STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055888	A. Building B. Wing	04/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Huntington Valley Healthcare Center	8382 Newman Avenue Huntington Beach, CA 92647

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39670 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the safe self-administration of medication for one nonsampled resident (Resident 41). * Two bottles of Systane eye drops (medication to temporarily relieve dry, irritated eyes) were kept at Resident 41's bedside table. Resident 41 had self-administered the Systane eye drop medication after being assessed to not self-administer her medications. This failure had the potential for the resident to administer the medications inaccurately and negatively affect the resident's physiological well-being. Findings: Review of the facility's P&P titled Self-Administration of Medications revised on 2/2021 showed the following: - As a part of the evaluation comprehensive assessment, the IDT assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident; - If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and the care plan; - Residents who are identified as being able to self-administer medications are asked whether they wish to do so; - For self-administering residents, the nursing staff determines who is responsible (the resident or the nursing staff) for documenting that medications are taken; and - Any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party. During the initial tour of the facility on 4/1/25 at 0808 hours, an observation and concurrent interview was conducted with Resident 41. Resident 41 was observed in bed. Two bottles of Systane eye drop medication were observed on top of Resident 41's bedside table. Resident 41 stated she did administer the Systane eye drops to herself. (continued on next page)

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

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/1/25 at 1559 hours, an observation and concurrent interview for Resident 41 was conducted with LVN 10. LVN 10 verified the two bottles of Systane eye drop medication were on Resident 41's bedside table. LVN 10 stated Resident 41 was not able to administer the eye drop medication on her own. LVN 10 stated Resident 41 could not keep the Systane eye drop medication at the bedside. Medical record review for Resident 41 was initiated on 4/3/25. Resident 41 was admitted to the facility on [DATE]. Review of Resident 41's H&P examination dated 10/11/24, showed Resident 41 had no capacity to understand and make decisions. Review of Resident 41's Self-Administration of Medication Observation form dated 1/10/25, showed Resident 41 was assessed and did not want to self-administer the medications. Review of Resident 41's Order Summary Report dated 4/3/25, did not show the physician's orders for the Systane eye drops and for Resident 41 to self-administer the medications. Review of Resident 41's plan of care did not show a care plan problem to address Resident 41's eye problem and her ability to self-administer the Systane eye drop medication. On 4/7/25 at 1339 hours, an interview and concurrent medical record review for Resident 41 was conducted with the DON. When asked for the facility's process for the resident to self-administer the medications, the DON stated the physician's orders, care plan, and assessment for self-administration of the medication for Resident 41 were needed. The DON verified there were no physician's orders and care plan for the self-administration of the medication for Resident 41.

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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 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** 50967 Based on interview, medical record review, and facility P&P review, the facility failed to obtain and/or maintain the copies of the advanced directives (written statement of a person's wishes regarding medical treatment) and provide the written information regarding how to formulate the advanced directives for four of 28 final sampled residents (Residents 44, 88, 97, and 106). * The facility failed to ensure a copy of the advance directive was available in Residents 44 and 106's medical record. * The facility failed to provide the written information and assistance regarding how to formulate an advance directive for Resident 88. * The facility failed to provide the written information regarding how to formulate the advance directive for Resident 97 was provided to the resident or responsible party. These failures had to the potential for residents' to receive inaccurate and delayed treatment compatible with the residents' wishes during an emergent situation. Findings: Review of the facility's P&P titled Advance Directives revised on 5/2024 showed the following: - The resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. Advance directives are honored in accordance with state law and facility policy; - Prior to or upon admission of a resident, the social service director (SSD) or designee inquires of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives; - The resident or representative is provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so; - Written information includes a description of the facility's policies to implement advance directives and applicable state law; - If the resident or representative indicates that he or she has not established advanced directives, the facility staff will offer assistance in establishing advance directives; - The resident or representative is given the option to accept or decline assistance, and care will not be contingent on either decision; (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Nursing staff will document in the medical record the offer to assist and the resident's decision to accept or decline assistance; - Information about whether or not the resident has executed an advance directive is displayed prominently in the medical record in a section of the record that is retrievable by any staff; and - If the resident or the resident's representative has executed one or more advance directive(s), or execute one upon admission, copies of these documents are obtained and maintained in the same section of the resident's medical record and are readily retrievable by any facility staff. 1. Medical record review for Resident 44 was initiated on 4/7/25. Resident 44 was readmitted to the facility on [DATE]. Review of Resident 44's H&P examination dated 2/26/25, showed Resident 44 had the capacity to understand and make decisions. Review of Resident 44's Advance Directive Acknowledgement dated 2/27/25, showed Resident 44 executed an advance directive. On 4/2/25 at 1215 hours, an interview and concurrent medical record review was conducted with LVN 12. LVN 12 verified the above findings; however, LVN 12 stated Resident 44's advanced directive was not available in the resident's medical record or EHR. LVN 12 stated the SSD was responsible to follow up and obtain a copy of Resident 44's advanced directive. Furthermore, LVN 12 stated if the resident executed an advanced directive, a copy must be available in the resident's medical record or in the EHR. On 4/3/25 at 1035 hours, an interview and concurrent medical record review was conducted with the SSD. The SSD verified the above findings and stated Resident 44's advanced directive was not available in the resident's medical record or EHR. The SSD stated she checked all the facility's residents advanced directive copies quarterly and when she was informed by the facility staff. Furthermore, the SSD verified there was no documented evidence a follow up was done to obtain a copy of Resident 44's advanced directive prior to 4/2025. 2. Medical record review for Resident 106 was initiated on 4/2/25. Resident 106 was admitted to the facility on [DATE]. Review of Resident 106's MDS dated [DATE], showed Resident 106's BIMS score was 11, indicating moderate cognitive impairment. Review of Resident 106's Advance Directive Acknowledgement dated 12/27/24, showed Resident 106 executed an advanced directive. On 4/2/25 at 1224 hours, an interview and concurrent medical record review was conducted with LVN 12. LVN 12 verified the above findings, however, LVN 12 stated Resident 106's advanced directive was not available in the resident's medical record or EHR. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/3/25 at 1049 hours, an interview and concurrent medical record review was conducted with the SSD. The SSD verified Resident 106's advanced directive was not available in the resident's medical record or EHR. The SSD stated Resident 106's advanced directive was discussed upon the resident's admission to the facility and must be revisited quarterly. Furthermore, the SSD verified there was no documented evidence a follow up was done to obtain a copy of Resident 106's advanced directive prior to April 2025. On 4/7/25 at 1420 hours, an interview was conducted with the Administrator. The Administrator was informed and acknowledged the above findings. 49258 3. Medical record review for Resident 88 was initiated on 4/1/25. Resident 88 was readmitted to the facility on [DATE]. Review of Resident 88's Advance Healthcare Directive Acknowledgement dated 11/27/24, showed Resident 88 had not executed an advance directive. Review of Resident 88's Social History Assessment (Admission/Annual) - V 3.4 dated 12/23/24, showed Resident 88 had no advance directive and Family Member 2 was Resident 88's primary agent. Review of Resident 88's MDS assessment dated [DATE], showed Resident 88 had moderate cognitive impairment. Further review of Resident 88's medical record failed to show the documented evidence the facility followed up with Resident 88 and/or Family Member 2 to provide the information and assistance on formulating the advance directive. On 4/3/25 at 0951 hours, an interview was conducted with RN 2. RN 2 stated part of the admission process, the RN had to check with the resident or their responsible party whether the resident had an advance directive. RN 2 stated the Advance Healthcare Directive Acknowledgement form would be provided to the resident or their responsible party. RN 2 stated if the resident or their responsible party indicated the resident did not have an advance directive, the social services staff would follow up with the resident to provide the written material on how to formulate the advance directive. RN 2 further stated the social services staff could also offer assistance on how to formulate the advance directive. On 4/3/25 at 1417 hours, an interview and medical record review for Resident 88 was conducted with the SSD. The SSD stated if the resident or their responsible party indicated the resident had not executed an advance directive, the social services staff should provide the written material titled Your Rights to Make Decisions About Medical Treatment, which had the information on how to formulate the advance directive. The SSD further stated an assistance should be offered or provided to the resident or their responsible party on how to formulate the advance directive and should be documented in the resident's progress notes or in the social history assessment. The SSD verified there was no documented evidence Resident 88 and Family Member 2 were provided the information and offered assistance on formulating the advance directive. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/4/25 at 1630 hours, an interview was conducted with the DON. The DON was informed and acknowledge the above findings. 48882 4. Medical record review for Resident 97 was initiated on 4/1/25. Resident 97 was admitted to the facility on [DATE]. Review of Resident 97's Physician Orders for Life-Sustaining Treatment (POLST) dated 1/28/25, under Section D Information and Signatures showed no advance directive was selected. However, the section for Health Care Agent if named in the Advance Directive showed Resident 97's responsible party. Review of Resident 97's Social History assessment dated [DATE], showed Resident 97 had no advance directive nor power of attorney, and the resident's family would like assistance in obtaining one. Review of Resident 97's H&P examination dated 1/30/25, showed Resident 97 did not have the mental capacity to make decisions. Review of Resident 97's medical record failed to show the Advance Healthcare Directive Acknowledgement form. Additionally, further review of Resident 97's medical record failed to show the documented evidence Resident 97's responsible party was provided with the information on formulating the advance directive. On 4/3/25 at 1600 hours, an interview and concurrent medical record review for Resident 97 was conducted with the SSD. The SSD verified the above findings. The SSD stated if the resident had no capacity to make decision, the information on how to formulate an advance directive should still be offered to the resident's responsible party. On 4/7/25 at 1403 hours, an interview was conducted with the DON. The DON stated upon admission to the facility, the facility staff was responsible for inquiring whether the resident had an advance directive. The DON stated if the resident or resident's responsible party indicated they wanted more information on how to formulate an advance directive, the DON expected the admitting nurse or the social services staff to provide the written material on how to formulate the advance directive. The DON further stated the facility staff should also document in the resident's progress notes that the information on how to formulate an advance directive had been offered to the resident or resident's responsible party. On 4/7/25 at 1430 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 35346 Based on observation and interview, the facility failed to provide a safe, clean homelike environment in three of 50 resident rooms (Rooms A, B, and C). This failure posed the risk of the residents not having a sanitary, comfortable living space and potential to negatively impact the residents' quality of life. Findings: 1. On 4/1/25 at 0817 hours, an observation of Room A was conducted. The vent cover inside Room A was observed with rust and black substance around the vent cover. In addition, a hole measuring approximately one inch in diameter was observed on the ceiling above a resident's bed inside Room A. On 4/1/25 at 1600 hours, an observation and concurrent interview was conducted with the Maintenance Director. The Maintenance Director verified the above findings. 2. On 04/1/25 at 0912 hours, an observation of Room C was conducted. The footboard for a resident's bed inside Room C was observed with ripped corners exposing the inner cardboard surface of the footboard. On 4/1/25, at 1548 hours, an observation and concurrent interview was conducted with the Maintenance Director. The Maintenance Director verified the above findings. 3. On 4/1/25 at 1607 hours, an observation and concurrent interview was conducted with the IP. The footboards of the residents' beds (three beds) inside Room B were observed with ripped corners exposing the inner cardboard surface of the footboards. The IP verified the findings.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49258 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to meet the professional standards of care for one nonsampled resident (Resident 370) observed for medication administration. * LVN 1 failed to follow the proper procedure for the administration of insulin. This failure posed the risk for the resident to develop complications related to the inappropriate technique with the administration of insulin (used to treat high blood sugar). Findings: Review of the facility's P&P titled Insulin Administration revised 5/2024 showed the Steps in the Procedure (Insulin Injections via Syringe) section including to clean the injection site with an alcohol wipe and allow to air dry. Review of the Administration Guide from the manufacturer of the Lantus insulin (undated) showed Step 4: Choose an Injection Site included the following: - Decide on an injection area- either upper arm, thigh, or abdomen. Injection sites within an injection area must be different from one injection to the next; - Use rubbing alcohol to clean the skin where you are going to inject. Alcohol can sometimes sting if it is not completely dry when you inject, so wait a few seconds for it to evaporate or pat the area dry with sterile cotton ball; and - Pinch the skin and hold it. Insert the needle the way your healthcare professional showed you. Medical record review for Resident 370 was initiated on 4/2/25. Resident 370 was admitted to the facility on [DATE]. Review of Resident 370's Order Summary Report showed a physician's order dated 3/26/25, to administer insulin glargine solution (Lantus) 100 units/ml 25 units subcutaneously (into the fatty tissue layer) two times a day for diabetes mellitus (high blood sugar). On 4/2/25 at 0943 hours, a medication administration observation was conducted with LVN 1. LVN 1 stated Resident 370 was to receive the Lantus insulin 25 units subcutaneously. LVN 1 was observed wiping Resident 370's left upper quadrant of the abdomen with an alcohol wipe and injected the Lantus insulin right away while the injected area was still visibly wet. LVN 1 did not wait for the area wiped with alcohol to dry before injecting the insulin to Resident 370. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/2/25 at 1426 hours, an interview was conducted with LVN 1. LVN 1 stated he received training regarding how to properly administer insulin or any injectable medications. LVN 1 stated prior to administering or injecting the insulin, the area where to inject the medication should be cleansed with alcohol and let it air dry. LVN 1 stated if the insulin was injected while the area was still wet with alcohol, it might sting and could cause pain to the resident, and it might alter the effect of the medication. LVN 1 verified Resident 370's left upper quadrant of the abdomen where he injected the insulin was not completely dry prior to administering the insulin. On 4/3/25 at 1346 hours, an interview and concurrent facility personnel record review was conducted with the DSD. Review of LVN 1's Licensed Nurse Competency Evaluation Worksheet (Medication Administration-Injection) signed 7/6/23, showed LVN 1 was trained to clean the injection site with an alcohol pad by beginning at the center of the injection site and clean in a circular motion to extend two inches from the center of the injection site; and to allow the site to air dry (about one minute). The DSD stated when the area to inject the medication was not completely dried, it might sting and alter the effect of the medication. The DSD was informed and acknowledged the above findings. On 4/4/25 at 1630 hours, the DON was informed and acknowledged the above findings.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35346 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to attain or maintain the highest practicable well-being for one of 28 final sampled residents (Resident 21) and two nonsampled residents (Residents 57 and 101) as evidenced by: * The facility failed to ensure the follow-up assessment and documentation were completed for Resident 21's foot scab and bilateral feet dryness. * The facility failed to ensure Resident 57's post fall neurological assessment and monitoring were accurately completed after the resident had a fall on 3/16/25. * The facility failed to ensure the attending physician was made aware regarding the recommendations from the acute care hospital for Resident 101 to be assisted in drinking the thickened liquid with a spoon. CNA 8 was observed using a plastic straw to provided assistance to Resident 101 when drinking the thickened liquids. These failures posed the risk of the residents not receiving appropriate care and the potential for a delay in providing care to the residents. Findings: 1. On 04/1/25 at 1225 hours, Resident 21's second right toenail was observed with a black circular mass underneath the toenail. On 04/3/25 at 0816 hours, an observation and concurrent interview was conducted with LVN 7. When asked about the wound treatments performed to Resident 21's skin, LVN 7 stated she and Resident 21's wound care specialist provided wound care to Resident 21's right heel on 4/3/25. LVN 7 stated she did daily wound care treatments to Resident 21's right heel. LVN 7 verified Resident 21's second right toenail had a black scab on it and both Resident 21's feet had dryness. LVN 7 stated she was not aware of Resident 21's other feet conditions, other than the right heel wound. Medical record review for Resident 21 was initiated on 4/3/25. Resident 21 was admitted to the facility on [DATE]. Review of Resident 21's Comprehensive Skin Evaluation/assessment dated [DATE], did not show Resident 21's right second toenail scab or bilateral feet dryness was addressed. Review of Resident 21's podiatry visit dated 2/27/25, showed Resident 21 was treated for mycotic (caused by fungus) toenails and dryness to both his feet. Resident 21's podiatry recommendations included to apply lotion three to four times daily to restore moisture to Resident 21's feet. 50967 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the facility's P&P titled Neurological Assessment revised on 4/2025 showed the following: - Routine Neurological Assessment is conducted to evaluate the resident for small changes over time that may be indicative of neurological injury; and - The following information should be recorded in the resident's medical record: a. The date and time the procedure was performed; b. The name and title of the individual(s) who performed the procedure; c. All assessment data obtained during the procedure; d. How the resident tolerated the procedure; e. If the resident refused the procedure, the reason(s) why and the intervention taken; and f. The signature and title of the person recording the date. Review of the facility's P&P titled Change in a Resident's Condition or Status revised on 2/2021 showed the following: - The nurse will notify the resident's attending physician or physician on call when there has been an accident or incident involving the resident and significant change in the resident's physical/emotional/mental condition; and - The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. Review of the facility's P&P titled Falls-Clinical Protocol revised on 5/2024 showed the facility staff and physician will continue to monitor and document the individual's response to the interventions intended to reduce falling or the consequences of falling. Medical record review for Resident 57 was initiated on 4/3/25. Resident 57 was admitted to the facility on [DATE]. Review of Resident 57's H&P examination dated 3/11/25, showed Resident 57 had the capacity to understand and make decisions. Review of Resident 57's MDS dated [DATE], showed Resident 57's BIMS score was 12, indicating moderate cognitive impairment. Review of Resident 57's Neurological Assessments from 3/16 to 3/19/25, showed missing the Neurological Assessment results for the following dates and times: - on 3/17/25, at 0130 hours, the left pupil response was not assessed; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- on 3/17/25, at 0530 hours, the left pupil response, extremities motor function, and pain response were not assessed; - on 3/17/25, at 1730 hours, the Neurological Assessment was not completed; - on 3/18/25 at 0130 hours, the Neurological Assessment was not completed; and - on 3/19/25, from 0930 to 1790 hours, the Neurological Assessment was not completed. Reviewed Resident 57's progress notes from 3/16 to 3/19/25, did not show the post fall monitoring was completed on the following dates and times: - on 3/17/25, from the day shift (0700-1500 hours) to evening shift (1500-2300 hours); - on 3/18/25, from the day shift to evening shift; and - on 3/19/25, for the day shift. On 4/7/25 at 0951 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified the above findings. The DON stated the Neurological Assessments must be completed by the licensed nurses to assess Resident's 57 neurological status post fall. Furthermore, the DON stated the post fall monitoring and documentation must be completed every shift for 72 hours. On 4/7/25 at 1025 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 verified the above findings. RN 1 stated the post fall monitoring must be documented to monitor Resident 57's condition and status. Furthermore, RN 1 stated the monitoring for the change of condition which included post fall, must be documented in Resident 57's medical record every shift for 72 hours and the Neurological Assessment must be completed to monitor the resident's neurological status. On 4/7/25 at 1420 hours, an interview was conducted with the Administrator. The Administrator was informed and acknowledged the above findings. 39670 3. On 4/1/25 at 0834 hours, an observation and concurrent interview for Resident 101 was conducted with CNA 8. Resident 101 was observed in bed and CNA 8 was observed assisting the resident with eating. CNA 8 stated Resident 101 was able to swallow the thickened liquids. A glass of thickened red color liquid with a white plastic straw was observed on top of the over bed table. CNA 8 stated Resident 101 was able to use the straw in drinking the thickened liquid but unable to hold the glass. Medical record review for Resident 101 was initiated on 4/3/25. Resident 101 was admitted to the facility on [DATE]. Review of Resident 101's Discharge Summary from the acute care hospital dated 12/6/24, showed the Speech Therapy Treatment Note/Discharge Note dated 11/28/24, for diet and swallow recommendations. The recommendations were as follows: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Nectar thick liquids, - Aspiration precautions: sit upright while eating and drinking, - Resident must be fed, - Liquid by spoon only, and - Maintain upright posture after eating for 30 minutes. Review of Resident 101's Order Summary Report dated 4/3/25, showed a physician's order dated 2/26/25, for regular diet, pureed texture, and thickened liquid nectar consistency for oral gratification only as tolerated. Further review of Resident 101's medical record failed to show documented evidence the Speech Therapy diet and swallowing discharge recommendations from the acute care hospital were communicated to the resident's attending physician and followed for Resident 101. On 4/3/25 at 1340 hours, an observation and concurrent interview for Resident 101 was conducted with CNA 8. Resident 101 was observed in bed awake and CNA 8 was observed assisting the resident with eating. Resident 101's food tray and a glass of red color thickened liquid covered with a lid with a white plastic straw were observed on top of the over bed table. CNA 8 stated she assisted Resident 101 with eating and drinking. CNA 8 verified she used the white colored plastic straw to help Resident 101 drink the thickened liquid. On 4/3/25 at 1352 hours, an interview and concurrent medical record review for Resident 101 was conducted with LVN 3. LVN 3 verified Resident 101 had a physician's order for pureed diet with thickened liquids. LVN 3 verified Resident 101's discharge summary recommendations from the acute care hospital included using spoon only for the thickened liquids. LVN 3 verified there was no documentation on the resident's medical record to show if the attending physician was made aware regarding the recommendations. On 4/7/25 at 0936 hours, an interview and concurrent medical record review for Resident 101 was conducted with RN 1. RN 1 verified the physician's order for oral gratification diet order for Resident 101. RN 1 was asked if a straw was allowed to use for the residents who were on thickened liquids, RN 1 stated no. RN 1 verified the discharge summary recommendations from the acute care hospital for the resident's diet and swallowing precautions. RN 1 stated Resident 101 was seen by the ST in the facility. RN 1 acknowledged there were no documentation showing the swallowing recommendations from the acute care hospital for Resident 101 was communicated to the facility staff and resident's physician. On 4/7/25 at 1012 hours, an interview and concurrent medical record review for Resident 101 was conducted with the DON. The DON was informed and verified the above findings.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39670 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the treatment was provided to prevent the decline in the ROM functions for one of three final sampled residents (Resident 63) reviewed for prevention of ROM functions. * The physician's order to apply an extension splint to Resident 63's left knee was not followed. In addition, Resident 63's skin was not assessed when the splint was applied. This failure had the potential for Resident 63 to sustain a decline in ROM functions, leading to muscle atrophy (loss of muscle mass and strength) and decrease in functioning. Findings: Review of the facility's P&P titled Restorative Nursing Services dated 5/2024 showed the restorative care will be provided to help promote optimal safety and independence. During the initial tour of the facility on 4/1/25 at 1045 hours, an observation and concurrent interview with Resident 63 was conducted. Resident 63 was observed wearing the left lower leg splint. Resident 63 stated there were screws placed on his leg to align his leg. Medical record review for Resident 63 was initiated on 4/7/25. Resident 63 was admitted to the facility on [DATE]. Review of Resident 63's Order Summary Report dated 4/7/25, showed a physician's order dated 3/27/25, to apply the left knee extension splint to the left knee everyday five times a week for up to five hours a day or as tolerated. However, there was no physician's order to include the skin assessment when the left knee splint was applied. Review of Resident 63's plan of care showed a care plan problem (undated) addressing the potential decline in the resident's ROM functions and mobility. The interventions included the application of the left knee extension splint for up to five hours as per the physician's order. However, there were no interventions included in the care plan to perform Resident 63's skin assessment when the left knee splint was applied to the resident. Review of Resident 63's Documentation Survey Report for April 2025 showed the RNA had applied the left extension knee splint to Resident 63. However, the record failed to show an accurate record of the time when the splint was applied and removed. In addition, there was no documented evidence the skin assessment was completed when the left knee extension splint was applied to Resident 63's left knee. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/7/25 at 0908 hours, an interview and concurrent medical record review for Resident 63 was conducted with RNA 1. RNA 1 verified Resident 63 had RNA services ordered and the application of the left knee extension splint. RNA 1 was asked what time the left knee splint was applied to Resident 63. RNA 1 reviewed the medical record and stated the left knee splint was applied to Resident 63's left knee for five hours every day. RNA 1 verified there was no documentation of the exact time when the left knee splint was applied and removed from Resident 63's knee. RNA 1 was asked about Resident 63's skin when the left knee splint was applied. RNA 1 stated the RNAs checked the resident's skin after the left knee splint was taken off from Resident 63. RNA 1 verified and acknowledged there was no documentation about the skin assessment of Resident 63's left knee when the left knee splint was applied. On 4/7/25 at 0931 hours, an interview and concurrent medical record review for Resident 63 was conducted with RN 1. RN 1 verified Resident 63's physician's order for the RNA services and the application of the left knee splint to Resident 63's left knee. RN 1 verified there was no physician's order to assess the resident's skin while the left knee splint was applied. RN 1 reviewed the RNA record and verified the hours of application for the left knee splint to Resident 63's knee was not documented, and the skin assessment was not included in the documentation. RN 1 stated a physician's order for the skin assessment at least every two hours should have been obtained and carried out to prevent any skin problem related to placement of the splint on the resident. RN 1 verified the care plan for the use of the splint did not include the skin assessment of the resident when the splint was in use. On 4/7/25 at 1042 hours, an interview for Resident 63 was conducted with the DON. The DON was informed and verified the above findings.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50967 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of 28 final sampled residents (Resident 73) received the appropriate care and services for an indwelling urinary catheter. This failure had the potential for the resident to develop complications associated with the use of indwelling urinary catheter. Findings: Review of the facility's P&P titled Urinary Catheter Care revised on 5/2024 showed the following: - Observed the resident for complications associated with urinary catheters; and - Report unusual findings to the physician or supervisor immediately if urine has an unusual appearance like color, blood, etc. and if signs and symptoms of urinary tract infection or urinary retention occur. Medical record review for Resident 73 was initiated on 4/4/25. Resident 73 was readmitted to the facility on [DATE]. Review of Resident 73's MDS dated [DATE], showed Resident 73's BIMS score was 12, indicating moderate cognitive impairment. Review of Resident 73's Order Summary Report dated 3/1/25, showed the following physician's orders: - to provide indwelling urinary catheter care with soap and warm water, rinse and pat dry every shift; and - for indwelling urinary catheter size 16 French/10 ml, to monitor for placement and function every day shift for urinary retention. On 4/1/25 at 0935 hours, during the initial tour of the facility, Resident 73 was observed with an indwelling urinary catheter connected to a urinary drainage bag placed at the side of the bed. The urinary drainage bag tubing was observed with sediments and cloudy urine. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/2/25 at 1206 hours, an observation and concurrent interview was conducted with LVN 1. Resident 73 was observed with an indwelling urinary catheter connected to a urinary drainage bag placed at the side of the bed. The urinary drainage bag tubing was observed with sediments and cloudy urine. Resident 73 stated the indwelling urinary catheter was changed last weekend. LVN 1 verified Resident 73's urine was cloudy with a lot of sediments in the indwelling urinary catheter tubing. LVN 1 stated a cloudy urine with sediments in the urinary catheter tubing showed signs of an infection. Furthermore, LVN 1 stated when a resident had a change of condition, the licensed nurses must complete a COC assessment report, inform the physician to obtain an order, inform the resident's responsible party, initiate a care plan, monitor the resident every shift for 72 hours, and document the assessment in the resident's progress notes. LVN 1 acknowledged Resident 73's cloudy urine with sediments in the resident's urinary catheter tubing was a change in the resident's condition. On 4/4/25 at 0955 hours, an observation, interview, and concurrent medical record review was conducted with LVN 12. Resident 73 was observed with cloudy urine and sediments in the urinary catheter tubing. LVN 12 verified the findings. LVN 12 was asked to show the COC documentation, progress notes, and care plan for Resident's 73's cloudy urine with sediments in the urinary catheter between the dates of 4/1-4/4/25. LVN 12 verified there were no COC documentation, progress notes, and care plan for Resident's 73's cloudy urine with sediments in the urinary catheter tubing between the dates of 4/1-4/4/25, in the resident's EHR. On 4/4/25 at 1029 hours, a follow-up interview and concurrent medical record review was conducted with LVN 1. LVN 1 was asked to show the COC documentation, progress notes, and care plan for Resident's 73's cloudy urine with sediments in the urinary catheter tubing between the dates of 4/1-4/4/25. LVN 1 verified there was no COC documentation, progress notes and care plan initiated or completed in Resident 73's EHR. LVN 1 stated he reported the resident's cloudy urine with sediments (change of condition) to RN 2 and LVN 9. LVN 1 stated RN 2 and LVN 9 were supposed to follow up and complete the documentation. On 4/4/25 at 1036 hours, an interview and concurrent medical record review was conducted with RN 2. RN 2 was asked regarding the facility expectation when a resident had a change of condition. RN 2 stated the licensed nurses must complete the COC documentation, inform the physician, and initiate a care plan in the resident's EHR. RN 2 stated she was not aware of Resident's 73's cloudy urine with sediments in the urinary catheter tubing. RN 2 verified there was no COC documentation, progress notes, and care plan for Resident's 73's cloudy urine with sediments in the urinary catheter tubing between the dates of 4/1-4/4/25, in the resident's EHR. On 4/7/25 at 1420 hours, an interview was conducted with the Administrator. The Administrator was informed and acknowledged the above findings.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49258 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary GT care and services for two of two final sampled residents (Residents 3 and 30) reviewed for enteral feeding. * The facility failed to ensure the intake and output were monitored for Resident 30 who was receiving an enteral feeding. * The facility failed to ensure Resident 3's enteral feeding formula was changed within 24 hours and label the resident's enteral feeding water bag with the date and time the bag was prepared. These failures posed the risk for developing complications related to enteral feeding and GT. Findings: Review of the facility's P&P titled Intake, Measuring and Recording revised 5/2024 showed the following: - The purpose of this procedure is to accurately determine the amount of liquid the resident consumes in a 24 hour period; - At the end of the shift, the facility staff should total the amounts of all liquids the resident consumed; - Record all the fluid intake on the intake and output record in cubic centimeters; - Post an intake and output record form in the resident's room; and - The following should be recorder in the resident's medical record, per facility guidelines: the date and time the resident's fluid intake was measured and recorded, the name and title of the individual who measured and recorded the resident's fluid intake, the amount of liquid consumed, the type of liquid consumed, if the resident refused the treatment, the reason why and the intervention taken, and the signature and title of the person recording the data. 1. On 4/1/25 at 1204 hours, during the initial tour of the facility, Resident 30 was observed awake and sitting on the bed. Family Member 5 was observed with Resident 30 in the room. An enteral feeding pump was observed on at 50 ml/hr. Family Member 5 stated Resident 30 had a GT and had been receiving an enteral feeding because the resident was not eating well in the past due to an illness. Family Member 5 stated Resident 30 could now eat a meal by mouth and at times would request the enteral feeding to stop so he could walk around. Medical record review for Resident 30 was initiated on 4/1/25. Resident 30 was admitted to the facility on [DATE]. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 30's H&P examination dated 2/23/25, showed Resident 30 had the capacity to understand and make decisions and a medical history of dysphagia (difficulty swallowing). Review of Resident 30's Order Summary Report showed a physician's order dated 2/22/25, to administer Glucerna (enteral feeding formula) at 50 ml/hr for 20 hours to provide 1000 ml/1380 kcal via GT; to start the infusion at 1200 hours, off at 0800 hours, or until the total volume was completed. Review of Resident 30's plan of care initiated on 2/26/25, showed a care plan problem addressing Resident 30's enteral nutrition and GT use related to aspiration pneumonia. The interventions included to monitor the intake and output per the facility protocol. Further review of Resident 30's medical record did not show documented evidence Resident 30's intake and output was being monitored. On 4/3/25 at 1410 hours, an interview and concurrent medical record review for Resident 30 was conducted with LVN 5. LVN 5 stated the facility did not usually record the intake and output for the residents who were on a tube feeding all throughout the residents' stay in the facility. LVN 5 stated the facility staff would monitor the intake and output only for a certain period. LVN 5 stated she could not recall and would have to verify with the DON when LVN 5 was asked what the intake and output monitoring protocol of the facility was. LVN 5 stated the care plan interventions should be implemented and followed. LVN 5 verified there was no documentation in Resident 30's medical record which showed the intake and output for Resident 30 was being monitored. On 4/3/25 at 1522 hours, an interview and concurrent medical record review for Resident 30 was conducted with the DON. The DON stated the facility's protocol for monitoring the intake and output was to monitor the residents who were admitted with a diet and eating by mouth for three days, and the residents who were admitted with the enteral feeding for 30 days. The DON stated it was important to monitor the intake and output to evaluate the nutritional intake of the resident. The DON stated monitoring the resident's intake would determine if the resident was able to tolerate the enteral feeding, and if the enteral feeding was stopped due to unusual occurrences. The DON further stated the care plan should always be implemented and followed. The DON verified Resident 30's medical record did not show documented evidence Resident 30 was being monitored for the intake and output related to the enteral feeding. 52559 2. Review of the facility's P&P titled Enteral Feedings - Safety Precautions revised 5/2024 showed enteral feedings are to be changed at least every 24 hours or as specified by the manufacturer guidelines and properly labeled with the nurse's initials, date and time the formula was prepared. Medical record review for Resident 3 was initiated on 4/1/25. Resident 3 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 3's H&P examination dated 1/17/25, showed Resident 3 had no capacity to understand and make decisions. Review of Resident 3's diagnosis information dated 9/23/22, showed Resident 3 had a medical history of dysphagia. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/1/25 at 1002 hours, Resident 3 was observed lying in bed. An enteral feeding pump was observed with Jevity 1.2 (enteral formula) bottle hanging from the feeding pump pole. The enteral formula bottle was labeled 3/28 for the start date but without the start time or the licensed nurse's initials. The enteral feeding water bag was observed without the date and time the bag was prepared. Review of Resident 3's Order Summary Report showed the following orders: - dated 1/15/25, to administer Jevity 1.2 via feeding pump at 30 ml per hour for 20 hours per day, to provide a total volume of 1200 ml. - dated 1/18/25, to administer water flush via feeding pump at 30 ml per hour for 20 hours per day from 1200-0800 hours. On 4/1/25 at 1010 hours, an interview and concurrent observation was conducted with LVN 6. Resident 3's enteral feeding formula was observed labeled 3/28 and without a start time or the licensed nurse's initials. The enteral feeding water bag was not labeled with the date and time when the bag was prepared. LVN 6 verified the findings and stated the enteral feeding formula and the water bag should be changed every 24 hours when starting the enteral feeding at 1200 hours. On 4/3/25 at 1327 hours, an interview was conducted with the DON and Administrator. The DON and Administrator were informed and acknowledged the above findings.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35346 Based on observation, interview, medical record review, and facility P&P review, the facility failed to to provide the necessary care and services to maintain the IV site accesses for two of 28 final sampled residents (Residents 67 and 667) and two nonsampled residents (Residents 366 and 916) as evidenced by: * The facility failed to ensure the PICC line baseline external catheter length and arm circumference measurements were obtained and documented for Residents 667 and 916. * The facility failed to ensure the arm circumference and external catheter length were measured on admission and during the midline dressing change for Resident 366's midline line use. * Residents 67's PIV site was not labeled with the date, time, and licensed nurse's initials. In addition, the facility failed to ensure a physician's order was obtained for the use of the PIV. These failures had the potential to delay the identification of intravenous catheter related complications for the residents. Findings: According to the National Library of Medicine, assessment of the PICC line included measuring external length of PICC and using this for future measurement comparison. Additionally, arm circumference is measured each shift and results compared to previous readings. Furthermore when doing dressing changes, the dressing is to be labeled with the date, time, and initials of staff doing dressing change. On 4/1/25 at 0830 hours, an observation and concurrent interview was conducted with Resident 667. Resident 667 was observed with a PICC to her left upper extremity. Resident 667 stated the PICC line was used to administer her antibiotic medication. Medical record review for Resident 667 was initiated on 4/1/25. Resident 667 was admitted to the facility on [DATE]. Review of Resident 667's H&P examination dated 3/29/25, showed Resident 667's diagnoses included status post tooth infection and brain abscess (build up of pus in the brain). On 4/1/25 at 1604 hours, an observation, interview, and concurrent medical record review was conducted with RN 1. When asked to show the date for Resident 667's PICC line dressing, Resident 667's left arm was observed with blood surrounding the PICC line. Resident 667 stated she had pain on her left shoulder and pain when raising her left arm. Resident 667 stated she noticed blood on the site of her PICC line after showering on 4/1/25. When asked about the baseline external catheter length and arm circumference measurements for Resident 667's PICC line, RN 1 stated Resident 667's medical record did not include the baseline measurements as mentioned above. 49258 (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 4/1/25 at 0952 hours, during the initial tour of the facility, Resident 366 was observed awake and lying in the bed. Resident 366 was observed with a midline to the left upper arm. Resident 366 stated he was getting IV antibiotic medication for his knee infection. Resident 366's midline dressing was observed dated 3/31/25. Medical record review for Resident 366 was initiated on 4/1/25. Resident 366 was admitted to the facility on [DATE]. Review of Resident 366's MDS assessment dated [DATE], showed Resident 366 was cognitively intact. Review of Resident 366's Order Summary Report showed the following physician's orders dated 3/17/25, to measure the length of the midline external catheter on admission and with each dressing change, and to include the measurement of the arm circumference for midline device every seven days (every Sunday at night shift) and as needed. Review of Resident 366's IV MAR for March 2025 showed the documentation of the midline dressing changed on 3/23/25; however, there was no documentation of the measurement of the arm circumference and the length of the midline external catheter. The section to document the measurement on the IV MAR showed, NA. Further review of the IV MAR did not show the documentation of the midline dressing change on 3/31/25, measurement of the arm circumference, and length of the midline external catheter. Further review of Resident 366's medical record failed to show any documentation of the measurement of the arm circumference and measurement of the length of the midline external catheter upon admission to the facility. On 4/1/25 at 1606 hours, an interview and concurrent medical record review for Resident 366 was conducted with RN 1. RN 1 verified the midline dressing for Resident 366 was dated 3/31/25, and the midline dressing was previously changed on 3/23/25. RN 1 stated the baseline measurement of the arm circumference should be assessed upon admission to the facility and during the midline dressing change because if the arm became swollen it could indicate complications or infection. RN 1 stated measuring the length of the midline external catheter could provide a reference every time it was measured during the midline dressing change to check if the catheter placement was still intact or maintained, or if it was dislodged. RN 1 verified there was no documentation in Resident 366's medical record to show the arm circumference was measured upon admission to the facility and during the midline dressing change. RN 1 also verified there was no documentation to show the length of the midline external catheter was measured. RN 1 stated the NAdocumented on the IV MAR could mean not applicable. RN 1 further stated she was the one who did the midline dressing change for Resident 366 on 3/31/25, but needed to document her assessment for the midline. When RN 1 was asked what the measurements of the arm circumference and length of the midline external catheter for Resident 366 were, RN 1 stated she would have to check her notes. On 4/4/25 at 1630 hours, the DON was informed and acknowledged the above findings. 39670 3. Medical record review for Resident 916 was initiated on 4/3/25. Resident 916 was admitted to the facility on [DATE]. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/1/25 at 0858 hours, Resident 916 was observed in bed. Resident 916 stated he had an infection on both feet and was on IV antibiotic. Resident 916 stated he had a PICC line on the right upper arm and showed his PICC line with the transparent dressing. The PICC line dressing was observed with a label dated 3/31/25. Review of Resident 916's Order Summary Report dated 4/3/25, failed to show a physician's order to measure the PICC line external catheter length with each dressing change and as needed and to document the arm circumference in centimeters upon admission to the facility. Further review of Resident 916's medical record failed to show the baseline measurements for the length of the external catheter and arm circumference above the insertion site were obtained upon admission to the facility. Review of Resident 916's plan of care failed to show a care plan was formulated to address Resident 916's use of the PICC line. Review of Resident 916's IV Administration Record for March 2025 failed to show documented evidence the arm circumference measurement was documented upon Resident 916's admission to the facility. On 4/1/25 at 1602 hours, an observation and concurrent interview for Resident 916 was conducted with RN 1. RN 1 verified Resident 916 was on IV antibiotic medication for an infection to the lower leg. RN 1 was asked about the baseline measurements of Resident 916's PICC length of the catheter and arm circumference. RN 1 verified and acknowledged the baseline measurements of Resident 916's PICC line length of the catheter and arm circumference were not obtained upon admission of Resident 916 to the facility. On 4/3/25 at 1331 hours, an interview and concurrent medical record review for Resident 916 was conducted with the ADON. The ADON stated upon admission to the facility for the resident who had a PICC line, the RN supervisor was responsible for the assessment, care and maintenance of the PICC line. The ADON verified there was no baseline measurements of the length of the catheter and arm circumference obtained for Resident 916's PICC line upon admission to the facility. The ADON verified there was no care plan formulated for Resident 916's use of PICC line. On 4/7/25 at 1012 hours, an interview and concurrent medical record review for Resident 916 was conducted with the DON. The DON was informed and verified the above findings. 50967 4. Review of the facility's P&P titled IV undated, showed the following: - Verify the physician's order; and - Document when the treatment was initiated. Medical record review for Resident 67 was initiated on 4/1/25. Resident 67 was admitted to the facility on [DATE]. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 67's MDS assessment dated [DATE], showed Resident 67's BIMS score was 12, indicating moderate cognitive impairment. Review of Resident 67's Order Summary Report dated 3/1/25, did not show a physician's order to start a peripheral intravenous access. On 4/1/25 at 1045 hours, during the initial tour of the facility, Resident 67 was observed awake, alert and sitting up in the wheelchair. Resident 67 was observed with the right wrist PIV not labeled with the date, time, and licensed nurse's initials. Resident 67 stated the PIV access was inserted by the facility's licensed nurse two to three days ago. On 4/1/25 at 1122 hours, an observation and concurrent interview was conducted with LVN 6. Resident 67 was observed with the right wrist PIV not labeled with the date, time, and licensed nurse's initials. LVN 6 verified the above findings. LVN 6 stated Resident 67 did not have a physician's order for the use of the PIV. On 4/4/25 at 1316 hours, an interview was conducted with RN 2. RN 2 was asked what must be obtained prior to starting a PIV for the resident. RN 2 stated there must be a physician's order to start the PIV. RN 2 stated after the PIV was started, it must be labeled with the date, time, and licensed nurse's initials to keep track when the PIV was placed and monitor for any signs of infection. Furthermore, RN 2 verified Resident 67 did not have a physician's order for the PIV and stated the facility's IV order set in the EHR did not include the physician's order for the PIV insertion. On 4/7/25 at 1420 hours, an interview was conducted with the Administrator. The Administrator was informed and acknowledged the above findings.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49258 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure two of two final sampled residents (Residents 21 and 30) and two nonsampled residents (Residents 7 and 101) reviewed for respiratory care were provided with the appropriate respiratory care and services when: * The facility failed to ensure Residents 7 and 30 were receiving the oxygen as per the physician's order and the nasal cannula tubing was stored in a sanitary manner. * The facility failed to ensure Resident 101's CPAP machine was cleaned as per the manufacturer's user guidelines. * The facility failed to ensure Resident 21's oxygen tubing was not on the floor. These failures had the potential to affect the respiratory health and well-being of these residents in the facility. Findings: Review of the facility's P&P titled Oxygen Administration revised 10/2010 showed the staff should verify there is a physician's order for oxygen administration and review the physician's orders or facility protocol for oxygen administration. Review of the facility's P&P titled Departmental (Respiratory Therapy) - Prevention of Infection revised 5/2024 showed under the Infection Control Considerations Related to Oxygen Administration, to change the oxygen cannula and tubing every seven days, or per the manufacturer's guidelines as needed and to keep the oxygen cannula and tubing used as needed in a plastic bag when not in use. 1. On 4/1/25 at 1013 hours, during the initial tour of the facility, Resident 7 was observed awake and sitting in a wheelchair outside the room. The nasal cannula was observed on the resident's bed and not stored in a plastic bag/container. The oxygen concentrator was observed on at two liters per minute. Resident 7 stated he used the oxygen on and off. Resident 7 stated he would put the oxygen tubing back on when he went back to bed. Medical record review for Resident 7 was initiated on 4/1/25. Resident 7 was admitted to the facility on [DATE]. Review of Resident 7's H&P examination dated 2/18/25, showed Resident 7 had the capacity to understand and make decisions. The H&P examination also showed Resident 7 had history of COPD. Review of Resident 7's plan of care initiated on 2/27/25, showed a care plan problem addressing Resident 7's use of oxygen continuously related to COPD. The interventions included to administer oxygen at two liters per minute via nasal cannula continuously. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 7's Order Summary Report showed a physician's order dated 3/10/25, to administer the oxygen at two liters per minute via nasal cannula continuously every shift. On 4/1/25 at 1025 hours, an observation, interview, and concurrent medical record review for Resident 7 was conducted with LVN 8. LVN 8 verified Resident 7 was not wearing the nasal cannula. LVN 8 verified Resident 7 had a physician's order to administer the oxygen at two liters per minute via nasal cannula continuously. LVN 8 was observed checking the resident's oxygen saturation level. LVN 8 stated Resident 7's oxygen saturation level was 93%. LVN 8 stated the licensed nurses and RT would communicate regarding the resident's use of oxygen and discussed the ongoing need for the oxygen. LVN 8 stated either the licensed nurse or RT could communicate with the physician regarding the resident's need for continuous oxygen, to titrate the oxygen according to the need of the resident, or to change the oxygen use to as needed. LVN 8 further stated the nasal cannula or oxygen tubing should be placed in a plastic bag when not in use to prevent contamination. LVN 8 was observed placing the nasal cannula tubing back inside the plastic bag hanging in Resident 7's drawer cabinet. 2. On 4/2/25 at 1020 hours, an observation was conducted with Resident 30. Resident 30 was observed lying in the bed with his eyes closed. The oxygen concentrator was observed on at two liters per minute. The nasal cannula tubing was observed wrapped around the elevated right bed rail. Medical record review for Resident 30 was initiated on 4/2/25. Resident 30 was admitted to the facility on [DATE]. Review of Resident 30's H&P examination dated 2/23/25, showed Resident 30 had the capacity to understand and make decisions. Review of Resident 30's Order Summary Report showed a physician's order dated 3/14/25, to administer oxygen at two liters per minute to keep the oxygen saturation level greater than 92% every shift. On 4/2/25 at 1226 hours, a follow-up observation and concurrent interview was conducted with Resident 30. Family Member 1 was observed at the bedside. The nasal cannula tubing was observed wrapped around the elevated right bed rail and the oxygen concentrator was observed on at two liters per minute. Family Member 1 stated Resident 30 had not been using the oxygen regularly since 3/29/25. Family Member 1 stated Resident 30 would use the oxygen when the resident had shortness of breath. On 4/2/25 at 1232 hours, an interview and concurrent medical record review for Resident 30 was conducted with RT 1. RT 1 verified the oxygen order for Resident 30 was continuous and the nasal cannula tubing was not stored in a sanitary manner. RT 1 stated the RT had followed up with the residents who were on oxygen therapy. RT 1 stated the RT would check the residents with oxygen therapy during the shift and touch base with the licensed nurses regarding the respiratory status of the residents. RT 1 stated Resident 30's oxygen saturation level was greater than 92% on room air. RT 1 stated the RT or licensed nurses could notify the physician if the oxygen was not being used because the resident's oxygen saturation level was above 92% on room air and the physician could change the oxygen order to as needed or titrate the oxygen per the resident's need. RT 1 verified there was no documentation showing the RT or licensed nurse reported to the physician regarding the respiratory status of Resident 30. RT 1 further stated the nasal cannula tubing should be placed in a plastic bag for infection prevention measure to prevent contamination. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/4/25 at 1630 hours, the DON was informed and acknowledged the above findings for Residents 7 and 30. 39670 3. Review of the facility's P&P titled CPAP/BiPAP Support dated 5/2024 showed specific cleaning instruction guidelines are obtained from the manufacturer of the PAP device. The components of the machine such as the masks, nasal pillows, tubing and headgear should be cleaned with a mild detergent daily and allow to airdry. On 4/1/25 at 0810 hours, and 4/3/25 at 0834 hours, an observation and concurrent interview for Resident 101 was conducted with CNA 8. Resident 101 was observed in bed and with a CPAP machine at the bedside drawer. The CPAP's mask was observed on top of the drawer and the tubing was placed inside the clear plastic bag. CNA 8 verified the CPAP machine (ResMed Air-curve 10) at Resident 101's bedside drawer. According to the ResMed Air-curve 10 (CPAP machine) user guide, under the Caring for the Device section, showed to regularly clean the tubing assembly, water tub, and mask to prevent the growth of the germs that can adversely affect the health. Clean the device weekly as directed. Medical record review for Resident 101 was initiated on 4/3/25. Resident 101 was admitted to the facility on [DATE]. Review of Resident 101's Order Summary Report dated 4/3/25, showed there was no physician's order obtained to clean the CPAP device weekly as directed by the user's guide. Review of Resident 101's plan of care failed to show documented evidence a care plan was developed to address Resident 101's use of the CPAP machine. On 4/3/25 at 1352 hours, an interview and concurrent medical record review for Resident 101 was conducted with LVN 3. LVN 3 verified there was no physician's order for the maintenance of the CPAP machine for Resident 101. LVN 3 was asked for the copy of the user guide of the CPAP machine for Resident 101. LVN 3 acknowledged there were no copies available of the user guide for the CPAP machine. On 4/7/25 at 1012 hours, an interview and concurrent medical record review for Resident 101 was conducted with the DON. The DON was asked about the CPAP machine's care and maintenance. The DON stated the care and maintenance for the CPAP machine should be done per the machine user guide from the manufacturer. The DON was informed and verified the above findings. 35346 4. On 04/1/25 at 0945 hours, Resident 21 was observed in bed with his oxygen tubing on the floor. Medical record review for Resident 21 was initiated on 4/1/25. Resident 21 was admitted to the facility on [DATE]. Review of Resident 21's H&P examination dated 1/11/25, showed Resident 21's diagnoses included post status hospital acquired pneumonia. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 21's Order Summary Report for April 2025 showed a physician's order dated 3/12/25, to administer oxygen at three liters per minute continuously via nasal cannula. On 04/1/25 at 1607 hours, an observation and concurrent interview was conducted with the IP in Resident 21's room. Resident 21 was observed with his oxygen tubing touching the floor. The IP verified the findings.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882 Based on interview, medical record review, and facility P&P review, the facility failed to provide the appropriate pain management for one of two final sampled residents (Resident 111) reviewed for pain management. * The facility failed to accurately document the monitoring of pain for Resident 111 and administer the pain medication according to the physician's order. In addition, the facility failed to ensure the non-pharmacological interventions were provided to Resident 111 prior to the administration of the pain medication. These failures had the potential to put Resident 111 at risk for ineffective pain management and adverse effects related to the use of unnecessary pain medication. Findings: Review of the facility's P&P titled Pain Assessment and Management revised 5/2024 showed the pain management program is based on a facility-wide commitment to appropriate assessment and treatment of pain, based on the professional standards of practice, the comprehensive care plan, and the resident's choices related to pain management. Non-pharmacological interventions may be appropriate alone or in conjunction with medications. Pharmacological interventions may be prescribed to manage pain, however they do not usually address the cause of pain and can have adverse effects on the resident (e.g., drowsiness, increased risk of falling; loss of appetite). When opioids are used for pain management, the resident is monitored for medication effectiveness, adverse effects, and potential side effects. Medical record review for Resident 111 was initiated on 4/1/25. Resident 111 was admitted to the facility on [DATE]. Review of Resident 111's Order Summary Report for April 2025 showed the following physician's orders: - dated 2/12/25, to monitor Resident 111's level of pain every shift, using the 0-10 pain scale as follows: 0= no pain, 1-4= mild pain, 5-6= moderate pain, and 7-10= severe pain, - dated 2/12/25, to implement the non-pharmacological interventions for pain prior to administering the pain medication; and to document 1. Back rub; 2. Repositioning; 3. Warm drink; 4. TV/Music; 5. Ice pack; 6. None. - dated 2/12/25, to administer oxycodone (narcotic opioid medication) 5 mg one tablet by mouth every six hours a needed for moderate to severe pain, pain levels of 6-10. Review of Resident 111's MAR for March 2025 showed Resident 111 was administered oxycodone 5 mg one tablet by mouth when the pain level was not within the ordered pain level parameters (pain 6-10) on the following dates and times: - dated 3/3/25 at 2007 hours, for a pain level of 0. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 3/17/25 at 1530 hours, for a pain level of 0; and at 2138 hours, for a pain level of 0. - dated 3/24/25 at 1525 hours, for a pain level of 0; and at 2120 hours, for a pain level of 0. Review of Resident 111's MAR for March and April 2025 showed Resident 111 was administered oxycodone 5 mg one tablet by mouth every six hours a needed for moderate to severe pain (pain levels of 6-10) on the following dates and times: - dated 3/8/25 at 0833 hours, for a pain level of 7. - dated 3/15/25 at 0949 hours, for a pain level of 6. - dated 4/3/25 at 1500 hours, for a pain level of 8. However, review of Resident 111's MAR for March 2025 showed the licensed nurses documented Resident 111's pain level as 0 for no pain for the following dates and shifts: - for the day shifts (from 0700 to 1500 hours) on 3/8, 3/15, and 3/24/25. - for the evening shifts (from 1500 to 2300 hours) on 3/3, 3/17, and 3/24/25. Further review of Resident 111's MAR for March and April 2025 showed the licensed nurses documented the non-pharmacological pain interventions (NPI) for the following dates and shifts: - dated 3/3/25 for the evening shift, the NPI was documented as none, - dated 3/15/25 for the day shift, the NPI was documented as none, - dated 3/24/25 for the evening shift, the NPI was documented as none, and - dated 4/3/25, for the day shift, the NPI was documented as none. Review of Resident 111's plan of care showed a care plan problem dated 2/12/25, addressing Resident 111's use of the oxycodone pain medication. The interventions showed to administer the medications as ordered. On 4/7/25 at 1005 hours, an interview and concurrent medical record review for Resident 111 was conducted with LVN 6. LVN 6 stated for the residents who reported pain, the non-pharmacological pain interventions would be implemented and documented prior to the administration of the pain medications. LVN 6 stated if the non-pharmacological pain interventions were effective, then the pain medication would not be needed. LVN 6 further stated if the non-pharmacological interventions were ineffective, then the pain medication would be administered as per the physician's order and within the ordered parameters. LVN 6 reviewed Resident 111's medical record and verified the above findings. LVN 6 stated if the oxycodone medication was administered, the pain level should not be documented as zero. LVN 6 further stated, if the pain medication was administered, the non-pharmacological pain intervention should not be documented as none. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/7/25 at 1403 hours, an interview and concurrent medical record review for Resident 111 was conducted with the DON. The DON stated prior to the administration of the pain medication, the licensed nurse was expected to assess the resident's level of pain, implement the non-pharmacological pain interventions and document the NPIs implemented. The DON further stated if the pain medication was administered to the resident, then the NPI should not be documented as none. Additionally, the DON stated she expected the licensed nurses to accurately document the resident's pain each shift. The DON stated if the pain medication was administered to the resident during the shift, then there should be a pain level documented for the monitoring of pain, for that shift in the MAR. The DON stated if the resident reported pain after the licensed nurse documented no pain, the DON expected the licensed nurse to update the pain monitoring for that shift in the MAR or the progress notes, to accurately reflect the resident's pain monitoring. The DON reviewed Resident 111's medical record and verified the above findings. On 4/7/25 at 1430 hours, an interview was conducted with the DON. The DON was informed and acknowledged above findings.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43119 Based on interview, medical record review, and facility P&P review, the facility failed to ensure the appropriate dialysis care was provided for two of 28 final sampled residents (Residents 70 and 88) reviewed for dialysis services. * The facility failed to ensure the dialysis communication records were accurately completed for Resident 70. * The facility failed to ensure the emergency dialysis kit was kept at Resident 88's bedside. In addition, the facility failed to ensure the licensed nurses assessed and documented Resident 88's dialysis access, and covered Resident 88's dialysis access site with a transparent dressing. These failures had the potential for the residents to experience medical complications. Findings: 1. Review of the facility's P&P titled Care of a Resident with End-Stage Renal Disease dated 2001 showed the residents with end-stage renal disease (ESRD) will be cared for according to currently recognized standards of care. Medical record review for Resident 70 was initiated on 4/1/25. Resident 70 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 70's H&P examination dated 5/10/24, showed Resident 70 had no capacity to understand and make decisions. Review of Resident 70's Admission Record showed Resident 70 had a diagnosis of ESRD and was dependent on renal dialysis. Review of Resident 70's Order Summary Report for April 2025 showed a physician's order dated 3/31/25, for hemodialysis every Monday, Wednesday, and Friday at the dialysis facility. Review of Resident 70's Dialysis Communication Record showed multiple blank entries as follows: - dated 12/16, 12/20, 12/29/24, 1/3, 1/6, 1/24, 2/24, 3/3, 3/24 and 3/26/25, for the dialysis access site assessment. On 4/3/25 at 1340 hours, an interview and concurrent medical record review was conducted with LVN 2. LVN 2 verified the above findings. LVN 2 stated the dialysis communication records should have been completely filled out accordingly prior to going to the dialysis center. On 4/7/25 at 1418 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. The DON stated the dialysis communication records should have been filled out completely as it served as a communication tool between the dialysis center and the facility. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	48882 2. Review of the facility's P&P titled Hemodialysis Catheters- Access and Care of, revised 2/2024 showed the central catheters for hemodialysis are generally inserted in the neck, chest, or groin area. This is not the preferred site for long-term placement. There is more risk of clotting and infection than with either fistulas (surgical connection of an artery and a vein) or grafts (the use of a synthetic or animal-derived tubing to connect the artery and vein). Under the section Care of Central Dialysis Catheters, showed the central catheter site must be kept clean and dry at all times. Those caring for the catheter site must wear a mask and gloves when doing so. The dressing changes, if ordered, should be done using sterile techniques. The licensed nurse should document in the resident's medical record every shift as follows: 1. Location of catheter. 2. Condition of the dressing (interventions if needed). Medical record review for Resident 88 was initiated on 4/1/25. Resident 88 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 88's H&P examination dated 2/3/25, showed Resident 88 had no capacity to make medical decisions. Review of Resident 88's MDS assessment dated [DATE], showed Resident 88 had moderately impaired cognition. The MDS also showed Resident 88 had a diagnosis of end-stage renal disease (loss of kidney function) and was dependent on renal dialysis and receiving dialysis treatment while a resident at the facility. Review of Resident 88's Order Summary Report showed the following physician's orders: - dated 4/1/25, a discontinued order for the dialysis schedule every Fridays at 1530 hours. Chair time: three hours, from 1545 to 1845 hours. - dated 4/1/25, for the dialysis center to provide the dialysis catheter access site care including changing the caps. - dated 4/1/25, for the dialysis emergency kit to be maintained at bedside every shift. - dated 4/4/25, to immediately apply pressure to stop the bleeding, if bleeding was noted from the dialysis access site. If the bleeding did not subside, call the physician and activate EMS services. Review of Resident 88's progress notes showed a Nurse's Note dated on 3/31/25 at 1304 hours, showing the licensed nurse receiving a call from Dialysis Center A to inform the facility that Resident 88 did not need to show up for dialysis on 3/31/25, and the resident no longer needed dialysis until further order. Review of Resident 88's MAR and TAR for April 2025 failed to show documentation Resident 88's right upper chest dialysis catheter was assessed by the licensed nurses. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 88's plan of care failed to show a care plan problem to address the care of Resident 88's right upper chest dialysis catheter. On 4/7/25 at 0959 hours, an interview and concurrent observation was conducted with LVN 6. LVN 6 stated Resident 88 was previously receiving dialysis treatments but recently no longer required the dialysis treatments. When asked about Resident 88's dialysis access, LVN 6 inspected Resident 88 and stated Resident 88 still had a dialysis access located in his right upper chest. When asked, LVN 6 stated Resident 88 should have an emergency dialysis kit at the bedside. When asked to show Resident 88's emergency dialysis kit, LVN 6 was observed checking Resident 88's closet and bedside drawer and LVN 6 stated Resident 88 did not have an emergency dialysis kit at his bedside. LVN 6 further stated even though, Resident 88 was no longer receiving the dialysis treatments, and he should still have an emergency dialysis kit at the bedside, in the event there was an emergency. On 4/7/25 at 1403 hours, an interview was conducted with the DON. The DON stated for any resident with a dialysis access, even if the resident was not currently receiving the dialysis treatment, there should be an emergency dialysis kit at the bedside, readily available. On 4/7/25 at 1525 hours, a follow-up interview, observation, and concurrent medical record review for Resident 88 was conducted with the DON. The DON stated the dressing on a resident's dialysis access was applied by the dialysis center after the dialysis treatment. The DON stated for a resident who was no longer receiving dialysis treatments, the licensed nurses were responsible for assessing the resident's dialysis access, checking for any bleeding or signs and symptoms of infection and documenting the assessment in the MAR, every shift. Additionally, the DON stated for the resident who was no longer receiving the dialysis treatment but still had a dialysis catheter, the facility staff was responsible for changing the dressings for the dialysis access site and covering the dialysis access with a transparent dressing. The DON reviewed Resident 88's medical record and verified the above findings. When asked when the last dressing change was provided for Resident 88's right chest dialysis access, the DON stated she was unable to find the documentation. A concurrent observation and interview was conducted at Resident 88's bedside. Resident 88 was observed with the right chest permacath (type of central catheter); however, a transparent dressing was not observed covering the permacath. The DON verified the above findings and stated there should be a transparent dressing covering Resident 88's dialysis permacath on the right upper chest. On 4/7/25 at 1535 hours, the DON was informed and acknowledged the above findings.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49258 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure dementia care interventions were being implemented for one of five sampled residents (Resident 105) reviewed for dementia care. This failure had the potential for Resident 105 to not receive the appropriate treatment and services needed for her dementia. Findings: Review of the facility's P&P titled Dementia - Clinical Protocol revised 11/2018 showed the following: - The staff and physician will evaluate individuals with new or worsening cognitive impairment and behavior and differentiate dementia from other causes; - The staff and physician will review current physical, functional, and psychosocial status of individuals with dementia, and will summarize the individual's condition, related complications, and functional abilities and impairments; - The IDT will identify and document the resident's condition and level of support needed during care planning and review changing needs as they arise; - Progressive or persistent worsening of symptoms and increased need of staff will be reported to the IDT; and - The staff will monitor the individual with dementia for changes and decline in function and will report theses findings to the physician. On 4/1/23 at 1147 hours, during the initial tour of the facility, Resident 105 was observed lying and sleeping in the bed. Medical record review for Resident 105 was initiated on 4/1/25. Resident 105 was admitted to the facility on [DATE]. Review of Resident 105's H&P examination dated 12/12/24, showed Resident 105 had no capacity to make medical decisions and had a medical history of dementia. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 105's plan of care revised on 12/19/24, showed a care plan problem addressing Resident 105's risk for altered mood and little interest or pleasure in doing things related to dementia. The interventions included to monitor/record/report to the physician as needed the resident's acute episode feelings or sadness, loss of pleasure and interest in activities, feelings of worthlessness or guilt, change in appetite/eating habits, change in sleep patterns, diminished ability to concentrate, and change in psychomotor skills; and to monitor/record/report to the physician as needed mood patterns signs and symptoms of depression (mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety (intense, excessive, and persistent worry and fear about everyday situations), and sad mood as per facility behavior monitoring protocols. Review of Resident 105's MDS assessment dated [DATE], showed Resident 105 had severe cognitive impairment and was dependent for most of her ADL care. Further review of Resident 105's medical record did not show documented evidence Resident 105 was being observed/monitored for the signs and symptoms of altered mood related to her dementia. On 4/3/25 at 1000 hours, a follow-up observation and concurrent interview was conducted with Resident 105. Resident 105 was observed awake and lying in the bed. Resident 105 did not answer any questions asked and just stared off. On 4/3/25 at 1005 hours, an interview and was conducted with CNA 4. CNA 4 stated Resident 105 knew her name and the facility, but everyday was different and Resident 105 needed reminders or reorientation from the facility staff. CNA 4 stated Resident 105 was confused, refused care, and combative at times. CNA 4 stated Resident 105 could be aggressive when being changed or cleaned but if Resident 105 was not being touched, the resident was fine. CNA 4 stated for the residents with dementia, two CNAs were needed for assisting with ADL care and the facility staff had to document their behavior and mood daily. CNA 4 was not able to show any documented behavior or mood related to dementia for Resident 105. On 4/4/25 at 1320 hours, an interview and concurrent medical record review for Resident 105 was conducted with LVN 5. LVN 5 stated Resident 105 was oriented to herself, normally sleepy, took her medications and drank the Ensure (protein drink supplement) and would go back to sleep. LVN 5 stated Resident 105 did not really interact with the facility staff and even with her family member. LVN 5 stated Resident 105 had a behavior of being angry. LVN 5 stated the facility staff would document the mood or behavior in the MAR and if the resident was acting out, a change of condition assessment would be done, and the physician would be notified. LVN 5 verified there was no documented evidence Resident 105 was being assessed or monitored for the signs and symptoms of altered mood and little interest or pleasure in doing things related to dementia as stated in the resident's plan of care. On 4/4/25 at 1446 hours, an interview and concurrent medical record review for Resident 105 was conducted with the DON. The DON stated if there was a monitoring for certain behaviors related to a disease like dementia in the plan of care, the monitoring should be initiated and implemented. The DON stated it was important to monitor the behavior manifested to identify if there was progression in the disease process and the facility staff and physician could intervene and manage the resident's care properly. The DON verified there was no documentation in Resident 105's medical record showing the resident was being assessed or monitored for the signs and symptoms of altered mood and little interest or pleasure in doing things related to dementia as stated in the resident's plan of care.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45064 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to provide the necessary pharmaceutical services as per the facility's P&P for one of 28 final sampled Resident (Resident 65) and one nonsampled resident (Resident 55). * The facility failed to ensure the administration of the controlled medication for Residents 55 and 65 was documented on the EMAR. This failure had the potential for the medications to be administered in error and opportunities for drug diversion or drug misuse. Findings: Review of the facility's P&P titled Controlled Substances revised 11/2022 showed the system of dispensing of controlled substances includes the following: Records of personnel access and usage; medication administration records. Review of the facility's P&P titled Medication Administration revised 5/2024 showed individual administering the medications initials the resident's MAR on the appropriate line after giving each medication. As required or indicated for a medication, the individual administering the medication records in the resident's medical record: the date and time the medication was administered; the dosage, the route of administration; the signature and title of the person administering the drug. 1. Medical record review for Resident 65 was initiated on 4/1/25. Resident 65 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 65's H&P examination dated 5/9/24, showed Resident 65 had the capacity to understand and make decisions. Review of Resident 65's Order Summary Report dated 4/1/25, showed a physician's order dated 3/23/25, to administer oxycodone-acetaminophen (controlled pain medication) 5-325 mg one tablet by mouth every six hours as needed for moderate pain (pain level of 4-6) to severe pain (pain level of 7-10), using the 0-10 pain scale; zero meaning no pain and 10 meaning the worst pain. Review Resident 65's Medication Count Sheet showed the oxycodone-acetaminophen 5-325 mg medication was dispensed and signed out on 3/31/25 at 1830 hours. Review of Resident 65's March 2025 MAR failed to show the documentation of the administration for the oxycodone-acetaminophen 5-325 mg medication on 3/31/25 at 1830 hours. On 4/1/25 at 1145 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 verified the above findings. 2. Medical record review for Resident 55 was initiated on 4/1/25. Resident 55 was admitted to the facility on [DATE], and readmitted on [DATE]. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 55's H&P examination dated 12/31/24, showed Resident 55 was unable to make decisions. Review of Resident 55's Order Summary Report dated 4/1/25, showed a physician's order dated 3/21/25, to administer lorazepam 0.5 mg one tablet by mouth every four hours as needed for anxiety manifested by verbalization of feeling anxious for 14 days. Review Resident 55's Medication Count Sheet showed the lorazepam 0.5 mg tablet medication was dispensed and signed out on 3/31/25 at 2340 hours. Review of Resident 55's March 2025 MAR failed to show the documentation of the administration for the lorazepam 0.5 mg medication on 3/31/25 at 2340 hours. On 4/1/25 at 1300 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 verified the above findings On 4/2/25 at 1453 hours, the DON was informed and verified the above findings. The DON stated the licensed nurse needed to document on the MAR when the medication was administered to the resident to ensure the medication administered was accounted for.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52559 Based on interview, medical record review, and facility P&P review, the facility failed to ensure one of five sampled residents (Resident 42) reviewed for unnecessary medication was free from unnecessary medications. The facility failed to adhere to Resident 42's blood pressure parameters prescribed by the physician for three medications: amlodipine (blood pressure medication), spironolactone (diuretic medication), and ethacrynic acid (diuretic medication). This failure had the potential for Resident 42 to receive unnecessary medications and to experience adverse effects. Findings: Review of the facility's P&P titled Administering Medications revised 5/2024 showed medications are administered in accordance with prescribed orders. Medical record review for Resident 42 was initiated on 4/3/25. Resident 42 was admitted to the facility on [DATE], and readmitted [DATE]. Review of Resident 42's Order Summary Report showed the following physician's orders: - dated 12/21/24, to administer one amlodipine 5 mg tablet by mouth one time a day for hypertension (high blood pressure). The physician's order showed to hold the amlodipine if the systolic blood pressure less than 115 mmHg or if the heart rate less than 56 bpm. - dated 2/23/25, to administer two ethacrynic acid 25 mg tablets by mouth two times a day for congestive heart failure. The physician's order showed to hold the ethacrynic acid if the systolic blood pressure less than 110 mmHg or if the heart rate less than 60 bpm. - dated 2/23/25, to administer one spironolactone 25 mg tablet by mouth two times a day for congestive heart failure. The physician's order showed to hold the ethacrynic acid if the systolic blood pressure less than 110 mmHg or if the heart rate less than 60 bpm. Review of Resident 42's H&P examination dated 2/24/25, showed Resident 42 had the capacity to understand and make decisions. Review of Resident 42's MAR for January 2025 showed Resident 42 was administered the amlodipine medication when Resident 42's blood pressure was below the parameters prescribed by the physician on 1/4/25 at 0900 hours. Resident 42's systolic blood pressure was 113 mmHg. Review of Resident 42's MAR for March 2025 showed Resident 42 was administered the ethacrynic acid and spironolactone medications when Resident 42's blood pressure was below the parameters prescribed by the physician on 3/30/25 at 1700 hours. Resident 42's systolic blood pressure was 104 mmHg. On 4/3/25 at 1030 hours, an interview and concurrent medical record review was conducted with LVN 4. LVN 4 reviewed Resident 42's medical record and verified the above findings. LVN 4 stated there was a reminder for the staff regarding the medication's parameters populated on the resident's MAR before the administration of the medications. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/3/25 at 1327 hours, an interview was conducted with the DON and Administrator. The DON and Administrator were informed and acknowledged the above findings.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45064 Based on observation, interview, and facility P&P review, the facility failed to provide the necessary pharmacy services to ensure the proper storage and labeling of the medications. * The facility failed to ensure the orally administered medications were stored separate from the externally used medications in Medication Carts D and E. * The facility failed to ensure Resident 111's gentamicin (used to treat skin infections) medication was labeled with the opened date. * The facility failed to ensure Resident 44's Preparation H (medication is used to temporarily relieve swelling, burning, pain, and itching caused by hemorrhoids) external cream and Lidocaine (pain reliever) cream were not stored at the bedside. These failures had the potential to negatively impact the residents' well-being, and the potential for the medications to lose the stability and effectiveness. Findings: Review of the facility's P&P titled Drug Storage and Labeling Drugs and Biologicals (undated) showed oral medications will be stored separately from ointment, creams, lotions, and liquids and for external use. 1. On 4/1/25 at 1056 hours, a medication cart inspection for Medication Cart D was conducted with the ADON. The following was observed inside the first drawer of Medication Cart D: - one box of AZO (urinary pain relief), one bottle of fish oil (dietary supplement)1000 mg softgels, and one bottle of vitamin B complex (nutritional supplement) were stored with one box of clonidine (medication to treat high blood pressure) transdermal patch, one box of dorzolamide HCL (eye drop to treat increased pressure in the eye) and timolol maleate ophthalmic solution (eye drop to treat increased pressure in the eye) medications. The ADON verified the above findings. 2. On 4/1/25 at 1210 hours, a medication cart inspection for Medication Cart E was conducted with RN 1. The following was observed: - one bottle of zinc (mineral supplement) 50 mg tablet and one box of Heparin (blood thinner) injection were stored with one box of Artificial Tears (moisturizing eye drops). RN 1 verified the above findings. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/2/25 at 1452 hours, an interview was conducted with the DON. The DON was informed and acknowledged of the above findings. The DON stated the external and internal medications should be stored separately. 52238 3. On 4/7/25 at 0923 hours, an observation and concurrent interview was conducted with LVN 7 after the wound care observation was completed. When asked, LVN 7 showed Resident 111's gentamicin ointment was missing the date when the medication was opened. LVN 7 verified the label of the medication should include the open date when the medication was opened. On 4/7/25 at 1301 hours, an observation and concurrent interview was conducted with DON. The DON stated if a medication was opened, the label should include the open date. The DON verified Resident 111's gentamicin ointment medication label did not have an open date. 50967 4. Medical record review for Resident 44 was initiated on 4/7/25. Resident 44 was readmitted to the facility on [DATE]. Review of Resident 44's H&P examination dated 2/26/25, showed Resident 44 had the capacity to understand and make decisions. Review of Resident 44's Order Summary Report dated 4/1/2025, showed a physician's order dated 3/8/25, to apply Preparation H External Cream 1%, rectally every day shift for hemorrhoid (swollen vein in the anal canal and lower rectum). Review of Resident 44's TAR for March 2025 showed missing documentations for the Preparation H External cream medication on the following dates for the day shift (0700-1500 hours): - on 3/11, 3/18, 3/23, and 3/25/25. On 4/7/25 at 1038 hours, an observation, interview, and concurrent medical record review was conducted with LVN 9. LVN 9 reviewed Resident 44's medical record and verified the above findings. LVN 9 stated she was scheduled to worked on 3/11, 3/18, and 3/25/25. LVN 9 stated she administered Resident 44's Preparation H cream which was stored at Resident 44's bedside. However, LVN 9 stated she forgot to document the medication administration on the TAR. LVN 9 was asked to show the Preparation H cream stored at the resident's bedside. The Preparation H cream and Lidocaine cream (an anesthetic medication used to prevent and to treat pain from some procedures) 2.5% were observed inside Resident 44's bedside drawer. LVN 9 verified the findings. LVN 9 reviewed Resident 44's medical record and verified the Preparation H cream and Lidocaine cream did not have a physician's order or care plan to be stored at the resident's bedside. Furthermore, LVN 9 stated each medication must have a physician's order, including all the medications stored at the resident's bedside. On 4/7/25 at 1420 hours, an interview was conducted with the Administrator. The Administrator was informed and acknowledged the above findings.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 43119 Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the food items were served in the appetizing temperatures as evidenced by: * The food temperatures were below the recommended temperature for hot meats, vegetables, and potatoes. This failure posed the risk for not providing palatable and appetizing food for the residents receiving a meal tray from the kitchen. Findings: Review of the facility's Diet Type Report dated 4/1/25, showed 116 of 123 residents consumed the foods prepared in the kitchen. Review of the facility's P&P titled Meal Service dated 2018 showed meals that meet the nutritional needs of the resident will be served in an accurate and efficient manner, and served at the appropriate temperatures. The food will be served on trayline at the recommended temperatures indicated below and recorded on the daily therapeutic menu. Hot food serving temperature must be at or above minimum holding temperature of 140 degrees Fahrenheit. The temperature of the foods should be periodically monitored throughout the meal service to ensure proper hot or cold holding temperatures. Further review of the facility's P&P showed the service temperature for meat, potatoes and vegetables was 160-180 degrees Fahrenheit. The recommended temperature at the delivery to the resident for hot entree, starch, and vegetables showed greater than or equal to 120 degrees Fahrenheit. During the initial tour of the facility and resident interview on 4/1/25, the residents had a concern regarding hot food items were served cold. Review of the Spring Cycle Menu Week 1 dated for 4/2/25, showed the regular menu included roast turkey with savory cream sauce, herb roasted red potatoes, rosemary cauliflower and peas, fresh green salad, and sherbet. On 4/2/25 at 1243 hours, a concurrent interview and test tray of the regular menu was conducted with the DSS, and eight surveyors were present. The DSS checked and verified the following temperatures: - Regular roast turkey with savory cream sauce - 79.7 degrees Fahrenheit; - Regular rosemary cauliflower and peas - 78.3 degrees Fahrenheit; - Regular herb roasted red potatoes - 81 degrees Fahrenheit; - Mechanical soft roast turkey with savory cream sauce - 101 degrees Fahrenheit; - Mechanical soft rosemary cauliflower and peas - 75.3 degrees Fahrenheit; and - Mechanical soft herb roasted red potatoes - 86.6 degrees Fahrenheit. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DSS verified the temperature of the turkey, cauliflower and peas, and herb roasted red potatoes were not hot. The DSS stated the holding temperatures for the hot foods including the meats, vegetables, and potatoes should be over 135 degrees Fahrenheit. The DSS acknowledged the test tray temperatures varying from 75 to 101 degrees Fahrenheit were below the recommended temperatures for a hot meal tray. The DSS stated the hot food should be hot.

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Huntington Valley Healthcare Center	8382 Newman Avenue Huntington Beach, CA 92647

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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 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. 43119 Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the sanitary requirements were met in the kitchen as evidenced by: * The facility failed to ensure the sanitary condition of the hood over the stove was maintained. * The facility failed to ensure the kitchen utensils had a smooth cleanable surface and in good condition. * The facility failed to ensure the kitchenware and kitchen utensils were clean and free of food particle or residue. * The facility failed to ensure the cutting boards were kept in a sanitary condition and with cleanable surface. * The facility failed to ensure the heavy-duty blender used for puree preparation, scoops used for food portioning, and clear plastic bins were air dried and clean prior to storing and stacking. * The facility failed to ensure the countertop mounted can opener was in a sanitary condition and free of rust. * The facility failed to ensure the microwave utilized to warm up the food was in a sanitary condition and free of rust. These failures had the potential for cross contamination and foodborne illnesses to the residents consuming the foods prepared in the facility's kitchen. Findings: Review of the facility's Diet Type Report dated 4/1/25, showed 116 of 123 residents consumed the foods prepared in the kitchen. 1. Review of the facility's P&P titled Hood, Vents and Filters dated 2018 showed the hoods must be cleaned every two weeks and must be free of dust and grease. According to the USDA Food Code 2022 Section 4-204.11 Ventilation Hood Systems, Drip Prevention. The dripping of grease or condensation onto food constitutes adulteration and may involve contamination of the food with pathogenic organisms. Equipment, utensils, linens, and single service and single use articles that are subjected to such drippage are no longer clean. On 4/1/25 at 0848 hours, during the initial kitchen tour, an observation and concurrent interview was conducted with the DSS. The kitchen hood over the stove had black, dirt, greasy residue. The DSS acknowledged the findings and stated the dietary staff cleaned the hood once a week and it should be free of dirt and grease for fire hazard prevention. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of the facility's P&P titled Sanitation dated 2018 showed all the utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seam, cracks, and chipped areas. The plastic ware, China, and glassware that becomes unsightly, unsanitary, or hazardous because of chips, cracks, or loss of glaze shall be discarded. The plastic ware is bleached as necessary to prevent staining. According to the USDA Food Code 2022 Section 4-502.11 Good Repair and Calibration, (A) Utensils shall be maintained in a state of repair and condition that complies with the requirements specified under Parts 4-1 and 4-2 or shall be discarded. According to the USDA Food Code 2022, Section 4-101.11, Multiuse, Characteristics, materials that are used in the construction of utensils and food contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be durable, corrosion-resistant, nonabsorbent, finished to have a smooth, easily cleanable surface, and resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition. On 4/1/25 at 0848 hours, during the initial kitchen tour, an observation and concurrent interview was conducted with the DSS. The following was observed and verified by the DSS: - Two rubber spatulas with red handles were chipped and cracked at the edges. - One ladle with black handle was partially melted. - Two slotted ladles with black handles were partially melted and one ladle was deformed. - Three stainless steel whisk with rubber handles were partially melted and cracked. - One white plastic spatula was worn out, discolored, and chipped at the edges. - One rubber spatula with black handle was discolored, worn out, and chipped at the edges. - One scoop used for food portioning with gray handle was partially melted. - One stainless steel dough cutter with white handle was discolored, peeling, and worn out. The DSS acknowledged the above findings and stated the worn out utensils should have been discarded. 3. Review of the facility's P&P titled Sanitation dated 2018 showed all the utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seam, cracks, and chipped areas. Review of the facility's P&P titled Sanitization dated 2001 showed all equipment, food contact surfaces and utensils are cleaned and sanitized using heat or chemical sanitizing solutions. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the USDA Food Code 2022, 4-601.11 Equipment, Food - Contact Surfaces, Nonfood Contact Surface, and Utensils, the equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations; and the nonfood- contact surface of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. According to the USDA Food Code 2017, 4-602.13, Non- Contact Surfaces, nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. On 4/1/25 at 0848 hours, during the initial kitchen tour, an observation and concurrent interview was conducted with the DSS. The following was observed and verified by the DSS: - Two stainless steel ladle were observed dirty and had dry, crusted residue. - One slotted stainless steel spoon was observed dirty and had dry, crusted residue and watermarks. - One slotted stainless steel spoon with black handle was observed dirty and had watermarks. - One stainless steel cake slicer with black handle was observed dirty and had dry, crusted residue and watermarks. - One stainless steel spatula with white handle was observed dirty and had dry, crusted residue and watermarks. - One rubber spatula with red handle was observed dirty and had dry, crusted residue. - One scoop with white handle used for food portioning was observed with bristle like residue. - One scoop with black handle used for food portioning was observed dirty and had dry, crusted residue. - One stainless steel measuring cup was observed dirty and had dry, crusted residue - One stainless steel dough cutter with white handle was observed dirty with watermarks. The DSS acknowledged the above findings and stated all the dirty utensils should have been cleaned and washed for bacteria growth prevention and infection control purposes. 4. Review of the facility's P&P titled Sanitation dated 2018 showed separate chopping boards are to be used for preparing meats and vegetables. After each use, chopping boards shall be thoroughly cleaned and sanitized. According to the USDA Food Code 2022, Section 4-501.12, Cutting Surfaces, for surfaces such as cutting boards and blocks that become scratched and scored may be difficult to clean and sanitize. As a result, pathogenic microorganisms transmissible through food may build up or accumulate. These microorganisms may be transferred to the foods that are prepared on such surfaces. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/1/25 at 0848 hours, during the initial kitchen tour, an observation and concurrent interview was conducted with the DSS. The brown and green cutting boards were observed fuzzy, heavily marred and had deep groves. The DSS verified the findings, and stated the cutting boards should have been replaced. 5. Review of the facility's P&P titled Sanitization dated 2001 showed food preparation equipment and utensils that are manually washed are allowed to air dry whenever practical. Drying food preparation equipment and utensils with a towel or cloth may increase risks for cross contamination. Review of the facility's P&P titled Dish washing dated 2018 showed dishes are to be air dried in racks before stacking and storing. According to the USDA Food Code 2022, 4-901.11, Equipment and Utensils, Air-Drying Required, that after cleaning and sanitizing, equipment, and utensils shall be air-dried or used after adequate draining before getting in contact with food. According to the USDA Food Code 2022, 4-903.11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles, cleaned equipment and utensils shall be stored in a self-draining position that allows air drying. On 4/1/25 at 0848 hours, during the initial kitchen tour, an observation and concurrent interview was conducted with the DSS. The following was observed and verified by the DSS: - One heavy-duty blender stored on the counter shelf was still wet with visible water inside. - Three stainless steel ladles were stored wet with visible water inside. - Six scoops used for food portioning were stored wet with visible water inside. - One scoop with blue handle used for food portioning was stored wet with visible water and dirty with food residue. - One scoop with white handle used for food portioning was stored wet with visible water and dirty with food residue. - One scoop with gray handle used for food portioning was stored wet with visible water and dirty with food residue. - Six clear plastic bins were observed wet and stacked on top of each other. The DSS acknowledged the above findings and stated all the utensils, blender, and bins should have been air dried to prevent bacteria growth. 6. Review of the facility's P&P titled Can Opener and Base dated 2018 showed proper sanitation and maintenance of the can opener and base is important to sanitary food preparation. Replace blade on can opener as needed. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the USDA Food Code 2017, Section 4-101.11, Multiuse, Characteristics, materials that are used in the construction of utensils and food contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be durable, corrosion-resistant, nonabsorbent, finished to have a smooth, easily cleanable surface, and resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition. On 4/1/25 at 0848 hours, during the initial kitchen tour, an observation and concurrent interview was conducted with the DSS. The countertop mounted can opener was observed with yellowish discoloration resembles a rust on the blade. The DSS verified the findings and stated the can opener should have been replaced. 7. According to the USDA Food Code 2017, Section 4-101.11, Multiuse, Characteristics, materials that are used in the construction of utensils and food contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be durable, corrosion-resistant, nonabsorbent, finished to have a smooth, easily cleanable surface, and resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition. On 4/1/25 at 0848 hours, during the initial kitchen tour, an observation and concurrent interview was conducted with the DSS. The microwave on a countertop table was observed old, had yellowish discoloration resembles a rust, and white residue inside the microwave's door. The DSS verified the findings and stated the microwave was old and needed to be replaced.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50967 Based on interview and facility document review, the facility failed to ensure the Facility Assessment addressed or included the following: 1. Active involvement of required individuals in developing the Facility Assessment; 2. Resources necessary to care for residents including weekends; 3. A plan to maximize recruitment and retention of direct care staff; and 4. A contingency plan for staffing needs. This failure had the potential to not meet the residents' care needs if the assessed population's needs and resources were not comprehensively identified and addressed. Findings: According to the CMS QSO-24-13-NH dated 6/18/24, with an implementation date of 8/8/24, CMS had issued a revised guidance for long-term care facility assessment requirement. The Facility Assessment should address and included the active involvement of the direct care staff in developing the Facility Assessment. Also included the staffing resources necessary to care for the residents, including the weekends; a plan to maximize recruitment and retention of direct care staff member, and a contingency plan for staffing needs for the events not to activate the facility's emergency plan. Review of the Facility's assessment dated [DATE], did not show the direct care staff member, direct care representatives, residents, residents' representatives, and residents' family members were actively involved in developing the Facility Assessment; the resources necessary to care for the residents including weekends; and a plan to maximize recruitment and retention of the direct care staff, or include a contingency plan for the staffing needs. On 4/7/25 at 1343 hours, an interview and concurrent facility document review of the Facility Assessment was conducted with the Administrator. The Administrator verified the Facility Assessment was dated 3/15/25, and verified there were no direct care staff, direct care representatives, residents, residents' representatives, and family members actively involved in developing the Facility Assessment. The Administrator further verified there were no resources necessary to care for the residents including on the weekends, and a plan to maximize recruitment and retention of the direct care staff or include a contingency plan for the staffing needs. The Administrator verified and acknowledged the Facility Assessment was not updated based on the latest guidance from the CMS.

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43119 Based on interview, medical record review, and facility P&P review, the facility failed to ensure the medical records for four of 28 final sampled residents (Residents 20, 29, 65, and 70) were accurate and complete. * The facility failed to ensure the Inventory of Personal Effects for Resident 20 was reviewed with and signed by the resident's representative upon the resident's admission to the facility. * The facility failed to ensure the Inventory of Personal Effects for Resident 29 was reviewed with and signed by the resident's representative upon the resident's admission to the facility. * Resident 65's POLST was incomplete and did not show the physician's phone number, the resident's signature, address and phone number, and the date when the POLST was completed by the resident. * Resident 70's POLST was incomplete and did not show the physician's phone number, license number, the resident's responsible party's signature, address and phone number, and the date when the POLST was completed by the responsible party. In addition, the facility failed to ensure the Inventory of Personal Effects for Resident 70 was reviewed with and signed by the resident's representative upon the resident's admission to the facility. These failures had the potential for the residents' care needs not being met as their medical information were incomplete and/or inaccurate. In addition, this had the potential for the resident's representative to ensure all of the resident's personal effects/belongings were accounted for. Findings: 1. Review of the facility's P&P titled Personal Property date revised 3/2021 showed the resident's personal belongings and clothing are inventoried and documented upon admission and updated as necessary. Medical record review for Resident 20 was initiated on 4/1/25. Resident 20 was admitted to the facility on [DATE]. Review of Resident 20's Inventory of Personal Effects undated showed the section for the signature of the resident or responsible party was left blank and undated. Review of Resident 20's Inventory of Personal Effects dated 2/4/23, showed the signature for the resident or responsible party was left blank and undated. 2. Medical record review for Resident 29 was initiated on 4/1/25. Resident 29 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 29's Inventory of Personal Effects undated showed the section for the signature of the resident or responsible party was left blank and undated. (continued on next page)

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	On 4/7/25 at 1418 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified the above findings for Residents 20 and 29. The DON stated the inventory of the resident's personal effects and belongings was done by the CNA upon the resident's admission to the facility. The DON stated the residents' inventory lists should have been completely filled out to account for the residents' personal belongings. 3. Medical record review for Resident 65 was initiated on 4/1/25. Resident 65 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 65's POLST dated 5/8/24, showed under Section D - Information and Signatures, the physician's telephone number and the resident's address and telephone number were left blank and undated. 4. Medical record review for Resident 70 was initiated on 4/1/25. Resident 70 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 70's POLST dated 5/7/24, showed under Section D - Information and Signatures, the physician's telephone number, license number, and the resident's name, signature, address and telephone number were left blank and undated. Review of Resident 70's Inventory of Personal Effects undated showed the section for the signature of the resident or responsible party was left blank and undated. Review of Resident 70's Inventory of Personal Effects dated 1/1/24, showed the section for the signature of the resident or responsible party was left blank and undated. On 4/7/25 at 1418 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified the above findings for Residents 65 and 70. The DON stated the POLST was completed by the RN upon the resident's admission to the facility and followed up by the social services staff. The DON stated the POLSTs for Residents 65 and 70 should have been completely filled out because it contained relevant information.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50967 Based on interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services for one of one final sampled residents (Resident 100) reviewed for hospice services. * The facility failed to ensure Resident 100's HA visits schedule for two times a week was followed per the hospice provider's calendar. This failure posed the risk for delays in the communication between the hospice provider and facility, which may affect the resident care. Findings: Review of the facility's P&P titled Hospice Program revised on 7/2017 showed the Hospice providers who contract with this facility are held responsible for meeting the same professional standards and timeliness of service as any contracted individual or agency associated with the facility. Review of the facility's contract with Hospice A dated 11/1/24, showed the following: - Hospice shall designate an interdisciplinary group member who shall be responsible for coordinating with the facility the provision of hospice services to each resident under hospice's care and communicating with the facility and other healthcare providers participating in the provision of care for the resident's terminal illness and related conditions, and other conditions, for ensuring the quality of care; - Hospice shall deliver hospice services to each resident under hospice's care in a timely manner; and - Hospice shall notify facility promptly of any change in the designated interdisciplinary group member. Medical record review for Resident 100 was initiated on 4/3/25. Resident 100 was readmitted to the facility on [DATE]. Review of Resident 100's H&P examination dated 10/5/24, showed Resident 100 had no capacity to make decisions. Review of Resident 100's MDS assessment dated [DATE], showed Resident 100's BIMS score was three, indicating severe cognition impairment. Review of Resident 100's Order Summary Report dated 4/1/25, showed a physician's order to admit the resident under the hospice care provided by Hospice A with admitting diagnosis of cerebral infarction (the death of neural (brain) tissue as a result of ischemia). Review of Resident 100's Hospice A's Patient Calendar for March and April 2025 showed the frequency of the HA visits were every Tuesdays and Thursdays. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 100's Hospice CHHA Flow Sheet did not show the HA visits for 3/25, 3/27, 4/1, and 4/3/25, as per the calendar. Resident 100's flow sheet showed the last HA visit was on 3/20/25. On 4/3/25 at 0907 hours, an interview and concurrent medical record review was conducted with LVN 11. LVN 11 verified the above findings. LVN 11 stated the HA must visit Resident 100 at least once a week. On 4/3/25 at 0914 hours, an interview was conducted with Family Member 4. Family Member 4 stated he had not seen the HA visited Resident 100 for the last week of March and this week. In addition, Family Member 4 stated he visited the resident every morning for three to four hours and had not received a call from the HA regarding the changes in the scheduled visits. On 4/3/25 at 0924 hours, an interview was conducted with the DON. The DON was asked for the frequency of Resident 100's hospice discipline visits and she stated the hospice staff including the RN Case Manager and HA must visit the resident at least once a week or more depending on their calendar schedule. The DON stated the hospice staff must communicate with Resident 100's licensed nurses when they visited and the licensed nurses must document the hospice discipline visit in the resident's medical record. Furthermore, the DON stated all the hospice staff must sign the flow sheet for Resident 100 located in the resident's hospice binder and the MRD checked the hospice binder. On 4/3/25 at 1338 hours, an interview was conducted with Hospice A Administrator. Hospice A Administrator stated all hospice discipline including the RN Case Manager and HA must sign Resident 100's flow sheet to show the visits and services were completed. In addition, Hospice A Administrator stated the HA must communicate with the facility staff and Resident 100's responsible party or family for any changes in the planned schedule visits. Hospice A Administrator was informed Resident 100's HA scheduled visit were not completed after 3/20/25. Hospice A Administrator stated she would call the assigned HA. On 4/3/25 at 1359 hours, an interview was conducted with LVN 6. LVN 6 was asked if she was aware of Resident 100's hospice HA visit last week of March and first week of April 2025. LVN 6 stated she worked on 4/1/25, during the day shift and she did not see any visit from the hospice HA nor received a call from Hospice A to reschedule the HA visits. On 4/3/25 at hours, an interview was conducted with Hospice A Case Manager. Hospice A Case Manager stated the hospice staff must sign the flow sheet with every visit to show the visit was completed and verified the HA's scheduled visits were every Tuesdays and Thursdays. Hospice A Case Manager was informed of Resident 100's missed HA's visits after 3/20/25. Hospice A Case Manager stated he would call the assigned HA for the resident. On 4/7/25 at 1420 hours, an interview was conducted with the Administrator. The Administrator was informed and acknowledged the above findings.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39670 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to implement the infection control practices designed to provide a safe and sanitary environment and help prevent the development and transmission of diseases and infections. * The facility failed to ensure the facility's monthly Infection Prevention and Control Surveillance Log was accurate. * The facility failed to implement the EBP as per the facility's P&P for Residents 916 with a central line (thin, flexible tube inserted into a large vein near the heart). * OT 1 failed to perform hand hygiene in between resident care for Residents 33 and 52 during the dining observation. * LVN 6 failed to don the gown before entering Resident 3's EBP room to change and administer the resident's enteral feeding. * LVN 1 failed to perform hand hygiene and change gloves prior to the administration of insulin medication for Resident 370. * The facility failed to ensure LVN 7 practiced sanitary techniques during the wound care treatment. These failures posed the risk for not identifying the infections and controlling the transmission of communicable diseases to the other residents throughout the facility. Findings: 1. Review of the facility's P&P titled Infection Prevention and Control revised 3/2024 showed the facility adopted an infection prevention and control program to help prevent to the extent possible the development and transmission of disease and infection. The IP (or designee), under the guidance of the Infection Control Committee and Medical Director shall be responsible to implement the infection prevention and control program. Review of the facility's monthly Infection Prevention and Control Surveillance Log showed inaccurate documentation for January and February 2025: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- For January 2025, the total number of residents who were screened as HAI were 49 and the total number of CAIs were 43. In addition, the total number of the residents who had met the criteria for true infections were 40 and the total number of the residents who did not met the criteria for true infection were 42. However, the Infection Control Monthly Summary for the Month of January 2025 showed the total number of the residents who were assessed as HAIs were 46 and CAIs were 36. The total number of the residents with infection who met the criteria were 42 and the total number of the resident who did not met the criteria for true infection was 22 . The data from the surveillance log did not match to the monthly reported data of infections of the facility. The reported percentage rate of infection of the facility was inaccurate for January 2025. - For February 2025, the total number of the residents on the surveillance log who were screened as HAI's were 67 and the total number of CAI's were 18. In addition, the total number of the residents who had met the criteria for true infections were 53 and the total number of residents who did not met the criteria for true infection were 26. However, the Infection Control Monthly Summary for February 2025 showed the total number of the residents who were assessed as HAIs were 35 and CAIs were 14. The total number of residents with infection who met the criteria were 39 and the total number of the resident who did not met the criteria for true infection was 17. The data from the surveillance log did not match to the monthly reported data of infections of the facility. The reported percentage rate of infection of the facility was inaccurate for the month of February 2025. On 4/7/25 at 0948 hours, an interview and concurrent facility document review was conducted with the IP. The IP stated she used the McGeer and Loeb's criteria to determine a true infection for the residents. The IP added she entered the signs and symptoms, and assessment of the residents who had an infection in the electronic tool found in the resident's EHR to determine a true infection. The electronic tool automatically analyzed the data to determine if it was a true infection or not. The IP stated the infection control summary was reported to the QAPI and used to determine the trend of the infection rate in the facility. The IP was informed of the reported numbers for the HAI and CAI on each month from the surveillance log did not match the total numbers on the infection control monthly summary report for January and February 2025. The IP verified the numbers were inaccurate due to the volume of the infections for those months. The IP stated the numbers of the infection should have matched to the monthly summary report to have an accurate information about the infection control of the facility. On 4/7/25 at 1112 hours, an interview and concurrent facility document review was conducted with the DON. The DON was informed and verified the above findings. 2. Review of the facility's P&P titled Enhanced Barrier Precautions revised 05/2024 showed the residents with a medical device such as central/vascular catheters was considered a high risk infections and would be placed on Enhanced Barrier Precaution to reduce the transmission of pathogens. During the initial tour of the facility on 4/1/25 at 0858 hours, Resident 916 was observed in bed. Resident 916 had a PICC line on the right upper arm with a transparent dressing. The transparent dressing was observed with a date label dated 3/31/25. However, Resident 916 was not on EBP. There was no posted signage of the EBP and no available supplies of PPE at the doorway observed. Medical record review for Resident 916 was initiated on 4/3/25. Resident 916 was admitted to the facility on [DATE]. (continued on next page)

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	055888	A. Building B. Wing	04/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Huntington Valley Healthcare Center	8382 Newman Avenue Huntington Beach, CA 92647

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 916's Order Summary Report dated 4/3/25, showed no documented evidence a physician's order was obtained for Resident 916's EBP related to the resident's central line. On 4/1/25 at 1602 hours, an observation and concurrent interview for Residents 916 was conducted with RN 1. RN 1 was asked about the facility's P&P for the residents who had a PICC line. RN 1 stated the residents with a central line should be on EBP. RN 1 verified and acknowledged Residents 916 had PICC line and was not placed on EBP per the facility's infection control P&P. On 4/7/25 at 1012 hours, an interview and concurrent medical record review for Residents 916 was conducted with the DON. The DON was informed and verified the above findings. 52559 3. Review of the facility's P&P titled Handwashing/Hand Hygiene revised 5/2024 showed all personnel are expected to adhere to hand hygiene policies to help prevent the spread of infections to others. Hand hygiene is indicated immediately before touching a resident, after touching a resident, and after touching a resident's environment. On 4/1/25 at 1218 hours, during the dining observation, OT 1 was observed serving Resident 33's lunch tray. OT 1 assisted Resident 33 by opening the covers to her hot water cups and placing a tea bag inside the cup. OT 1 used Resident 33's knife to stir in the tea bag. After assisting Resident 33, OT 1 was observed grabbing a straw from the counter and sat next to Resident 52. OT 1 then placed the straw into Resident 52's cup filled with liquid and held the cup towards the resident's mouth. OT 1 opened the covers to Resident 52's entree. OT 1 was observed turning to their left side and cutting another resident's bread with the resident's knife and fork. OT 1 was then observed wiping Resident 52's mouth with a towel. OT 1 stood up, walked towards the counter and opened multiple drawers. OT 1 then sat down next to Resident 52 and continued to feed her. OT 1 removed the Resident 52's towel placed on her chest and discarded the towel into the soiled barrel. Then, OT 1 was observed grabbing a new towel from a plastic bag filled with clean towels. OT 1 placed the new towel on the resident's chest. OT 1 was observed wheeling Resident 52 out of the dining room and into the resident's room. OT 1 was not observed performing hand hygiene in between helping the residents with their meals. On 4/1/25 at 1235 hours, an interview was conducted with OT 1. OT 1 verified she help Resident 52 in the dining room during lunch four times a week because self-feeding was part of the resident's OT plan. OT 1 also stated she helped the facility staff during lunch time in the dining room by passing out meal trays to the residents. OT 1 was informed of the dining room observation where she did not perform hand hygiene in between helping residents with their meals. OT 1 verified she did not perform hand hygiene after assisting Resident 33 with her meal tray, prior to helping Resident 52 with her meal, and prior to and after cutting the bread of another resident. OT 1 stated she assumed she did not need to perform hand hygiene in between assisting residents with their meals because she was not in contact with bodily fluids. On 4/2/25 at 1523 hours, an interview was conducted with the IP. The IP was asked what the expectation was when the facility staff were feeding for multiple residents. The IP stated the expectation was to perform hand hygiene by using the hand sanitizer between each resident care. On 4/3/25 at 1327 hours, an interview was conducted with the DON and Administrator. The DON and Administrator were informed and acknowledged the above findings. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. On 4/1/25 at 1009 hours, an observation was conducted outside of Resident 3's room. The signage outside of Resident 3's room showed the resident was on EBP. The EBP sign showed the facility staff must wear the gloves and gown for the following high-contact resident care activities: device care or use for feeding tube, central line, urinary catheter, providing hygiene, and wound care. Resident 3 was observed in bed next to an enteral feeding pump. Medical record review for Resident 3 was initiated on 4/1/25. Resident 3 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 3's diagnosis information dated 9/23/22, showed Resident 3 had a medical history of dysphagia (difficulty swallowing). Review of Resident 3's H&P examination dated 1/17/25, showed Resident 3 had no capacity to understand and make decisions. Review of Resident 3's Order Summary Report showed the following physician's orders: - dated 1/15/25, to administer Jevity 1.2 (enteral feeding formula) via feeding pump at 30 ml per hour for 20 hours. - dated 1/18/25, to administer water flush via feeding pump at 30 ml per hour for 20 hours. Review of Resident 3's plan of care showed a care plan problem addressing Resident 3's EBP related to the enteral tube use. The interventions included the facility staff must use gloves and gowns when caring for devices or medical treatments. On 4/1/25 at 1251 hours, LVN 6 was observed in Resident 3's room wearing gloves but was not wearing the gown. LVN 6 was observed changing Resident 3's enteral feeding formula, water bag, and tubing set. LVN 6 was observed performing hand hygiene and exiting Resident 3's room. On 4/1/25 at 1310 hours, an interview was conducted with LVN 6. LVN 6 verified she changed and connected Resident 3's enteral feeding. LVN 6 verified Resident 3 was on EBP due to the resident's enteral tube. LVN 6 stated she should have been wearing a gown and gloves when providing high contact resident care. LVN 6 verified she did not wear a gown prior to changing and connecting Resident 3's enteral feeding. On 4/2/25 at 1416 hours, an interview was conducted with the IP. The IP was asked what the expectation was when a licensed nurse went into a resident's room with EBP to change and connect the resident's enteral feeding. The IP stated the facility staff are expected to wear the proper PPE and perform hand hygiene when providing high-contact resident care. The IP stated the facility staff were aware when a resident was on EBP because there was signage outside of the resident's room, the EBP was included in the resident's care plan, and there was a list of residents with EBP at the nurse stations. On 4/3/25 at 1327 hours, an interview was conducted with the DON and Administrator. The DON and Administrator were informed and acknowledged the above findings. 49258 (continued on next page)

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