serious condition that occurs when the heart cannot pump enough blood to meet the body's needs). A review of Resident 77's care plan dated 8/14/2024, indicated the resident had an Activities of Daily Living (ADLs) self-care performance deficit related to impaired balance, limited mobility, limited range of motion (ROM), and pain. The care plan indicated Resident 77 required staff participation to use the toilet, required assistance with washing their hands, adjusting clothing, cleaning themselves, transferring onto the toilet, transferring off the toilet, and using the toilet. The care plan further indicated Resident 77 required total assistance with transfers. A review of Resident 77's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 8/19/2024, indicated the resident had moderately impaired cognition (some loss in the ability to think, remember, express thoughts and make decisions), required set up or clean up assistance with eating and supervision or touching assistance with oral hygiene. The MDS indicated Resident 77 required substantial / maximal assistance with toileting hygiene, showering / bathing themselves, upper / lower body dressing, putting on/taking off footwear, and personal hygiene. The MDS further indicated Resident 77 was always incontinent (unable to control) of urine and bowel. During an observation on 10/28/2024 at 11 AM. Resident 77 was observed lying in bed calling out for help stating, Can somebody change my diaper? During an interview on 10/28/2024 at 11:15 AM, Resident 39 stated he needed to be changed but no one was available to help him. Resident 39 stated that the staff had too many assignments. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 10/28/2024 at 11:20 AM a Certified Nursing Assistant (CNA) was observed passing by Resident 77's room. During an observation on 10/28/2024 at 11:25 AM Licensed Vocational Nurse (LVN) 3 was observed standing across from Resident 77's room. Resident 77 was observed calling out for help stating, Can you change my diaper? LVN 3 did not respond to Resident 77. During a concurrent observation and interview on 10/28/2024 at 11:50 AM, CNA 5 stated they did not know who was covering for them during lunch. CNA 5 was observed assisting Resident 77 clean up (over 45 minutes later). During an interview on 10/29/2024 at 12:39 PM with a resident's family member (FM 2), FM 2 stated they believed the facility was short staffed. FM 2 stated that sometimes when they would call the facility, they would be on hold for up to 30 minutes waiting for someone to answer the phone. FM 2 stated she had seen staff not respond to the call lights right away because there was not enough staff. b. During an interview on 10/30/2024 at 6:17 AM, LVN 7 stated the facility was short staffed CNAs all the time. LVN 7 stated it was difficult to do the work because they felt very stretched. LVN 7 stated it was difficult to respond to all the residents needs in a timely manner because there was not enough staff to help with the workload. During an interview on 10/30/2024 at 6:24 AM, LVN 8 stated the facility was short staffed CNAs. LVN 8 stated it was difficult to for the CNAs to do work because each CNA had more residents to take care of and the CNAs take longer to reply to residents when they call. During an interview on 10/30/2024 at 6:30 AM, CNA 6 stated the facility was short staffed every other day. CNA 6 stated on a day when the facility was fully staffed, they would have 8 - 12 residents in their assignment. CNA 6 stated that they had 16 residents in their current assignment. CNA 6 stated there were only 4 CNAs working on their shift and there were supposed to be 6 CNAs working. CNA 6 stated they had difficulty responding to call lights right away because there was not enough staff and residents had to wait longer for assistance because the facility was short staffed. During an interview on 10/30/2024 at 6:45 AM, CNA 2 stated there was an issue with not having enough staff to care for the residents. CNA 2 stated that on their shift today (11 PM - 7:30 AM shift), there were supposed to be six CNAs on the shift but there were four CNAs. CNA 2 stated that when the facility was short staffed, CNAs would be assigned more residents than they could handle. CNA 2 stated it could be difficult to provide good quality care for the residents because it could get busy. During an interview on 11/1/2024 at 11:50 AM, the Director of Staff Development (DSD) stated the facility did not have staffing issues and that since she started at this position the facility had hired more staff. The DSD stated she received positive feedback from family that services were better. The DSD stated that if there was not enough staff it could affect the quality of care for the residents. During an interview on 11/1/2024 at 12:05 PM, the DSD stated everybody was responsible for answering call lights as soon as possible and that when a resident called out for help staff should not ignore the resident. The DSD stated when someone was on break, whoever was not scheduled for break, should be responsible in answering the residents needs. The DSD stated if a resident sat in a soiled incontinent brief for a long period of time, 30 minutes or more, there was a potential for skin breakdown. The DSD stated it was uncomfortable for the resident to sit in a soiled incontinent brief. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/1/2024 at 1:17 PM, the Director of Nursing (DON) stated staffing was stabilized at this time, but in the last nine months the facility did not meet the required hours in the facility's subacute unit. The DON stated registry was being used for the LVNs and not for the CNAs. A review of the facility's policy and procedure dated 8/30/2024 and titled, Staffing, Sufficient, and Competent Nursing, indicated the facility provided a sufficient number of nursing staff to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment. The policy indicated licensed nurses and certified nursing assistants were available 24 hours a day, seven days a week to provide competent resident care services including, assuring resident safety, attaining or maintain the highest practicable physical, mental and psychosocial well-being of each resident, assessing, evaluation, planning and implementing resident care plans and responding to resident needs.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49836 Based on observation, interview, and record review, the facility failed to ensure Certified Nursing Assistants (CNAs) were competent in identifying residents who were a fall risk to assure safety when: -Two CNAs (CNA 1 and CNA 2) were unable to verbalize what a yellow star (fall risk) above a resident's bed (Resident 6) meant. This deficient practice had the potential to place resident's who were a fall risk (including Resident 6) at risk for injury and recurrent falls. Findings: A review of the admission record indicated Resident 6 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE], with diagnoses including cerebral infarction (when blood flow to the brain in blocked, causing brain tissue to die) and dementia (a chronic condition that causes a gradual decline in cognitive abilities, such as thinking, remembering, and reasoning to such an extent that the loss interferes with a person's daily life and activities). A review of the At Risk for Fall and Injury care plan dated 5/17/2024, indicated the goal for Resident 6 was to minimize falls and injuries and the interventions included to place Resident 6's bed in the lowest position, with floor mats bilaterally (both sides). A review of the facility's Fall Risk assessment dated [DATE] indicated Resident 6 had a history of falls and was a high fall risk. A review of the history and physical report dated 5/24/2024, indicated Resident 6 did not have the capacity to make decisions or make needs known. A review of the Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 7/15/2024, indicated Resident 6 had severe cognitive impairment (problems concentrating, completing tasks, following instructions and understanding) and needed maximum assistance with all activities of daily living (ADL). During an observation on 10/29/2024 at 10:52 AM in Resident 6's room, there was a yellow star above Resident 6's bed. During a concurrent interview, Resident 6's CNA (CNA 1) was asked if she knew what the yellow star above Resident 6's bed meant and stated she was new at the facility and did not know. CNA 1 then went to ask another CNA what it meant. CNA 1 then stated it meant Resident 6 was a fall risk. During an observation on 10/30/2024 at 6:45 AM in Resident 6's room, there was a yellow star above Resident 6's bed. During a concurrent interview, Resident 6's CNA (CNA 2) was asked if she knew what the yellow star above Resident 6's bed meant, CNA 2 stated she did not know. CNA 2 stated she did not recall being educated on the meaning of the yellow star. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/1/2024 at 11:50 AM, the Director of Staff Development (DSD) stated she was responsible for the CNA's orientation and in services. The DSD stated that all the CNAs should be knowledgeable about the facility's fall prevention program which included recognizing what the yellow star above the beds of those resident's who were identified as a high fall risk. The DSD stated that a huddle (meeting) was done prior to each shift and the CNAs were informed which residents were a high fall risk. During a concurrent review of the calendar of in services from July -October 2024 with the DSD, there was no indication any in services were provided regarding safety and fall prevention to the nursing staff. The DSD stated that if the CNA's were not able to identify those residents who were a high risk for falls it placed the residents at risk for actual falls and potential injuries. During an interview on 11/1/2024 at 1:17 PM, the Director of Nursing (DON) stated safety and fall prevention had not been an in-service topic, as it was not an identified concern in the facility. The DON stated that all facility staff were educated and should be familiar with the facility's fall prevention program which included the yellow star above residents bed who were identified as a high fall risk. The DON stated other than an Annual Competency Evaluation for all staff, staff competency was not being routinely monitored unless there was a concern. A review of the facilities policy and procedure dated 8/30/2024 and titled, Staffing, Sufficient and Competent Nursing, indicated competency requirements and training for nursing staff were established and monitored by nursing leadership to ensure that gaps in education were identified and addressed. Education topics and skills needed were determined based on the resident population, and tracking or other mechanisms were in place to evaluate the effectiveness of training.

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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 0740 Level of Harm - Actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50296 Based on observation, interview, and record review, the facility failed to ensure one sampled resident (Resident 39), who had a diagnosis of major depressive disorder (a common and serious medical illness, with severe low mood, sadness and despair) was provided necessary behavioral health care. The facility failed to: -Monitor Resident 39 for signs and symptoms of sad feelings and depression, per the Mood Problem with Crying Episodes Care Plan initiated 9/9/22. -Provide Resident 39 with a psychiatrist (a medical practitioner specializing in the diagnosis and treatment of mental illness) or psychologist (a professional who practices and studies mental states, perceptual, emotional, and social processes and behavior, involves the experimentation, observation, and interpretation of how individuals relate to each other and to their environments) to evaluate and assess the resident's mood. -Evaluate the effectiveness of the care plan for Resident 39's depressive symptoms. As a result, on 10/28/24, Resident 39 expressed feelings of frustration since the last comprehensive assessments on 12/1/23 and 2/29/24 and began to cry with tears streaming down his face. Findings: A review of Residents 39's admission record indicated the resident was admitted to the facility on [DATE], with diagnoses including nontraumatic intracerebral hemorrhage (a type of stroke that occurs when a pool of clotted blood forms in the brain tissue), major depressive disorder (a common and serious medical illness, severe low mood, sadness and despair), hemiplegia (loss of the ability to move one side of the body), hemiparesis (weakness on one side of the body), abnormalities in gait and mobility. A review of Resident 39's Mood Problem Care Plan initiated 3/10/21, manifested by feeling down, trouble sleeping, and feeling bad, indicated the interventions were to encourage Resident 39 to verbalize feelings and offer understanding. The Mood Problem Care Plan did not indicate an intervention to monitor the resident for adverse signs and symptoms. In addition, upon request from facility staff, the care plan was not updated, reviewed or revised quarterly, as there were no current dates to reflect the review. A review of Resident 39's Mood Problem with Crying Episodes Care Plan initiated 9/9/22, with psychologist visits every three weeks indicated the interventions were to monitor / record / report to physician as needed acute episodes of sad feelings, sign and symptoms of depression, and monitor for feelings of worthlessness or guilt. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055870	A. Building B. Wing	11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0740 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 39's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 12/1/2023, indicated the resident presented with feeling down, depressed, or hopeless for 2-6 days. Resident 39's functional abilities and goals indicated the resident used a wheelchair, was dependent on staff assistance for oral hygiene and toileting hygiene. The MDS indicated Resident 39 did not attempt or perform the ability to walk. A review of Resident 39's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 2/29/24, indicated the resident presented with feeling down, depressed, or hopeless for 2-6 days. Resident 39's functional abilities and goals indicated the resident used a wheelchair, was dependent on staff assistance for oral hygiene and toileting hygiene. The MDS indicated Resident 39 did not attempt or perform the ability to walk. According to a review of Resident 39's CSC - PHQ 2 to 9 Evaluation (a self-report patient health questionnaire, social services trauma assessment, tool used to gauge the resident's level of depression) dated 10/21/24, the resident felt down, depressed, or hopeless 12-14 days (nearly every day). During an interview on 10/28/24 at 11:05 AM, the Social Services Director (SSD) stated in her opinion the PHQ questions did not reflect how depressed Resident 39 may be. For example, the SSD stated, she performed an interview with Resident 39 using the CSC -PHQ assessment, the questions asked did not reflect how depressed the resident really appeared. During a concurrent observation and interview on 10/28/24 at 11:15 AM, Resident 39 was in his room, lying in the bed, and the call light was noted within reach. Resident 39 stated he did not like the care he received, and that the facility was not doing enough to provide the assistance he needed to get better. Resident 39 stated he did not know what was needed to get better and started to cry. Resident 39 was observed laying on his right side and began an expressionless cry with tears coming down his face. During an interview on 10/30/24 at 12:49 PM, Certified Nurse Assistant (CNA) 3 stated Resident 39 expressed feeling down and sad to the nursing staff in the past. CNA 3 stated she had observed Resident 39 cry about feeling down in the past and that the nurses were aware. CNA 3 stated when the resident expressed those feelings, CNA 3 tried to get Resident 39 to smile and focus on something happy. A review of Resident 39's clinical record indicated there was no monitoring / recording / reporting to the physician as needed of acute episodes of sad feelings, sign and symptoms of depression, or monitor for feelings of worthlessness or guilt, per Resident 39's care plan. A review of Resident 39's October Medication Administration Record (MAR) with Licensed Vocational Nurse (LVN) 1 indicated the resident was not being monitored for mood problem behavior or episodes sadness, hopelessness, or depression. During an observation on 10/30/24 at 1:02 PM, LVN 1 entered the nurse's computer system to review Resident 39's monitoring which remained blank. During a concurrent interview, LVN 1 stated Resident 39 was not being monitored for a mood problem. LVN 1 stated, The resident did not appear down or depressed and did not have diagnoses of psychosis (a mental disorder, collection of symptoms that affect the mind, where there has been some loss of contact with reality), aggressive behavior, or did not verbalize wanting to harm himself or others. (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	During concurrent interview and record review on 10/30/24 at 1:22 PM, with the Social Services Director (SSD), Resident 39's PHQ / trauma assessment by Social Services dated 10/21/24, was reviewed. The SSD stated the evaluation was performed 72 hours after admission, but if the resident had been at the facility for a while, then trauma assessments were done quarterly (Resident 39's last PHQ trauma assessment was dated 5/2024). The SSD confirmed that Resident 39 was not being monitored for signs and symptoms of depression, nor had a visit from a psychiatrist or psychologist. During a concurrent interview and record review on 11/1/24 at 1:31 PM with the Director of Nursing (DON), Resident 39's CSC - PHQ Evaluation dated 10/21/24 was reviewed. The DON stated the process to monitor a resident with behavioral issues begins with a psychologist or psychiatrist on staff who would place an order to monitor the resident. The DON stated a change of condition would be done to monitor the resident per the doctor's orders and psych evaluation. The DON stated the impact to the residents who were not monitored resulted in the resident's behavioral situation as unmanaged. The DON stated the CSC - PHQ Evaluation occurred during the time when the new social services director was hired and the old director was leaving. The DON stated Resident 39 was not receiving medication for his depression diagnosis therefore he would not be monitored. The DON stated the facility is obligated to provide the needed care. A review of the facility's policy and procedure titled, Behavioral Assessment, Intervention and Monitoring, dated 8/30/24, indicated the facility would provide behavioral health services to maintain the highest practicable physical, mental, and psychosocial well-being. The policy indicated nursing staff would identify, document, and inform the physician about specific changes in the resident's mental status, behavior, and cognition. The policy indicated new onset or changes in behavior would be documented.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49130 Based on observation, interview, and record review, the facility failed to ensure availability of divalproex (a medication used to treat a seizure [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness]) extended release (ER - a medication form that is slowly released into the body over a period of time) in the correct dose, and pyridoxine (a vitamin B6 used to treat or prevent low levels of vitamin B6) in accordance with physician's orders or professional standards of practice, affecting two of three sampled residents during medication administration (Residents 4 and 63). This deficient practice had the potential to result in seizures for Resident 4, and vitamin B6 deficiency, anemia, and mental status changes for Resident 63. Cross Reference F759 Findings: a. A review of Resident 4's Admission Record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with a diagnosis including epilepsy (a chronic brain disease causing seizures). A review of Resident 4's History and Physical dated 10/8/2024, indicated Resident 4 had mental capacity. A review of Resident 4's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 9/4/2024, indicated the resident had intact cognition (able to understand and make decisions), and required supervision from facility staff for eating and oral hygiene, During an observation of medication administration on 10/29/2024 at 10:08 AM with Licensed Vocational Nurse (LVN) 3, LVN 3 prepared the following medications to administer to Resident 4: -one tablet of cranberry 450 milligrams (mg - a unit of measurement for mass) -one tablet of multivitamin with minerals -one tablet of loratadine (a medication used to treat seasonal allergies) 10 mg -one tablet of amlodipine (a medication used to treat high blood pressure) 5 mg -one tablet of baclofen (a medication used to treat muscle stiffness and spasms) 10 mg -one tablet of divalproex ER 500 mg -one capsule of tamsulosin (a medication used to treat prostate [a gland below the bladder and in front of the rectum in men] problems) 0.4 mg (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-one tablet of topiramate (a medication used to treat seizures and prevent headaches) 25 mg -a small amount of bengay cream (a cream with combination of camphor 14% (percent), menthol 10% and methyl salicylate 30% used to treat localized pain -one drop in each eye of timolol (a medication used to treat high pressure inside the eyes) eye drops. During a concurrent interview and record review on 10/29/2024 at 10:08 AM with LVN 3, the pharmacy label on Resident 4's medication card for divalproex ER 500 mg was reviewed. The pharmacy label indicated, Divalproex Sod ER 500 mg tab, Generic for: Depakote ER 500 mg tab, take one tablet with 250 mg (750 mg) by mouth every 12 hours for seizure/epilepsy. LVN 3 stated the medications listed above were the only medications that Resident 4 was supposed to receive. LVN 3 stated she did not think the pharmacy label required another tablet of divalproex ER 250 mg in addition to divalproex ER 500 mg to make the total dose of 750 mg. LVN 3 stated she thought the divalproex ER 500 mg medication card included total dose of 750 mg and did not have a medication card for divalproex ER 250 mg available in her medication cart. A review of the Physician's Order Summary Report dated 10/29/2024, indicated for Resident 4 to receive Divalproex Sodium ER Tablet Extended Release 24 hour, give 750 mg by mouth every 12 hours for seizure related to epilepsy, order date: 9/28/2023, start date: 9/28/2023. A review of Resident 4's medication administration record (MAR) dated 10/1 to 10/31/2024, 9/1 to 9/30/2024 and 8/1 to 8/31/2024, indicated divalproex sodium ER 750 mg dose was documented as administered every 12 hours. The MAR indicated there was no documented administration of divalproex ER 250 mg along with divalproex ER 500 mg dose as indicated on the pharmacy label of medication card. A review of pharmacy delivery receipts from 5/2024 to 10/2024, indicated there were zero deliveries from the pharmacy to the facility for Resident 4's divalproex ER 250 mg. During an interview on 10/29/2024 at 11:37 AM, LVN 3 stated she should have had another medication card for Resident 4's divalproex ER 250 mg to make the total dose of 750 mg. LVN 3 stated facility staff should ensure medications were in stock and ordered the medication before it was out of stock. LVN 3 stated divalproex was for Resident 4's seizure, and this was the first time when they realized that Resident 4 was not receiving the right dose. LVN 3 stated, Resident 4 could suffer from seizures, fall, get injured and could end up in the hospital. During an interview on 10/30/2024 at 12:59 PM, the Director of Nursing (DON) stated The facility nurse should have checked the Depakote order. The DON stated it was the nurses' responsibility to ensure correct doses of medications were administered to Resident 4 and that divalproex ER 250 mg was started on 9/28/2023 and never sent to the facility. The DON stated there was potential harm to Resident 4 for not receiving the correct dose, and a risk of seizure, related injuries, and hospitalization . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055870	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/01/2024

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/31/2024 at 12:43 PM, Registered Pharmacist (RPH) 1 stated the Pharmacy (PH) 1 needed to receive two separate refill requests for Resident 4's divalproex ER 500 mg and 250 mg in order to be fulfilled and delivered to the facility, but the facility solely sent a refill request for divalproex ER 500 mg. The RPH 1 stated PH 1 delivered divalproex ER 500 mg and divalproex ER 250 mg to make the total dose of 750 mg on 1/2/2024. RPH 1 stated there were no orders delivered to the facility for Resident 4's divalproex ER 250 mg from 1/2/2024 to 10/28/2024. b. A review of Resident 63's Admission Record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Type II diabetes mellitus without complications and unspecified anemia (a condition where the body does not have enough healthy red blood cells). A review of Resident 63's H&P, dated 4/24/2024, indicated the resident had the capacity to understand and make decisions. A review of Resident 63's MDS, dated [DATE], indicated had intact cognition, required supervision or touching assistance for eating and was dependent or required moderate assistance for toileting, showering, dressing and personal hygiene. During a concurrent observation and interview on 10/29/2024 at 11:06 AM with LVN 4, LVN 4 prepared the following medications to administer to Resident 63: -one tablet of hydralazine (a medication used to treat high blood pressure) 25 mg -one tablet of baclofen 5 mg -one capsule of gabapentin 300 mg -one-half (1/2) tablet of labetalol (a medication used to treat high blood pressure and heart conditions) 100 mg -one tablet of cranberry 450 mg -7.5 milliliters (ml - a unit of measurement for volume) of ferrous sulfate (a medication used to treat low levels of iron) 220 mg/5 ml -one tablet of vitamin C (a supplement used to treat low vitamin C levels) 500 mg -one tablet of vitamin D3 (a vitamin used to treat low level of vitamin D) 25 micrograms (mcg - a unit of measurement for mass) -one tablet of amlodipine (a medication used to treat high blood pressure) 5 mg -one tablet of magnesium 480 mg (elemental magnesium 240 mg) -20 ml of levetiracetam (a medication used to treat seizures) 100 mg/ml solution -one tablet of multivitamin with minerals. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LVN 4 stated Resident 63 was supposed to receive two tablets of pyridoxine 50 mg, but it was not in stock, so would not be administering pyridoxine 50 mg. A review of the Physician's Order Summary Report, dated 10/29/2024, indicated Resident 63 was to receive Pyridoxine HCl oral tablet 50 mg, give two tablets by mouth one time a day for supplement, order date: 4/24/2024, start date: 4/25/2024. During an interview on 10/30/2024 at 12:59 PM, the DON stated it was important for the facility to have vitamins such as pyridoxine in stock, to treat vitamin deficiency for Resident 63. A review of the facility's policy and procedure (P&P) titled, Administering Medications, dated 8/2024, indicated, Medications are administered in a safe and timely manner, and as prescribed. Medications are administered in accordance with prescriber orders, including any required time frame. The individual administering the medication checks the label to verify the right resident, right dosage, before giving the medication. The P&P indicated, if a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall document, given at another time or, another medication.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 43851 Based on interview and record review, the facility failed to limit an as needed medication, Lorazepam (used to treat anxiety), to 14 days for one of six sampled residents (Resident 84). This deficient practice had the potential for Resident 84 to receive more medication as necessary and experience adverse (harmful) effects from the medication. Findings: A review of Resident 84's Admission Record indicated the facility admitted the resident on 7/19/2024 with diagnoses that included generalized anxiety disorder (a mental disorder that causes people to experience excessive and persistent worry that's difficult to control). A review of Resident 84's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 7/25/2024, indicated the resident had moderately impaired cognition (some loss in the ability to think, remember, express thoughts and make decisions) and was dependent on help for personal hygiene. The MDS indicated Resident 84 had a feeding tube was not taking anti-anxiety medication. A review of the Physician's Order dated 10/10/2024 indicated Resident 84 was to receive Lorazepam 0.25 milligrams (mg) via G-Tube (a tube inserted through the abdomen that delivers nutrition directly to the stomach) every 8 hours as needed for anxiety manifested by being unable to relax. The physician's order did not indicate a stop date for the medication. During a concurrent interview and record review on 11/1/2024 at 10:12 AM, Resident 84's physician's order dated 10/10/2024 was reviewed with Registered Nurse (RN) 3. RN 3 stated Resident 84's physician's order for Lorazepam was not limited to 14 days and should be limited to 14 days as indicated in the policy. RN 3 stated, I don't know what happened. RN 3 stated there was a potential for Resident 84 to receive a lot of dosages of Lorazepam and stated, We don't know how it will affect the resident. During a concurrent interview and record review on 11/1/2024 at 1:52 PM, Resident 84's physician's order dated 10/10/2024 was reviewed with the Director of Nursing (DON). The DON stated Resident 84's physician's order for Lorazepam did not follow the facility's policy. The DON stated as needed Lorazepam should be limited to 14 days, as it was a psychotropic medication (drug that affects behavior, mood, thoughts, or perception). The DON stated if there was not a limit given on Resident 84's Lorazepam there was a potential the resident could receive more medication then necessary and experience adverse effects from the medication. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure titled, Psychotropic Medication Use, reviewed 8/30/2024, indicated a psychotropic medication was any medication that affects brain activity associated with mental processes and behavior. Drugs in the following categories were considered psychotropic medication and were subject to prescribing, monitoring, and review requirements specific to psychotropic medications like Anti-anxiety medications. Psychotropic medications were not prescribed or given on a PRN basis unless that medication was necessary to treat a diagnoses specific condition that was documented in the clinical record. The PRN orders for psychotropic medications were limited to 14 days. For psychotropic medications that were not antipsychotics: If the prescriber or attending physician believes it was appropriate to extend the PRN order beyond the 14 days, he or she would document the rationale for extending the use and include the during for the PRN order.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49130 Based on observation, interview, and record review, the facility failed to maintain a medication error rate of less than 5% (percent) during medication pass for two of three sampled residents (Residents 4 and 63) observed during medication administration by failing to: -Ensure availability and administration of Resident 4's divalproex (a medication used to treat a seizure [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness]) extended release (ER - a medication form that is slowly released into the body over a period of time) in correct dose and in accordance with physician's orders. -Ensure availability and administration of Resident 63's metformin (a medication used to treat diabetes mellitus [DM-a disorder characterized by difficulty in blood sugar control and poor wound healing]) in timely manner, cranberry (a supplement used to prevent urinary tract infection [UTI - an infection in the bladder/urinary tract]) in correct dose, and pyridoxine (a vitamin B6 used to treat or prevent low levels of vitamin B6) in accordance with physician's orders. These failures resulted in an overall medication error rate of 12.9 % exceeding the 5% threshold and placed Residents 4 and 63 at risk to experience seizures, hyperglycemia (high blood glucose [simple sugar- the body's primary source of energy from food]), urinary tract infection or other medical complications leading to hospitalization . Cross Reference F755 Findings: a. A review of Resident 4's Admission Record indicated the resident was orignally admitted to the facility on [DATE] and readmitted on [DATE] with a diagnosis including epilepsy (a chronic brain disease causing seizures). A review of Resident 4's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 9/4/2024, indicated the resident had intact cognition (able to understand and make decisions) ted Resident 4 required setup or clean-up assistance and supervision from facility staff for eating and oral hygiene, respectively, and was fully dependent (helper does all of the effort) to requiring moderate assistance for performing some activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) such as toileting, showering, dressing and personal hygiene. A review of Resident 4's History and Physical (H&P), dated 10/8/2024 indicated the resident had mental capacity. During an observation of medication administration on 10/29/2024 at 10:08 AM with Licensed Vocational Nurse (LVN) 3, LVN 3 prepared the following medications to administer to Resident 4: -one tablet of cranberry 450 milligrams (mg - a unit of measurement for mass) (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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-one tablet of multivitamin with minerals -one tablet of loratadine (a medication used to treat seasonal allergies) 10 mg -one tablet of amlodipine (a medication used to treat high blood pressure) 5 mg -one tablet of baclofen (a medication used to treat muscle stiffness and spasms) 10 mg -one tablet of divalproex ER 500 mg -one capsule of tamsulosin (a medication used to treat prostate [a gland below the bladder and in front of the rectum in men] problems) 0.4 mg -one tablet of topiramate (a medication used to treat seizures and prevent headaches) 25 mg -a small amount of bengay cream (a cream with combination of camphor 14% (percent), menthol 10% and methyl salicylate 30% used to treat localized pain -one drop in each eye of timolol (a medication used to treat high pressure inside the eyes) eye drops. During a concurrent interview and record review on 10/29/2024 at 10:08 AM with LVN 3, the pharmacy label on Resident 4's medication card for divalproex ER 500 mg was reviewed. The pharmacy label indicated, Divalproex Sod ER 500 mg tab, Generic for: Depakote ER 500 mg tab, take 1 tablet with 250 mg (750 mg) by mouth every 12 hours for seizure/epilepsy. LVN 3 stated the medications listed above were the only medications that Resident 4 was supposed to receive. LVN 3 stated she did not think the pharmacy label required another tablet of divalproex ER 250 mg in addition to divalproex ER 500 mg to make the total dose of 750 mg. LVN 3 stated she thought the divalproex ER 500 mg medication card included total dose of 750 mg and did not have a medication card for divalproex ER 250 mg available in her medication cart. A review of the Physician's Order Summary Report dated 10/29/2024, indicated Resident 4 to receive Divalproex Sodium ER Tablet Extended Release 24 hour, give 750 mg by mouth every 12 hours for seizure related to epilepsy, order date: 9/28/2023, start date: 9/28/2023. A review of Resident 4's medication administration record (MAR) dated 10/1 to 10/31/2024, 9/1/ to 9/30/2024 and 8/1 to 8/31/2024, indicated divalproex sodium ER 750 mg dose was documented as administered every 12 hours. The MAR indicated there was no documented administration of divalproex ER 250 mg along with divalproex ER 500 mg dose as indicated on the pharmacy label of medication card. A review of the pharmacy delivery receipts from 5/2024 to 10/2024, indicated there were zero deliveries from the pharmacy to the facility for Resident 4's divalproex ER 250 mg. (continued on next page)

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	055870	A. Building B. Wing	11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunray Healthcare Center	3210 W Pico Blvd Los Angeles, CA 90019

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/29/2024 at 11:37 AM, LVN 3 stated she should have had another medication card for Resident 4's divalproex ER 250 mg to make the total dose of 750 mg. LVN 3 stated facility staff should ensure medications were in stock and ordered the medication before it was out of stock. LVN 3 stated divalproex was for Resident 4's seizure, and this was the first time when they realized that Resident 4 was not receiving the right dose. LVN 3 stated, Resident 4 could suffer from seizures, fall, get injured and could end up in the hospital. During an interview on 10/30/2024 at 12:59 PM, the Director of Nursing (DON) stated, The facility nurse should have checked the Depakote order, and it was the nurses' responsibility to ensure correct doses of medications were administered to Resident 4. The DON stated divalproex ER 250 mg was started on 9/28/2023 and never sent to the facility. The DON stated there was a potential harm to Resident 4 for not receiving the correct dose, and a risk of seizure, related injuries, and hospitalization . During an interview on 10/31/2024 at 12:43 PM, the Registered Pharmacist (RPH) 1 stated the Pharmacy (PH) 1 needed to receive two separate refill requests for Resident 4's divalproex ER 500 mg and 250 mg in order to be fulfilled and delivered to the facility, but the facility solely sent refill request for divalproex ER 500 mg. RPH 1 stated PH 1 delivered divalproex ER 500 mg and divalproex ER 250 mg to make the total dose of 750 mg on 1/2/2024. RPH 1 stated there were no orders delivered to the facility for Resident 4's divalproex ER 250 mg from 1/2/2024 to 10/28/2024. b. A review of Resident 63's Admission Record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Type II diabetes mellitus without complications and unspecified anemia (a condition where the body does not have enough healthy red blood cells). A review of Resident 63's H&P, dated 4/24/2024 indicated the resident had the capacity to understand and make decisions. A review of Resident 63's MDS, dated [DATE] indicated the resident had intact cognition and required required moderate assistance for toileting, showering, dressing and personal hygiene. During a concurrent observation and interview on 10/29/2024 at 11:06 AM with LVN 4, LVN 4 prepared the following medications to administer to Resident 63: -one tablet of hydralazine (a medication used to treat high blood pressure) 25 mg -one tablet of baclofen 5 mg -one capsule of gabapentin 300 mg -One-half (1/2) tablet of labetalol (a medication used to treat high blood pressure and heart conditions) 100 mg -one tablet of cranberry 450 mg -7.5 milliliters (mL - a unit of measurement for volume) of ferrous sulfate (a medication used to treat low levels of iron) 220 mg/5 mL (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-one tablet of vitamin C (a supplement used to treat low vitamin C levels) 500 mg -one tablet of vitamin D3 (a vitamin used to treat low level of vitamin D) 25 micrograms (mcg - a unit of measurement for mass) -one tablet of amlodipine (a medication used to treat high blood pressure) 5 mg -one tablet of magnesium 480 mg (elemental magnesium 240 mg) -one 20 mL of levetiracetam (a medication used to treat seizures) 100 mg/mL solution -one tablet of multivitamin with minerals. LVN 4 stated Resident 63 was supposed to receive one tablet of metformin 500 mg with breakfast, but she did not know if Resident 63 had consumed breakfast, so LVN 4 stated she would not be administering metformin 500 mg. LVN 4 stated Resident 63 was supposed to receive two tablets of pyridoxine 50 mg but did not have it in stock so would not be administering pyridoxine 50 mg. A review of the Physician's Order Summary Report, dated 10/29/2024 indicated Resident 63 was to receive Metformin hydrochloride (HCl) oral tablet 500 mg, give 1 tablet by mouth two times a day for DM, give with meals, order date: 10/3/2024, start date: 10/4/2024. Cranberry oral capsule, give 425 mg by mouth one time a day for UTI prophylaxis (ppx - prevention), order date: 9/30/2024, start date: 10/1/2024. Pyridoxine HCl oral tablet 50 mg, give 2 tablets by mouth one time a day for supplement, order date: 4/24/2024, start date: 4/25/2024. During an interview on 10/29/2024 at 11:35 AM, LVN 3 stated she did not know if Resident 63 had breakfast and metformin was supposed to be given early morning with breakfast, so metformin was not given to Resident 63. LVN 3 stated metformin was prescribed to treat resident's diabetes, and not receiving medication could cause Resident 63 to have hyperglycemia leading to loss of consciousness and hospitalization . During an interview on 10/29/2024 at 3:30 PM, LVN 4 stated Resident 63 did not receive metformin because he did not eat and the color frame on health record indicated metformin was a late administration. LVN 4 stated LVN 3 informed her that she had given metformin to Resident 63 but was not documented in the MAR. LVN 4 stated there was a risk for Resident 63 to become hypoglycemic (low blood glucose level) if metformin was administered again after being given but not documented in MAR. LVN 4 stated Resident 63 was supposed to receive cranberry 425 mg instead of 450 mg. LVN 4 stated she should have verified the dose and strength of cranberry capsule before giving to the resident. LVN 4 stated cranberry was given to prevent UTI and she did not know the risk of receiving higher than prescribed dose. During an interview on 10/31/2024 at 2:51 PM, LVN 4 stated Resident 63's metformin was supposed to be given on 10/29/2024 at 7 AM or 7:15 AM. LVN 4 stated metformin was not administered to Resident 63 on 10/29/2024 until 11:41 AM. LVN 4 stated not administering metformin to Resident 63 in timely manner increased risk for hyperglycemia and hospitalization . (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 10/30/2024 at 12:59 PM with the DON, Resident 63's administration details for metformin oral tablet 500 mg, dated 10/30/2024 was reviewed. The administration details indicated one tablet of metformin 500 mg was administered to Resident 63 on 10/29/2024 at 11:41 AM. The DON stated metformin for Resident 63 was administered late and not administering metformin in a timely manner increased Resident 63's risk for hyperglycemia that could progress into coma, hospitalization , and death. The DON stated it was important for the facility to have vitamins such as pyridoxine in stock to treat vitamin deficiency for resident. The DON stated cranberry given at an incorrect dose would not be effective for the resident to prevent UTI and could progress to sepsis (a life-threatening blood infection), painful urination and needing aggressive treatment. A review of the facility's policy and procedure (P&P) titled, Administering Medications, dated 8/2024, indicated medications were administered in a safe and timely manner, and as prescribed. Medications were administered in accordance with prescriber orders, including any required time frame. The individual administering the medication checks the label to verify the right resident, right dosage, before giving the medication. The P&P indicated if a drug was withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall document, given at another time or another medication.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49130 Based on observation, interview, and record review, the facility failed to: -Ensure storage and/or removal of undated and/or expired insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication), per manufacturer's requirements affecting two residents (Residents 42 and 87) in one of one inspected medication room (Station A Medication Room). -Ensure storage and/or removal of undated and/or expired insulin, fluticasone-salmeterol (a medication delivered in the form of inhalation powder through a device used to treat breathing problems), lansoprazole suspension (a medication used to treat gastroesophageal reflux disease (GERD - a digestive disorder when stomach contents leak into the esophagus [a muscular tube that moves food and liquids from the mouth to the stomach]) and gabapentin solution (a medication used to treat nerve pain and seizures [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness]), per manufacturer's requirements, affecting seven residents (Residents 13, 17, 35, 37, 40, 62 and 63) and in two of two inspected medication carts (Middle Medication Cart and Medication Cart 4 Subacute). -Ensure secure storage of timolol (a medication used to treat high pressure inside the eyes) eye drops affecting one of three sampled residents during medication administration (Resident 4). These failures resulted in and had the potential to result in Residents 4, 13, 17, 35, 37, 40, 42, 62, 63 and 87 receiving medications without supervision, or that had become ineffective or toxic due to improper storage or labeling possibly leading to misuse and health complications such as hyperglycemia (high blood glucose [simple sugar- the body's primary source of energy from food]), difficulty breathing and hospitalization . Findings: a. During a concurrent observation and interview on 10/29/2024 at 3:36 PM with Licensed Vocational Nurse (LVN) 4 in the Station A Medication Room, the following medications were stored in the medication refrigerator in a manner contrary to manufacturer's requirements, or not labeled with an open date as required by manufacturer's specifications: -Humulin R 100 units (a unit of measurement for insulin) / milliliters (ml - a unit of measurement) vial for Resident 87 that was unsealed and with an opened date of 9/3/2024. -Humulin R 100 units/ml vial for Resident 42, that was unsealed and with no open date. According to the manufacturer's product labeling, in-use (opened) vial stored at room temperature, below 30-degree Celsius [(C) is a unit of temperature] (86-degree Fahrenheit [(F) a unit of temperature] must be used within 31 days or be discarded. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LVN 4 stated Humulin R for Resident 87 expired on 10/4/2024 and the Humulin R for Residents 87 and Resident 42 would be unsafe and ineffective to administer to the residents, causing abnormal blood sugar levels because they were not labeled and/or removed from medication stock after their expiration date, as required per manufacturer. During an interview on 10/30/2024 at 2:01 PM, the Director of Nursing (DON) stated insulin should have been labeled with an open date when the insulin vial was opened. The DON stated the insulin labeled with the open date should have been removed from the refrigerator when expired to prevent medication errors and accidental administration. The DON stated there was a risk for insulin to be used that had lost its potency (effectiveness) and would not be effective for the resident, increasing the risk of adverse events such as hyperglycemia and hospitalization . b. During an observation and inspection of the Middle Medication Cart on 10/30/2024 at 3:07 PM with LVN 5, the following medications were found either expired or stored in a manner contrary to their respective manufacturer's requirements: -Insulin Lispro Kwik Pen (a type of insulin injection delivery device) 100 units/ml for Resident 63 with an opened date of 9/22/2024. According to the manufacturer's product labeling, once opened / in-use or once stored at room temperature, below 86 F (30 C), Insulin Lispro Kwik Pen must be used within 28 days or be discarded. Resident 63's Insulin Lispro KwikPen expired on 10/20/2024. -Basaglar (Generic name - Insulin Glargine) Kwik Pen 100 units/ml for Resident 37 with an opened date of 9/9/2024. According to the manufacturer's product labeling, once stored at room temperature (up to 86 F [30 C]), in use (opened) Basaglar Kwik Pen must be used within 28 days or be discarded. Resident 37's Basaglar Kwik Pen expired on 10/7/2024. -Admelog (Generic name - Insulin Lispro) SoloStar 100 units/ml prefilled pen for Resident 35 with an opened date of 9/13/2024. According to the manufacturer's product labeling, once stored at room temperature (up to 86 F [30 C]), in use (opened) Admelog SoloStar must be used within 28 days or be discarded. Resident 35's Admelog expired on 10/11/2024. -Humulin N KwikPen 100 units/ml for Resident 13 with an opened date of 10/12/2024. According to the manufacturer's product labeling, once stored at room temperature (below 86 F [30 C], in use (opened) Humulin N KwikPen must be discarded after 14 days. Resident 13's Humulin N KwikPen expired on 10/26/2024. -Fluticasone Propionate and Salmeterol Inhalation Powder 500 micrograms (mcg - a unit of measurement for mass)/50 mcg for Resident 17 with an opened date of 9/14/2024. According to the manufacturer's product labeling, the medication should be discarded one month after being opened or after removal from the moisture-protective foil pouch or after all blisters have been used (when the dose indicator reads 0') whichever comes first. Resident 17's fluticasone and salmeterol inhalation powder expired on 10/14/2024. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/30/2024 at 3:07 PM, LVN 5 stated the expired insulins lost potency and would increase the potential for adverse effects when administered to the residents. LVN 5 stated the blood glucose levels would not be controlled leading to high blood glucose, complications related to diabetes (a disorder characterized by difficulty in blood sugar control and poor wound healing) and hospitalization . LVN 5 stated the fluticasone and salmeterol inhalation powder should have been removed from the medication cart at one month expiration date and medication would not be effective to treat resident's shortness of breath due to asthma or COPD increasing the resident's risk for hospitalization . During an observation and inspection of Medication Cart 4 Subacute on 10/30/2024 at 4:18 PM with LVN 6, the following medications were found stored in a manner contrary to their respective manufacturer's requirements, or not labeled with resident name: -Lansoprazole Oral Suspension 3 milligrams (mg - a unit of measurement for mass)/ml for Resident 62 stored in the medication cart with an opened date of 10/16/2024. According to the manufacturer's product labeling, lansoprazole suspension should be stored in the refrigerator with a beyond-use date of not more than 30 days. -Gabapentin 250 mg/5 ml oral solution for Resident 40 stored in the medication cart with an opened date of 10/22/2024. According to the manufacturer's product labeling, gabapentin oral solution should be stored in the refrigerator at 2 -8 C (36 -46 F). -Humulin 70/30 100 units/ml, an unopened insulin vial with no resident label, no pharmacy label, and no labeled date. According to the manufacturer's product labeling, not-in-use (unopened) Humulin 70/30 vials should be stored in refrigerator (36 to 46 F [2 to 8 C]), if stored at room temperature, below 86 F (30 C) the vial must be discarded after 31 days, in-use (opened) vials could be stored in a refrigerator (36 to 46 F [2 to 8 C]) and must be used within 31 days or be discarded, and if stored at room temperature, below 86 F (30 C), the vial must be discarded after 31 days. During an interview on 10/30/2024 at 4:18 PM with LVN 6, LVN 6 stated expired medications, and lansoprazole suspension and gabapentin solution, that were not stored in the refrigerator according to the manufacturer requirements, would not be effective or safe to be administered to residents. LVN 6 stated, The chemistry and components in the bottle may change. LVN 6 stated he could not determine expiration date for the Humulin 70/30 insulin because it did not have date opened or a pharmacy label, and it would not be effective or safe to administer due to improper storage and labeling, with the potential of misuse or diversion. During an interview on 10/31/2024 at 3:22 PM, the DON stated the facility staff should have removed the insulin if expired and that the expired insulins could cause hyperglycemia leading to hospitalization and mortality. The DON stated fluticasone and salmeterol inhalation powder for asthma and COPD, if not removed after manufacturer recommended expiration date, the medication would not be effective, and resident could experience an asthma attack. The DON stated gabapentin solution's therapeutic effect could be altered and would not relieve nerve pain for the resident causing discomfort and pain, due to the medication not being stored in refrigerator as required. The DON stated lansoprazole suspension effectiveness and safety would be compromised and would not treat acid reflux for the resident because it was not stored in refrigerator as required. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. During an observation of Resident 4's medication administration on 10/29/2024 at 10:08 AM in Resident 4's room, timolol 0.5% (percent) ophthalmic (for the eyes) solution was found unattended on bedside cart. LVN 3 administered timolol eye drops into Resident 4's eyes before administering the rest of Resident 4's medications as prescribed. During an interview on 10/29/2024 at 11:35 AM, LVN 3 stated she planned to administer timolol eye drops to Resident 4 as the first medication before preparing other medications during medication pass. LVN 3 stated surveyor started following her and she did not realize that she had left the timolol eye drops at Resident 4's bedside. LVN 3 stated timolol eye drops should not have left unattended and unsecured by resident's bedside because that increased risk for misplacement, misuse, and diversion. During an interview on 10/30/2024 at 12:59 PM, the DON stated it was important to secure medications and should not be left unattended at resident's bedside. The DON stated securing medications was important to maintain residents' safety and to prevent an untoward accident, unintentional use, misuse and diversion. A review of the facility's policy and procedure (P&P) titled, Medication Labeling and Storage, dated 2/2023, indicated the facility stored all mediations and biologicals in locked compartments under proper temperature humidity and light controls. Medications requiring refrigeration were stored in a refrigerator located in the medication room at the nurses' station or other secured location. The P&P indicated the medication label included at a minimum: medication name, expiration date, when applicable resident's name, and precautions. Multi-dose vials that have been opened or accessed were dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial. The P&P indicated medications were stored in an orderly manner in cabinets, drawers, carts, or automated. Each resident's medications were assigned to an individual to prevent mixing medications of several residents.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38740 Based on observation, interviews, and record review, the facility failed to honor and update food preferences for 1 of 20 sampled residents (Resident 1). Resident 1's food preferences were not updated on the dietary profile and tray card and the resident received food he did not like. This deficient practice caused decreased meal satisfaction and overall caloric intake for Resident 1. Findings: A review of an admission records indicated Resident 1 was readmitted to the facility on [DATE] with diagnoses including acute embolism and thrombosis of right femoral vein (when blood clot forms in blood vessels and partially or completely blocks blood flow), Guillain-Barre Syndrome (a condition that causes nerve damage), spinal stenosis (a condition that can put pressure on the spinal cord and the nerves that affect the neck or lower back), muscle weakness. A review of the care plan dated 2/20/2024 indicated Resident 1 refused whole breakfast and preferred juice and milk. The care plan interventions indicated to honor food preferences and to update food preferences as needed. A review of the dietary profile/preferences for Resident 1 dated 2/20/2024 indicated the resident liked 8 oz of cranberry juice and 8 oz of whole milk for breakfast and lunch. The profile / preferences indicated 8 oz of juice and water for dinner, Resident 1 preferred to have juice and milk for breakfast and no meal. Resident 1 disliked pizza, tuna, iceberg lettuce, cucumber, green peas, and chicken breast. A review of the dietary profile/preferences for Resident 1 dated 6/17/2024 indicated the resident preferred 4 oz of juice and 8 oz of milk for breakfast and 4 oz of milk and water for lunch and dinner. There was no documentation on dislikes and the juice cup size was changed. A review of the care plan dated 7/1/2024 indicated Resident 1 was on a fortified diet with regular texture and there was no documentation regarding resident food preferences. A review of the Minimal Data Set (MDS - a federally mandated resident assessment tool) dated 8/16/2024, indicated Resident 1's current mental function was cognitively intact (able to understand and make decisions). A review of the dietary profile/preference for Resident 1 dated 9/29/2024 indicated there was no preference documented and the likes or dislikes were not documented. There were no beverages preferences were documented. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Resident 1 on 10/30/2024 at 2:36 PM, the resident stated he was not happy with the food at the facility. Resident 1 stated his food preferences were not honored and food preferences were not listed on the meal ticket/card that was placed on his lunch tray. Resident 1 stated he disliked tuna and chicken, but he gets them because his food preferences were not listed on the meal ticket. Resident 1 stated he wanted cranberry juice in a large cup, but he received juice in a 1/2 cup 4 ounces (oz) cup. Resident 1 stated that his juice preferences were not written on his meal ticket, and it was written in the past. During an interview on 11/1/2024 at 10:39 AM, the Dietary Supervisor (DS) stated she reviewed residents diet preferences on a quarterly or as needed basis. During a concurrent interview and record review of the dietary profile/preferences for Resident 1 dated 9/29/2024, the DS stated the dietary profile was blank and I don't see any of Resident 1's likes or dislikes documented. The DS stated the dietary profile had lots of information missing from previous months, that there was a menu update at that time and Resident 1's preferences were removed accidentally. The DS stated she was not aware of the preferences being removed and that they were not following what the resident liked. The DS stated this concern had a potential for the resident to feel frustrated if the food preferences were not acknowledged. A review of facility policy and procedure titled, Resident Food Preferences, revised July 2017 indicated, Upon the resident's admission (or within twenty-four (24) hours after admission) the dietitian or nursing staff will identify resident's food preferences .when possible, staff will interview the resident directly to determine current food preferences based on history and life patterns related to food and mealtimes.

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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** 38740 Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices in the kitchen when: -There was one carton of thickened milk with manufactures instruction to discard if not used within 4 days of opening stored in the reach in refrigerator with no open date. There was one carton of open and thickened apple juice mislabeled with a use by date that exceeds facility guidelines for fruit juice storage. There was one half of a peeled onion wrapped in a plastic wrap and stored in the bulk onion storage container at room temperature. -Nutritional supplement labeled store frozen with manufactures instruction to use within 14 days of thawing, were not monitored for the correct date they were thawed to ensure expired shakes were discarded after this time frame. 30 strawberry flavored nutrition supplements were stored in the reach in refrigerator with different thaw dates. This deficient practice had the potential to result in food borne illness in 13 residents who are on nutrition supplements at the facility. -One can opener blade was dirty with sticky and brown residue. The blade was worn and nicked with the potential to harbor harmful bacteria that were not easily cleanable. These deficient practices had the potential to result in harmful bacteria growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead food borne illness in 70 out of 97 residents who received food from the facility. Findings: a. During an observation in the kitchen on [DATE] at 8:30 AM, there was one open carton of thickened milk with no open date and one carton of opened thickened apple juice with open date of [DATE]. The use by date of [DATE] exceeded facility storage period for open juice, as the facility storage period for open juice box was one week. During a concurrent interview, the Dietary Supervisor (DS) stated once the carton of milk or juice was open it was good for a week. The DS stated usually beverages were finished in three days and the labels and dates informed staff know when it was time to discard the product. The DS stated expired milk and beverages can cause stomachache and the thickened apple juice was labeled with manufactures expiration date. The DS stated once a product was open it should be marked use within 7 days per fancily guidelines. During an observation in the kitchen dry storage area on [DATE] at 9 AM, there was one half of an onion that was peeled and wrapped in plastic and stored in the large bulk containers where onions were stored. During a concurrent observation and interview, the DS stated once the onion was peeled and cut it should be stored in the refrigerator. The DS stated peeled and cut onion would go bad when stored at room temperature. The DS discarded the onion. (continued on next page)

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	055870	A. Building B. Wing	11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunray Healthcare Center	3210 W Pico Blvd Los Angeles, CA 90019

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 9:05 AM, [NAME] 1 stated he used the onion and got confused and left it in the container outside instead of storing in the refrigerator. [NAME] 1 stated he had just put the onion there after using it for lunch preparation and that cut onions should be stored in the fridge or else they would go bad and make residents sick. A review of facility policy titled, Food Receiving and Storage, revised 2014 indicated, All foods stored in the refrigerator or freezer will be covered, labeled, and dated (use by date). A review of facility document posted in the kitchen titled, Food Share-Shelf-Life guide, (undated) indicated juice in cartons, fruit drinks and punch store for ,d+[DATE] days when open. A review of manufacturer's instruction for storage of the thickened milk product indicated to Store in a cool, dry place. Do not expose to moisture and heat. Do not freeze. Refrigerate after opening. Discard if not used within 4 days of opening. https://www.hormelhealthlabs.com/product/thick-easy-dairy-drinks-copy/?srsltid=AfmBOorBC6kXLjkG9dNR6L7y_7ni8MEWRS2M_9-ufVR3NoUk7S8nUa1C b. During an observation in the kitchen on [DATE] at 8:30 AM, there were 30 single serve cartons of strawberry flavor nutrition supplements stored in the reach in refrigerator with a received date of [DATE]. There was a removed from freezer date of [DATE] and a thawing date [DATE] all written on the box. During a concurrent observation and interview with dietary supervisor (DS) on [DATE] at 8:30 AM, the DS stated the single service carton of nutrition supplements were delivered frozen and were stored in the freezer. Then they were removed from the freezer to be served. The DS stated she did not know why there were two separate dates for thawing and that the produce was good for 14 days once removed from the freezer. The DS stated the nutrition supplement was milk based and residents could get sick when they drink expired milk. The DS stated since there were multiple thawing dates, she did not know the real thaw date and discarded the nutrition supplements. A review of facility document posted in the kitchen titled, Food and Dining Manual-Shelf Life/Use By Dates, indicated 'Health shake thaw - use by date two weeks.' c. During an observation in the kitchen food preparation area on [DATE] at 9:30 AM, one can opener blade was noted to be worn out and nicked. The blade was not smooth to the touch due to the nicked / dented surface of the blade. The blade was also dirty with sticky brown substance on the blade. During a concurrent interview, the DS verified there was only one can opener in the kitchen and stated that the blade needed to be changed. The DS stated the can opener was washed in the dish machine and that she would order a new blade to replace the current blade with dents. The DS stated when there was a dent in the blade, it did not get cleaned well and could contaminate food. A review of the facility policy titled, Sanitization, revised ,d+[DATE] indicated, All utensils, counters, shelves and equipment are kept clean, maintained in good repair and are fee form breaks, corrosions, open seam, cracks and chipped areas that may affect their use or proper cleaning. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the 2022 U.S. Food and Drug Administration Food Code, ,d+[DATE].15 Can Openers. Indicated, Once can openers become pitted or the surface in any way becomes uncleanable, they must be replaced because they can no longer be adequately cleaned and sanitized.

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50296 Based on interview and record review, the facility failed to provide a contract between the facility and the cosmetologist (a person who gives beauty treatments to skin and hair, not employed by the facility) and failed to provide the cosmetologist with an orientation program per the facility policy. This deficient practice caused an increased risk in the services being in accordance with professional standards of practice. Findings: A review of Residents 47's admission record indicated the resident was admitted to the facility on [DATE], with diagnoses including Alzheimer's disease (characterized by a progressive decline in mental abilities), need for assistance with personal care, and dementia (a chronic condition that causes a gradual decline in cognitive abilities, such as thinking, remembering, and reasoning). A review of Resident 47's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 10/7/24, indicated the resident usually understands verbal content, and had the ability to express ideas and wants. During observation on 10/28/24 at 11:23 a.m., a cosmetologist (COSM) walked into Resident 47's room and started to perform a haircut on the resident. The COSM did not knock on the door before entering or pull the curtain for privacy. During an interview on 10/30/24 at 11:32 a.m., the (COSM) stated she provided services to the facility for two years and there was no contract between the COSM and the facility. The COSM stated the services were provided once a week on Mondays. During an interview on 10/31/24 at 8:35 a.m., the Administrator (ADM) stated there was not a contract with the COSM and the facility. During an interview on 10/31/24 at 10:17 a.m., the Director of Staff Development (DSD) stated there was no knowledge of who the COSM was until the Department arrived on 10/28/24. The DSD stated the facility had contracts with outside services and the COSM did not have a vendor file with the facility. The DSD stated all contracts were kept with the Social Services Director (SSD). During an interview on 10/31/24 at 10:28 a.m., the Social Services Director (SSD) stated the COSM had been coming to the facility for two years and he was not sure if the COSM had a license to cut hair. The SSD stated the COSM did not have a vendor file or a contract with the facility. A review of Resident 47's care plan printed on 10/31/24, indicated there was no request from family or the facility for the resident to receive a hair cut or barber services. (continued on next page)

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/1/24 at 1:31 p.m., the ADM stated all vendors should have a contract with the facility. During a concurrent interview, the Director of Nursing (DON) stated vendors should go through the same process that employees go through and there could be concern if a vendor was not equipped or skilled to do the service. During a concurrent interview and record review of the facility's vendor list dated 11/1/24 (two years after start of service), the COSM's name, vendor ID, and phone number were listed, but there was no contract listed next to the COSM name or a cosmotology license number. The Payroll Staff stated the COSM was not on the payroll and was not an employee of the facility. A review of the facility's policy and procedure titled, Orientation Program for Newly Hired Employee, Transfers, Volunteers, dated 8/30/24, indicated an orientation program shall be conducted for those providing services under contractual arrangements. The policy indicated newly hired personnel / volunteers / transfers / contractors must attend a 10-hour orientation program. The program included a tour of the facility, instructions in emergency situations, introduction to resident care procedures and administrative structure.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50296 Based on observation, interview, and record review, the facility failed to ensure the audible resident call system remained functional. The resident call light for room [ROOM NUMBER] A was not audible when pressed. This deficient practice had the potential to prevent staff from answering call lights promptly. Findings: A review of Residents 1's admission record indicated the resident was admitted to the facility on [DATE], with diagnoses of Guillain-Barre Syndrome (the body's immune system attacks the nerves that lies outside the brain and spinal cord), spinal stenosis (narrowing of the spinal canal that puts pressure on the spinal cord and nerve), and muscle weakness. A review of the Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 9/16/2024 indicated Resident 1 was dependent to roll left to right and chair to bed transfer. The MDS indicated the resident had frequent bowel incontinence and was at risk for pressure ulcers. During an interview on 10/30/2024 at 1:14 p.m., Resident 1 stated the call system was broken. Resident 1 stated the automated voice should announce when the call light was pushed. Resident 1 stated the automated voice would be on at 7 am and off at 8 pm. During an interview on 10/30/24 at 1:35 p.m., Certified Nurse Assistant (CNA) 4 stated the call light system would light up outside the room and the announcement for which room could be heard. CNA 4 stated the announcement had not been working for about six months. During an interview on 10/30/24 at 1:54 p.m., with Maintenance (Staff 2), Staff 2 stated when the call light was pushed the light comes on to the metal panel across from the nurse's station, outside the room, and the room number was announced overhead. During a concurrent observation, the call light was pushed in room [ROOM NUMBER] A, the light was seen at the metal panel across from the nurse's station and outside the room. The announcement of the room number was not heard. Staff 2 stated would call to have the system serviced. During observation on 11/1/24 at 7:30 a.m., upon entrance into the facility, the audible call light system could be heard announcing the room number. During observation on 11/1/24 at 8:35 a.m., in the conference room, the audible call light system could not be heard once residents pressed the call light system for assistance. During concurrent interview on 11/1/24 at 1:31 p.m., the Director of Nursing (DON) stated it was important for both the audible and visual call systems to work. The Administrator (ADM) stated the supplement for the audible not working was for the CNAs to be stationed at the end of each hallway to see the call lights. The ADM stated the expectation was to respond to the call lights promptly. A review of the facility's policy and procedure titled, Call System, Resident, dated 8/30/24, indicated call system remains functional at all times.