STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055906	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rinaldi Convalescent Hospital	16553 Rinaldi St Granada Hills, CA 91344

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38469 Based on interview and record review, the facility failed to ensure a facility staff knocked and requested permission prior to entering a resident`s room for two of two residents (Resident 40 and 188) reviewed under the care area of dignity.  This deficient practice violated the resident`s rights to be treated with respect and dignity which had the potential to affect the resident`s sense of self-worth and self-esteem. Findings: a. During a review of Resident 40's Admission Record, the Admission Record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including, hypertension (high blood pressure) and type 2 diabetes mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy.). During a review of Resident 40`s Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 01/27/2025, the MDS indicated the resident`s cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was intact and required partial/moderate assistance with toileting hygiene, shower, and dressing. During a concurrent observation and interview on 02/10/25 at 11:01 a.m., observed Certified Nurse Assistant 1 (CNA 1) enter Resident 40`s room without knocking and asking permission from Resident 40. During an interview, CNA 1 stated that she should have knocked and asked permission from Resident 40 before entering the room to show respect for the resident's privacy. CNA 1 stated she was disrespectful to Resident 40 when she entered the resident's room without knocking or asking for permission. During an interview on 02/12/25 at 08:27 a.m., with the Minimum Data Set Coordinator 1 (MDSC 1), MDSC1 stated staff must knock and ask the resident`s permission prior to entering their rooms. MDSC1 stated that the residents have the right to say no if they do not want any staff to enter their room at a particular time and it is an invasion of their privacy when staff just enter their room without requesting permission from the residents. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility`s policy and procedures titled Dignity, last reviewed on 01/30/2025, the policy indicated that Each resident shall be cared for in a manner that promotes and enhances his or her sense of well -being, level of satisfaction with life, and feeling of self-worth and self-esteem .staff are to knock and request permission before entering resident`s rooms b. During a review of Resident 188's Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE], with diagnoses including, hypertension and depression (a common mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest in activities). During a review of Resident 188`s Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 01/22/2025, the MDS indicated the resident`s cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was intact and required substantial assistance from staff for toileting hygiene, shower, dressing and personal hygiene. During a concurrent observation and interview on 02/10/25 at 11:01 a.m., observed Certified Nurse Assistant 1 (CNA1) enter Resident 188`s room without knocking and asking permission from Resident 188. During an interview, CNA 1 stated that she should have knocked and asked permission from Resident 188 before entering the room to show respect for the resident's privacy. CNA1 stated she was disrespectful to Resident 188 when she entered the resident's room without knocking or asking for permission. During an interview on 02/12/25 at 08:27 a.m., with the Minimum Data Set Coordinator 1 (MDSC 1), MDSC1 stated staff must knock and ask the resident`s permission prior to entering their rooms. MDSC1 stated that the residents have the right to say no if they do not want any staff to enter their room at a particular time and it is an invasion of their privacy when staff just enter their room without requesting permission from the residents. During a review of the facility`s policy and procedures titled Dignity, last reviewed on 01/30/2025, the policy indicated that Each resident shall be cared for in a manner that promotes and enhances his or her sense of well -being, level of satisfaction with life, and feeling of self-worth and self-esteem .staff are to knock and request permission before entering resident`s rooms

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 47883 Based on interview and record review, the facility failed to follow the facility's policy and procedure titled, Advance Directives (written statement of a person's wishes regarding medical treatment made to ensure those wishes are carried out should the person be unable to communicate them to a doctor), for one out of the five sampled residents (Resident 16) reviewed under Advance Directives care area, by failing to maintain a current copy of the resident's advance directives in the resident's clinical record. This deficient practice had the potential for the facility to not honor the resident's medical decisions regarding end-of-life treatment and had the potential to cause conflict with Resident 16's wishes regarding health care. Findings: During a review of Resident 16's Admission Record, the Admission Record indicated that the facility initially admitted Resident 16 on 1/9/2024 and readmitted the resident on 1/23/2024 with diagnoses including hemiplegia and hemiparesis (weakness or the inability to move on one side of the body, making it had to perform everyday activities like eating or dressing), gastrostomy (G-Tube- a tube inserted through the abdomen that delivers nutrition directly to the stomach), and encephalopathy (the group of condition that cause brain dysfunction and can appear as confusion, memory loss and personality change). During a review of Resident 16's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 1/13/2025, the MDS indicated that the resident had severely impaired cognition (a severely damaged mental abilities, including remembering things, making decisions, concentrating, or learning). The MDS further indicated that Resident 16 and was totally dependent on staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a review of Resident 16's History and Physical (H&P), dated 2/11/2025, the H&P indicated Resident 16 did not have the capacity to understand and make decisions. During a concurrent interview and record interview with the Director of Social Services (DSS), on 2/11/2025 at 1:27 p.m., Resident 16's clinical records were reviewed. The DSS stated that the resident's Advance Directive acknowledgement form indicated that Resident 16 had an advance directive. The DSS stated that the advance directive was not in the resident's chart. The DSS stated that a copy of Resident 16's advance directive should have been kept in the resident's chart to provide guidance to the facility staff about the resident's wishes. During an interview with the Director of Nursing (DON) on 1/12/2025 at 4:46 p.m., the DON stated that a copy of Resident 16's advance directive should have been kept in the resident's chart to ensure the staff honor the resident's wishes regarding their care and to provide clear guidance for the staff. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policies and procedures titled Advance Directives, revised 1/30/2025, the policy and procedure indicated If resident or resident representative has executed one or more advance directive(s), or executes one upon admission, copies of these documents are obtained and maintained in the same section of the residents medical record and are readily retrievable by any facility staff.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 44309 Based on interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan (a plan of care that summarizes a resident's health conditions, specific care and services facility staff need to provide a resident to promote healing and prevent a worsening of a condition, and current treatments) to meet the resident`s needs for two of three sampled residents (Resident 27 and Resident 12) by failing to:  1. Develop and implement a comprehensive person-centered care plan addressing Resident 27`s Restorative Nursing Assistant exercise program (RNA-nursing aide program that helps residents to maintain their function and joint mobility). This deficient practice had the potential to result in Resident 27`s inadequate care. 2. Develop and implement a comprehensive person-centered care plan addressing Resident 12's use of a floor mat (a cushioned floor pad designed to help prevent injury should a person fall). This deficient practice placed Resident 12 at risk for injury by failing to provide ongoing assessment, monitoring, and re-evaluation of the resident's use of the floor mat. Findings: 1. During a review of Resident 27's Admission Record (face sheet), the Admission Record indicated that the facility admitted the resident on 8/23/2023, with diagnoses including dysphasia (swallowing difficulties), unspecified dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), seizure (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), and severe protein-calorie malnutrition (when someone loses weight, because of not eating enough proteins and calories to meet nutritional needs) and repeated falls. During a review of Resident 27's Minimum Data Set (MDS - a resident assessment tool) dated 1/24/2025, the MDS indicated that the resident`s cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated that Resident 27 required substantial/maximal staff assistance (helper does more than half the effort) for toileting hygiene, showering/bathing, upper and lower body dressing and personal hygiene. During a review of Resident 27's Physician Order Summary Report dated 10/30/2023, the order summary report indicated the following: RNA exercise program, partial weight bearing (a small amount of weight is allowed on the affected area), resident may be up in the wheelchair daily as tolerated. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 2/12/2025 at 1:37 p.m., with MDS Coordinator 1(MDSN 1), Resident 27`s physician orders, care plans, and restorative treatment records were reviewed. MDSC 1 stated licensed staff did not develop a comprehensive care plan with person-centered interventions for the resident`s RNA exercise program. MDSC 1 stated the potential outcome of not developing a person-centered care plan with goal and intervention for a resident who has weakness is the lack of care and the inability to implement the specific services and monitoring that resident requires. During an interview on 12/13/2025 at 2:00 p.m., with the facility`s Director of Nursing (DON), the DON stated licensed staff are required to develop a person-centered care plan based on the residents` needs and identified problems. The DON stated licensed staff did not develop a care plan with goal and interventions for Resident 27`s RNA treatment. The DON stated that the potential outcome of not developing a care plan with goal and interventions is the inability to monitor to see if there are any decline/improvement in the resident`s condition and consequently providing inadequate care to the resident. During review of the facility's Policy and Procedure (P&P) titled, Care Plan-Comprehensive, last reviewed 1/15/2025, the P&P indicated that the Interdisciplinary Team, in conjunction with the resident, his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. The care pan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The comprehensive, person-centered care plan includes measurable objectives and timeframes, describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychological well-being. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents` conditions change. During review of the facility's Policy and Procedure (P&P) titled, Resident Mobility and Range of Motion, last reviewed 1/15/2025, the P&P indicated that residents with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in ROM. The care plan will be developed by the interdisciplinary team based on the comprehensive assessment and will be revised as needed. The care plan will include specific interventions, exercises and therapies to maintain, prevent avoidable decline in, and/or improve mobility and ROM. The care plan will include the type, frequency and duration of the interventions, as well as measurable goals and objectives. The resident and representative will be included in determining these goals and objectives. Documentation of the resident`s progress toward the goals and objectives will include attempts to address any changes or decline in the resident`s condition or needs. 49947 2. During a review of Resident 12's Admission Record, the Admission Record indicated the facility admitted Resident 12 on 11/18/2024 with diagnoses including, but not limited to unspecified dementia (general term for a progressive state of decline in mental abilities), lack of coordination, a displaced (moved from proper or usual place) subtrochanteric (area below the trochanter [area below the neck of the femur located near the hip]) fracture of the right femur (longest and strongest bone in the body located from the hip to knee), subsequent (following) encounter for closed fracture (a broken bone that doesn't break the skin), and a history of falling (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 12's Physician's Progress Note, dated 11/20/2024, the Physician's Progress Note indicated Resident 12 did not have the capacity to understand and make decisions and required skilled nursing services after surgery to his right femur on 11/16/2024. During a review of Resident 12's Minimum Data Set (MDS - an assessment and care screening tool) dated 11/22/2024, the MDS indicated the resident was not able to understand others or make himself understood. The MDS indicated Resident 12 needed maximal assistance and/or dependence on staff for bathing, dressing, and toileting. The MDS indicated Resident 12 was dependent on staff to roll left to right, sit to lying and maximal assistance for sit to stand with no attempts to walk due to medical condition and safety concerns. The MDS further indicated Resident 12 had a fall in the last month prior to admission with a fracture that required surgery. During a review of Resident 12's Care Plans (CP), the CPs did not indicate documented evidence of a comprehensive care plan addressing the floor mat found next to the resident's bed. During an observation on 2/10/2025 at 9:47 a.m., in Resident 12's room, Resident 12 was lying in bed with a floor mat the length of the bed on the right side of the bed. During a concurrent observation and interview on 2/10/2025 at 9:53 a.m., with Licensed Vocational Nurse (LVN) 3, in Resident 12's room, LVN 3 confirmed there was a floor mat next to Resident 12's bed. LVN 3 stated Resident 12 has the floor mat next to his bed because he moves around a lot in bed and was a fall risk. LVN 3 stated he was not aware if the floor mat was care planned, but that care planning interventions such as a floor mat was necessary for all staff to consistently provide the floor mat and prevent injury. During a concurrent interview and record review on 2/10/2025 at 11:45 a.m., reviewed Resident 12's CPs with Assistant Director of Nursing (ADON). The ADON verified there was not documented evidence the comprehensive care plan was initiated addressing the floor mat next to Resident 12's bed. The ADON further stated the floor mat should have been care planned as it serves as a guide for all members of the staff to properly care for the resident and without the CP, they are unable to reassess the effectiveness of the floor mat. During a review of the facility provided Policy and Procedure (P&P) titled, Care Planning - Interdisciplinary Team, last reviewed 1/30/2025, indicated the interdisciplinary team is responsible for the development of resident care plans based on resident assessment. During a review of the facility provided P&P titled, Care Plans, Comprehensive Person-Centered, last reviewed 1/30/2025, indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The comprehensive care plan describes the services that are furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The care plan reflects currently recognized standards of practice for problem areas and conditions. Assessments of resident's are ongoing, and care plans are revised as information about the resident and the residents' conditions change. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility provided P&P titled, Falls and Fall Risk, Managing, last reviewed 1/30/2025, indicated the IDT team will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk. The P&P further indicated the staff will monitor and document each resident's response to interventions intended to reduce falling or the risk of falling.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44309 Based on interview, and record review, the facility failed to: 1. Review and update a care plan (a document outlining a detailed approach to care customized to an individual resident's need) addressing a resident`s anticoagulation therapy (the use of medications to prevent blood clots) after the physician made changes to the prescribed medications for one of two sampled residents (Resident 29) reviewed under dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed). This deficient practice had the potential to result in Resident 29 not receiving the necessary services and treatment related to anticoagulant therapy. 2. Indicate specific interventions in the care plan related to a resident's Activities of Daily Living (a term used to collectively describe fundamental skills required to independently care for oneself, such as eating, bathing, and mobility) needs for one of two (Resident 70) residents reviewed under Care Planning. This deficient practice had the potential for the residents to not receive the necessary care and services related to Resident 70's ADL Self-Care Deficit. 3. Update a resident's care plan addressing use of an anti-anxiety (reduction of the feelings of fear, dread, and uneasiness) medication for one of two sampled residents (Resident 12) reviewed under the unnecessary medication care area. This deficient practice had the potential to confuse staff and allow for Resident 12 to receive unnecessary anti-anxiety medication interventions. Findings: 1. During a review of Resident 29's Admission Record (face sheet), the Admission Record indicated that the facility originally admitted the resident on 10/13/2021, and readmitted on [DATE], with diagnoses including end stage renal disease (ESRD-irreversible kidney failure), dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), and paroxysmal atrial fibrillation (A-Fib: an irregular and often very rapid heart rhythm). During a review of Resident 29's Minimum Data Set (MDS- a resident assessment tool) dated 1/17/2027, the MDS indicated that the resident`s cognitive skills (the brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was moderately impaired (decisions poor, cues/supervision required). The MDS indicated that Resident 29 required substantial/maximal staff assistance (helper does more than half the effort) for showering/bathing, lower body dressing, and putting on/taking off footwear. The MDS further indicated that Resident 29 was taking anticoagulant (blood thinner-a family of medications that stop your blood from clotting too easily). (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 29`s General Acute Care Hospital 1 (GACH 1) Physician Transfer Orders dated 12/27/2024, the transfer orders indicated that the resident`s physician discontinued the following orders: -Plavix (a blood thinner) 75 milligrams (mg-a unit of measure of mass) give one tablet by mouth one time a day for Deep Vein Thrombosis (DVT- occurs when a blood clot forms in one or more of the deep veins in the body, usually in the legs) prophylaxis (PPX- preventative treatment against disease). - Aspirin (a blood thinner) 81 mg give one tablet by mouth one time a day for Cerebrovascular Accident (CVA- a stroke happens when there is a loss of blood flow to part of the brain) PPX. During a review of Resident 29`s Physician`s Order Summary Report dated 12/27/2024, the order summary report indicated that Resident 29`s physician ordered Eliquis (a blood thinner) 2.5 mg, one tablet by mouth two times a day for A-Fib with start date of 12/28/2024. During a review of Resident 29's care plan titled Anticoagulant and antiplatelet therapy (a type of blood thinner) Aspirin and Plavix related to CVA/DVT PPX initiated on 11/17/2021, and last revised on 12/4/2024, the care plan indicated a goal that the resident will be free from discomfort or adverse reactions (an undesired effect of a drug or other type of treatment) related to anticoagulant and aspirin therapy use through the review date. The care plan interventions were to perform daily skin inspection, review medication list for adverse effects, and to monitor/document and report to the physician any sign and symptoms of anticoagulant therapy complications. During a concurrent interview and record review on 2/12/2025 at 2:16 p.m., with MDS Coordinator 1 (MDSC 1), Resident 29`s physician orders and care plans were reviewed. MDSC 1 stated Resident 29 was readmitted from GACH 1 to the facility on [DATE]. MDSC 1 stated on 12/27/2024, Resident 29`s physician discontinued aspirin and Plavix orders and prescribed Eliquis 2.5 mg two times a day instead. MDSC 1 stated Resident 29`s anticoagulant therapy care plan was not revised/updated after discontinuation of aspirin and Plavix and the care plan does not reflect the current prescribed medication Eliquis. MDSC 1 stated resident care plans are required to be updated and revised as their medications are changing. MDSC 1 stated the potential outcome of not revising/updating residents care plans is inaccurate medical record and insufficient care for the resident. During an interview on 2/13/2025 at 1:45 p.m., with the Director of Nursing (DON), the DON stated the purpose of reviewing and re-evaluating the care plans is to check the effectiveness of the care plan interventions and make sure all the pertinent information and intervention regarding residents` care are included in the care plan. The DON stated Resident 29`s anticoagulation therapy care plan was not revised after the physician made changes to the medications on 12/27/2024. The DON stated residents` care plans are required to be updated with the current medications they are taking. The DON stated the potential outcome of not reviewing and revising a resident`s care plan is inadequate care and monitoring of the resident. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During review of the facility's Policy and Procedure (P&P) titled, Care Plan-Comprehensive, last reviewed 1/15/2025, the P&P indicated that the Interdisciplinary Team, in con junction with the resident, his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. The care pan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The comprehensive, person-centered care plan includes measurable objectives and timeframes, describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychological well-being. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents` conditions change. The Interdisciplinary team reviews and update the care plan when there is has been a significant change in the resident`s condition, when the desired outcome is not met, when the resident has been readmitted to the facility from a hospital stay and at least quarterly. 38469 2. During a review of Resident 70's Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE], with diagnoses including dementia (a group of thinking and social symptoms that interferes with daily functioning) and schizophrenia (a chronic mental illness characterized by disruptions in thought process, perceptions, emotions, and social interactions). During a review of Resident 70`s Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 12/26/2024, the MDS indicated the resident`s cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was severely impaired and was totally dependent on staff for eating, oral hygiene, toileting hygiene, shower, dressing and personal hygiene. During a concurrent interview and record review on 02/11/25 at 01:38 p.m., with Minimum Data Set Coordinator 1 (MDSC 1), Resident 70`s Care Plan for ADL Self-Care Deficit, initiated on 6/21/2024 and revised on 01/04/2025 was reviewed. The care plan did not indicate specific interventions on how to provide the resident`s grooming, oral hygiene, toileting hygiene, shower and personal hygiene needs. MDSC 1 stated that the CP should have specific interventions regarding the resident's ADL care. MDSC 1 if the interventions are not specific, there is a potential for staff to not provide Resident 70`s ADL care specific to the resident's needs.  During a review of the facility`s policy and procedures titled Care Plans, Comprehensive Person-Centered, last reviewed on 01/30/2025, indicated that A comprehensive, person-centered care plan that includes measurable objectives and timetable to meet the resident`s physical, psychosocial and functional needs is developed and implemented for each resident .describes the services that are to be furnished to attain or maintain the resident`s highest practicable physical, mental, and psychosocial well-being . 49947 (continued on next page)

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Rinaldi Convalescent Hospital	16553 Rinaldi St Granada Hills, CA 91344

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During a review of Resident 12's Admission Record, the Admission Record indicated the facility admitted Resident 12 on 11/18/2024 with diagnoses that included, but not limited to unspecified dementia (general term for a progressive state of decline in mental abilities), lack of coordination, a displaced (moved from proper or usual place) subtrochanteric (area below the trochanter [area below the neck of the femur located near the hip]) fracture of the right femur (longest and strongest bone in the body located from the hip to knee), subsequent (following) encounter for closed fracture (a broken bone that doesn't break the skin), and a history of falling. During a review of Resident 12's Physician's Progress Note, dated 11/20/2024, the Physician's Progress Note indicated Resident 12 did not have the capacity to understand and make decisions and required skilled nursing services after surgery to his right femur on 11/16/2024. During a review of Resident 12's Minimum Data Set (MDS - an assessment and care screening tool) dated 11/22/2024, the MDS indicated the resident was not able to understand others or make himself understood. The MDS indicated Resident 12 needed maximal assistance and/or dependence on staff for bathing, dressing, and toileting. The MDS indicated Resident 12 was dependent on staff to roll left to right, sit to lying and maximal assistance for sit to stand with no attempts to walk due to medical condition and safety concerns. The MDS further indicated Resident 12 had a fall in the last month prior to admission with a fracture that required surgery. During a review of Resident 12's Physician's Orders, on 12/16/2024 Resident 12 physician ordered Xanax (medication used to reduce anxiety) 1 mg (unit of measurement) to be given as 1 tablet by mouth as needed for anxiety up to two times a day for 14 days. During a review of Resident 12's Electronic Medical Administration Record (EMAR - online charting system) on 2/12/2025 at 11:35 a.m., the EMAR indicated Xanax was completed and discontinued on 12/30/2024. During a review of Resident 12's Anti-Anxiety CP on 2/12/2025, last revised on 12/18/2024, the CP indicated Resident 12 uses Xanax 1 mg. During a concurrent interview and record review on 2/12/2025 at 12:15 p.m., reviewed Resident 12's CPs and physician orders with the Assistant Director of Nursing (ADON). The ADON verified Xanax was completed and discontinued on 12/30/2025 and Xanax was not reordered since then. The ADON further confirmed Resident 12's anti-anxiety CP incorrectly reflects Resident 12 is still taking Xanax. The ADON stated not updating the care plan can cause confusion among the staff members directly involved in Resident 12's care. During a review of the facility provided Policy and Procedure (P&P) titled, Charting and Documentation, last reviewed 1/30/2025, the P&P indicated the documentation in the medical record will be objective, complete and accurate. The P&P also indicated progress or changes in the care plan goals and objectives should be documented in the resident's, medical record During a review of the facility provided P&P titled, Care Plans, Comprehensive Person-Centered, last reviewed 1/30/2025, indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Assessments of resident's are ongoing, and care plans are revised as information about the resident and the residents' conditions change.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 38469 Based on observation, interview, and record review, the facility failed to ensure a resident who required assistance with nail trimming was provided care and services to maintain good personal hygiene for one of one sampled resident (Resident 19) reviewed under Activities of Daily Living (ADLs- is a term used to collectively describe fundamental skills required to independently care for oneself, such as eating, bathing, and mobility). This deficient practice had the potential to result in a negative impact on the resident's self- esteem and self-worth due to an unkempt appearance. Findings: During a review of Resident 19's Admission Record (AR), the Admission Record indicated the facility originally admitted the resident on 12/10/2018 and readmitted the resident on 2/07/2025, with diagnoses including hypertension (high blood pressure [the force of the blood pushing on the blood vessel walls is too high]) and type two (2) diabetes mellitus (a chronic condition that affects the way the body processes blood glucose [sugar]). During a review of Resident 19's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 11/07/2024, the MDS indicated that the resident`s cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was intact and is dependent on staff for toileting, shower, dressing and moderate assistance for personal hygiene. During a review of Resident 19's Care Plan (CP-a written document that summarizes a resident's needs, goals, and care/treatment) for Activities of Daily Living revised on 11/19/2024, the CP indicated that the resident has ADL Self-Care Deficit related to the resident's medical comorbidities and aging process. The CP indicated that the resident required moderate assistance with personal hygiene care. During an observation on 02/10/2025 at 9:13 a.m., observed Resident 19 in bed, awake and able to respond to interview. Observed Resident 19 with long and curvy fingernails. Asked Resident 19 when was the last time she had her nails trimmed, Resident 19 stated she does not remember and stated she wants her fingernails short so it will look good and will not break. During a concurrent observation and interview on 02/12/25 at 02:11 p.m., with Minimum Data Set Coordinator 1 (MDSC 1), observed MDSC 1 asked Resident 19 to show her hands and asked the resident if the resident wanted her fingernails trimmed. Resident 19 stated nobody has offered to trim her fingernails. MDSC 1 stated if Resident 19 scratched herself it can potentially cause a skin tear because her fingernails are long. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility`s policy and procedure titled Activities of Daily Living, Supporting, last reviewed on 1/30/2025, the policy indicated that Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living .residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38469 Based on interview and record review, the facility failed to implement a resident centered activities program by failing to provide activities that meet the resident's spiritual or religious needs for one of one sampled resident (Resident 70) reviewed under the Activities care area. This deficient practice violated the resident`s right to receive religious services which has the potential to affect the resident`s sense of self-esteem and self-worth. Findings: During a review of Resident 70's Admission Record, the Admission Record indicated the resident was originally admitted on [DATE] and readmitted to the facility on [DATE], with diagnoses including dementia (a group of thinking and social symptoms that interferes with daily functioning) and schizophrenia (a chronic mental illness characterized by disruptions in thought process, perceptions, emotions, and social interactions). During a review of Resident 70`s Admission Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 06/26/2024, the MDS indicated the resident`s cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was severely impaired and was totally dependent on staff for eating, oral hygiene, toileting hygiene, shower, dressing and personal hygiene. The MDS also indicated in Section F that it is important to the resident to participate in religious services. During an interview and record review on 02/11/2025 at 4:04 p.m., with the Activity Director (AD), reviewed the following Resident 70`s records: a. MDS Section F (Activities) dated 06/26/2024, indicated that participating in religious services is important to Resident 70. b. Care Plan (a care plan is a form where you can summarize a person's health conditions, specific care needs, and current treatments) for Activity Preferences, initiated on 06/25/2024 and revised on 01/04/2025. The care plan did not indicate an intervention to provide religious services. c. Communion List for the months of November 2024, December 2024 and January 2025, did not indicate Resident 70 as having participated in a religious activity or was provided a room visitation by the religious organization`s representative. The AD stated that Resident 70's care plan should have included an intervention that addressed the resident's activity preference to receive religious services. The AD stated during admission the resident, or their representative is asked regarding the resident's religious affiliation so the facility can arrange for religious services to meet the resident's spiritual needs. The AD stated the facility failed to invite or arrange for Resident 70 to be visited by a religious provider. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility`s policy and procedure titled Spiritual and Religious Activities, last reviewed on 01/30/2025, the policy and procedure indicated that Spiritual and religious activities are provided to the resident population .and are programmed in accordance with the residents` preferences and religious affiliation .

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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. 44309 Based on interview, and record review, the facility failed to ensure one of one sampled resident (Resident 27) received treatment and services to prevent decrease in range of motion (ROM- full movement potential of a joint) by failing to clarify Resident 27`s physician order for Restorative Nursing Assistant (RNA- nursing aide program that helps residents to maintain their function and joint mobility) exercise program. This deficient practice had the potential to place the resident at risk for further range of motion (ROM- full movement potential of a joint) decline. Findings: During a review of Resident 27's Admission Record (face sheet), the Admission Record indicated that the facility admitted the resident on 8/23/2023, with diagnoses including dysphasia (swallowing difficulties), unspecified dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), seizure (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), severe protein-calorie malnutrition (when someone loses weight, because of not eating enough proteins and calories to meet nutritional needs) and repeated falls. During a review of Resident 27's Minimum Data Set (MDS - a resident assessment tool) dated 1/24/2025, the MDS indicated that the resident`s cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated that Resident 27 required substantial/maximal staff assistance (helper does more than half the effort) for toileting hygiene, showering/bathing, upper and lower body dressing, putting on/taking off footwear, and personal hygiene. During a review of Resident 27's Physician Order Summary Report dated 10/30/2023, the order summary report indicated the following: RNA exercise program, partial weight bearing (a small amount of weight is allowed on the affected area), resident may be up in the wheelchair daily as tolerated. During a review of Resident 27's Restorative Treatment Record dated 2/1/2025 through 2/12/2025, the record did not indicate any treatment entries. During an interview on 2/12/2025 at 10:36 a.m., with Certified Nursing Assistant 2 (CNA 2), CNA 2 stated that she sometimes works as an RNA. CNA 2 stated Resident 27 normally wants to stay in her bed and agrees to be transferred on her wheelchair mostly in the afternoons. CNA 2 stated she has never provided RNA exercises to Resident 27. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 2/12/2025 at 1:37 p.m., with MDS Coordinator 1 (MDSN 1), Resident 27`s physician orders, and restorative treatment records were reviewed. MDSC 1 stated Resident 27`s physician ordered for RNA exercise program, partial weight bearing on 10/30/2023, when Resident 27 was enrolled in a hospice program (compassionate care for people who are near the end of life). MDSC 1 stated residents who are enrolled in hospice do not receive RNA exercises. MDSC 1 further stated Resident 27`s physician order for RNA exercise program required clarification. MDSC 1 stated this order did not specify the type of exercises to be performed, and the location of affected area for partial weight bearing. MDSC 1 stated licensed staff did not clarify this order since 10/30/2023. MDSC 1 stated Resident 27`s restorative treatment records for the months of 01/2025 and 02/2025 did not indicate any treatment entries. MDSC 1 stated that she (MDSC 1) is unsure if staff provided RNA exercises to Resident 27. During a concurrent interview and record review on 2/13/2025 at 1:55 p.m. with the Director of Rehabilitation (DOR), Resident 27`s physician orders were reviewed. The DOR stated that Resident 27 was never evaluated by the rehabilitation department because she was on a hospice program. The DOR stated Resident 27`s physician ordered RNA exercise program, partial weight bearing, on 10/30/2023, while the resident was enrolled in a hospice program. The DOR stated Resident 27`s physician order for RNA exercise program required clarification. The DOR stated that the order did not specify the type of exercises to be performed, the frequency, and the location of affected area for partial weight bearing. The DOR stated Resident 27`s RNA exercise order was never clarified or implemented by facility staff. The DOR stated the licensed staff should have contacted resident 27`s physician and clarified the RNA exercise program order. The DOR stated the potential outcome of not clarifying and providing RNA treatment as ordered by the physician is a decline in Activities of Daily Living (ADLs- activities such as bathing, dressing and toileting a person performs daily), and muscle weakness. During review of the facility's Policy and Procedure (P&P) titled, Restorative Nursing Services, last reviewed 1/15/2025, the P&P indicated that residents would receive restorative nursing care as needed to help promote optimal safety and independence. Restorative nursing care consists of nursing interventions that may or may not be accompanied by formalized rehabilitative services. Residents may be started on a restorative nursing program upon admission, during the course of stay or when discharged from rehabilitative care. Restorative goals and objectives are individualized and resident-centered and are outlines in the resident`s plan of care. During review of the facility's Policy and Procedure (P&P) titled, Resident Mobility and Range of Motion, last reviewed 1/15/2025, the P&P indicated that residents with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in ROM. The care plan will be developed by the interdisciplinary team based on the comprehensive assessment and will be revised as needed. The care plan will include specific interventions, exercises and therapies to maintain, prevent avoidable decline in, and/or improve mobility and ROM. The care plan will include the type, frequency and duration of the interventions, as well as measurable goals and objectives. The resident and representative will be included in determining these goals and objectives.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44309 Based on interview and record review, the facility failed to provide appropriate care and services to maintain acceptable parameters of nutritional status for one of one sampled resident (Resident 27) by failing to: 1. Communicate Resident 27's nutritional intake (the amount of food a person eats) percentage with the facility`s Registered Dietician (RD-a health professional who has special training in diet and nutrition).  2. Inform Resident 27`s physician regarding resident`s refusal to eat as indicated in her care plan (written guide that organizes information about the resident's care). This deficient practice had the potential to place Resident 27 at risk for weight loss. Findings: During a review of Resident 27's Admission Record (face sheet), the Admission Record indicated that the facility admitted the resident on 8/23/2023, with diagnoses including dysphasia (swallowing difficulties), unspecified dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), seizure (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), and severe protein-calorie malnutrition (when someone loses weight, because of not eating enough proteins and calories to meet nutritional needs). During a review of Resident 27's Minimum Data Set (MDS - a resident assessment tool) dated 1/24/2025, the MDS indicated that the resident`s cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated that Resident 27 required staff supervision or touching assistance (helper provides verbal cues) when eating. The MDS further indicated that Resident 27 did not have a weight loss in the last six months. During a review of Resident 27's Physician Order Summary Report dated 10/16/2023, the order indicated that the resident should be provided with a fortified (a food that has extra nutrients added to it), high protein, mechanical soft texture diet (a soft food diet focuses on easy digestion and easy chewing) with a thin consistency fluid (regular fluid). During a review of Resident 27`s Nutrition assessment dated [DATE], the assessment indicated that the resident`s weight has been stable. The assessment indicated that Resident 27`s diet was changed to fortified, high calorie diet to prevent a weight loss. The assessment further indicated that Resident 27 required feeding assistance during meals. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 27's Nutritional Problem care plan (written guide that organizes information about the resident's care) initiated on 8/29/2023 and last revised on 11/5/2024, the care plan indicated a goal that the resident will not experience significant weight changes and will consume at least 50 percent of all meals daily through the review date. The care plan interventions were to provide a fortified/high protein, mechanical soft texture diet, monitor/document and report to the physician sign and symptoms of dysphagia (difficulty swallowing) such as choking, refusing to eat, holding food in mouth, several attempts to swallow, monitor food intake, and record per meal and to provide feeding assistance to the resident. During a concurrent observation and interview on 2/10/2025 at 12:20 p.m., inside Resident 27`s room, Resident 27 was observed lying in bed with her eyes closed. Certified Nursing Assistant 3 (CNA 3) present at the resident`s bedside stated that Resident 27 refused to eat lunch. CNA 3 stated that today Resident 27 did not eat her breakfast either. CNA 3 stated Resident 27 normally refuses to eat. CNA 3 stated if the staff ask Resident 27 to eat more than one time, she will scream and get angry. During an interview on 2/11/2025 at 12:36 p.m. with CNA 2, CNA 2 stated that Resident 27 refused to eat lunch today. During a concurrent interview and record review on 2/12/2025 at 11:37 a.m., with the facility`s Registered Dietician (RD), Resident 27`s weights, meal intake log, and care plans were reviewed. RD stated that Resident 27`s weight has been stable. RD stated that Resident 27`s meal intake log for 1/14/2025-2/12/2025 indicated that the resident`s meal intake percentage was consistently between 0-25%. RD stated based on the log, Resident 27 refused to eat lunch and breakfast on 2/7/2025 and 2/10/2025, and refused to eat breakfast on 2/9/2025, 2/11/2025, and 2/12/2025. RD stated Resident 27`s meal intake percentage is concerning, and staff did not notify her regarding Resident 27`s refusal to eat and low meal intake percentage. RD stated the potential outcome is a delay in conducting assessment and adding appropriate interventions to prevent weight loss.  During a concurrent interview and record review on 2/12/2025 at 1:15 p.m., with MDS Coordinator 1 (MDSC1), Resident 27`s care plans and nursing progress notes were reviewed. The MDSC 1 stated that she (MDSC 1) was aware that Resident 27 has been refusing to eat her breakfast and lunch. The MDSC 1 stated licensed staff did not initiate any care plan addressing Resident 27`s refusal to eat. MDSC 1 stated one of Resident 27`s nutritional care plan intervention is to report to her physician if the resident refuses to eat. MDSC 1 stated based on Resident 27`s meal intake log, Resident 27 refused to eat lunch and breakfast on 2/7/2025 and 2/10/2025, and refused to eat breakfast on 2/9/2025, 2/11/2025, and 2/12/2025. MDSC 1 stated that there is no documentation in the resident`s nursing progress notes regarding notifying physician of her refusal to eat. MDSC 1 stated that the potential outcome of not notifying a resident`s physician regarding her/his refusal to eat is a weight loss due to lack of appropriate care and interventions. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility`s Policy and Procedure (P&P) titled Food and Nutrition Services, last reviewed 1/15/2025, the P&P indicated that the multidisciplinary staff, including nursing staff, the attending physician and the dietician will assess each resident`s nutritional needs, food likes, dislikes and eating habits, as well as physical, functional and psychosocial factors that affect eating and nutritional intake and utilization. Nursing personnel, with the assistance of food and nutrition services staff, will evaluate and document as indicated food and fluid intake of residents with, or at risk for significant nutritional problems. Variation from usual eating or intake patterns will be recorded in the resident`s medical record and brought to the attention of the nurse. A nurse will evaluate the significance of such information and report it, as indicated, to the attending physician and dietician.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49947 Based on interview and record review, the facility failed to ensure that pain management was provided, consistent with professional standards of practice for two of two sampled residents (Resident 22 and 10) being investigated under the pain care area when: a. Resident 22 was not assessed before and after tramadol (a controlled [a medication's use and distribution are tightly controlled because of their abuse potential or risk] medication given for pain) was administered on 2/9/2025 at 8:30am. b. Resident 10 was not assessed before and after oxycodone with acetaminophen tablet (brand name is Percocet, a narcotic pain medication) was administered on 1/21/2025 at 1:10 a.m., 1/31/2025 at 1:45 a.m., and 2/01/2025 at 2 a.m. This deficient practice resulted in Resident 10 and Resident 22's pain not being assessed and placed the residents at risk for having unmanaged pain that may diminish the residents' quality of life. Findings: a. During a review of Resident 22's Admission Record, the Admission Record indicated the facility admitted Resident 22 on 6/15/2024 with diagnoses that included, but not limited to repeated falls, depression (persistent feelings of sadness and hopelessness) and anxiety disorder. During a review of Resident 22's Physician's Progress Note, dated 1/17/2024, the Physician's Progress Note indicated Resident 22 does have the capacity to understand and make decisions. During a review of Resident 22's Minimum Data Set (MDS - an assessment and care screening tool) dated 1/21/2025, indicated the resident was able to understand others and make himself understood. The MDS indicated Resident 22 needed partial assistance from staff for bathing, dressing, and toileting. The MDS further indicated Resident 22 was on a scheduled pain medication regimen and received as needed (PRN) pain medication. During a review of Resident 22's Physician's Orders, on 2/11/2025 at 10:40 a.m., the Physician's Orders indicated an order for tramadol 50 milligrams (mg, metric unit of measurement, used for medication dosage and/or amount), give 1 tablet by mouth every 12 hours PRN pain level 6-10 (numeric pain scale in which a resident's pain is indicated with zero being no pain and 10 for the worst pain imaginable) was ordered on 1/16/2025 During a review of Resident 22's Care Plan for Chronic Pain, initiated 1/27/2025, the care plan indicated the resident will not have an interruption in normal activities due to pain through the review date. The care plan indicated the following: -Administer analgesia (pain medication) as per orders. -Evaluate the effectiveness of pain intervention. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rinaldi Convalescent Hospital	16553 Rinaldi St Granada Hills, CA 91344

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 22's Controlled Drug Record (CDR - record of all resident's controlled medications; the licensed nurse must sign once medication is removed from supply) the document indicated Tramadol was removed from the blister pack (or called bubble pack, a card that packages doses of medication within small, clear, plastic bubbles [or blisters] that is punched out to administer to a resident) on 2/9/2025 at 8:20 a.m. During a review of Resident 22's MAR for the month of 1/2025 and 2/2025, the MAR did not indicate Resident 22 was given tramadol on 2/9/2025 or assessed for pain prior to tramadol administration. During a concurrent interview and review of the Nursing Staffing Assignment and Sign-In Sheet at 2/11/2025 at 11:10 a.m. with the Director of Staff Development (DSD), the DSD confirmed Licensed Vocational Nurse (LVN) 2 used medication cart (Cart 1) on 2/9/2025 from 7:00 a.m. - 3:30 p.m. The DSD further stated the initials in the CDR for Tramadol on 2/9/2025 at 8:30 a.m. belonged to LVN 2. The DSD stated LVN 2 would not be into work until the upcoming weekend and provided his phone number. During a phone interview on 2/12/2025 at 2:44 p.m. with LVN 2, LVN 2 stated when a resident is requesting a medication for pain, pain must be assed first. LVN 2 further stated when controlled drug is removed from the bubble pack, the licensed nurse is to sign the controlled drug record, give the medication to the resident, and then sign the MAR. LVN 2 stated once the medication is signed in the MAR, the MAR prompts a pain re-evaluation task 1 hour from when the medication is given. LVN 2 stated he was unsure why the medications were not signed in the MAR, that he must have forgotten to but that it is very important to prevent extra doses and to re-evaluate the resident's pain. During a concurrent interview and record review with the Assistant Director of Nurses (ADON) on 2/11/2025 at 11:34 a.m., reviewed Resident 22's Tramadol CDR and 2/2025 MARs. The ADON confirmed the entries on the CDR for Tramadol 2/9/2025 at 8:30 a.m. had no corresponding entries in Resident 22's 2/2025 MAR. The ADON stated the licensed nurses need to sign both the CDR and MAR to ensure all the licensed nurses know when the next dose is due, the initial pain assessment, reassess the effectiveness of the medications, and to prevent medication error. During a review of the facility's policy and procedure titled, Controlled Medications, last reviewed 1/30/2025, the document indicated the following: When a controlled medication is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and the medication administration record (MAR): 1) Date and time of administration. 2) Amount administered. 3) Signature of the nurse administering the dose on the accountability record at the time the medication is removed from the supply. 4) Initials of the nurse administering the dose on the MAR after the medication is administered. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility provided Policy and Procedure (P&P) titled, Pain - Clinical Protocol, last reviewed 1/30/2025, indicated staff will reassess the individual's pain and will evaluate and report the resident's use of standing and PRN analgesics. During a review of the facility provided P&P titled, Charting Errors and/or Omissions, last reviewed 1/30/2025, indicated accurate medical records shall be maintained by this facility. 34659 2. During a review of Resident 10's Admission Record (front page of the chart that contains a summary of basic information about the resident), the Admission Record indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including chronic pain syndrome (a condition characterized by persistent or recurring pain that lasts for more than 3 months). During a review of Resident 10' s Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 1/15/2025, the MDS indicated Resident 10 was cognitively (the process of acquiring knowledge and understanding through thought, experience, and the senses) intact with skills required for daily decision making. The MDS indicated Resident 10 required setup or clean-up assistance for eating and moderate assistance (helper does less than half the effort) for oral hygiene and personal hygiene. During a review of Resident 10's Physician's Orders, the orders indicated the following orders: oxycodone with acetaminophen tablet (brand name is Percocet, a narcotic pain medication) 5-325 milligrams (mg, metric unit of measurement, used for medication dosage and/or amount), give one tablet by mouth every six hours as needed (PRN, or pro re nata, Latin for as needed) for pain 4-10, (numeric pain scale in which a resident's pain is indicated with zero being no pain and 10 for the worst pain imaginable), dated 9/15/2024. During a review of Resident 10's Care Plan for Chronic Pain, initiated 3/16/2023, the care plan indicated the resident will not have an interruption in normal activities due to pain through the review date. The care plan indicated the following: - Administer analgesia (pain medication) as per orders. - Evaluate the effectiveness of pain intervention. During a review of Resident 10's CDR, the document indicated the medication Percocet was removed from the blister pack (or called bubble pack, a card that packages doses of medication within small, clear, plastic bubbles [or blisters] that is punched out to administer to a resident) on the following dates: 1/21/2025 1:10 a.m. 1/31/2025 1:45 a.m. 2/01/2025 2 a.m. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 10's MAR for the month of 1/2025 and 2/2025, the MAR did not indicate Resident 10 was given Percocet on the above dates. There was no documentation on Resident 10's MAR that their pain had been assessed prior to giving the Percocet for the above dates. During a medication cart observation and concurrent record review with Licensed Vocational Nurse 5 (LVN 5) on 2/12/2025 at 2:04 p.m., observed the contents of Medication Cart 2. Reviewed Resident 10's CDR for Percocet which indicated Percocet was signed out to be given to Resident 10 on 1/21/20025 at 1:10 a.m., 1/31/2025 at 1:45 a.m., and 2/01/2025 at 2 a.m. However, there was no corresponding entry in Resident 10's 1/2025 and 2/2025 MARs. LVN 5 stated the process is that when a controlled drug is removed from the bubble pack, the licensed nurse is to sign the controlled drug record, give the medication to the resident, and then sign the MAR. LVN 5 stated the licensed nurse should have signed the MAR after giving the medication. LVN 5 stated this process is important so that a resident's physician knows how much medication is being given and will indicate whether a resident's pain relief is achieved. During a concurrent interview and record review with the Director of Nurses (DON) on 2/12/2025 at 4:34 p.m. , reviewed Resident 10's Percocet CDR and Resident 10's 1/2025 and 2/2025 MARs. The DON confirmed the entries on the CDR for 1/21/2025 at 1:10 a.m., 1/31/2025 at 1:45 a.m. and 2/01/2025 at 2 a.m. had no corresponding entries in Resident 10's 1/2025 and 2/2025 MARs. The DON stated the licensed nurses need to sign both the CDR and MAR to ensure the licensed nurses know when the next dose is due, to prevent medication error, and to provide pain relief. During a concurrent interview and record review with LVN 7 on 2/13/2025 at 7:17 a.m., reviewed Resident 10's Percocet CDR, 1/2025 MAR, and 2/2025 MAR. LVN 7 confirmed that they signed Resident 10's Percocet CDR for 1/21/2025, 1/31/2025, and 2/01/2025. LVN 7 stated there may have been an emergency that interrupted them from signing the MAR and forgot to return later to sign the MAR. LVN 7 stated if the MAR is not signed the licensed nursing staff will know not know what level the resident's pain is or if it was relieved by the medication. LVN 7 stated if the MAR is not signed then the next licensed nurse may give the pain medication too soon. During a review of the facility's policy and procedure titled, Controlled Medications, last reviewed 1/30/2025, the document indicated the following: When a controlled medication is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and the medication administration record (MAR): 1) Date and time of administration. 2) Amount administered. 3) Signature of the nurse administering the dose on the accountability record at the time the medication is removed from the supply. 4) Initials of the nurse administering the dose on the MAR after the medication is administered.

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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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 34659 Based on observation, interview, and record review, the facility failed ensure staffing information of the actual hours worked by licensed and unlicensed nursing staffing directly responsible for resident care pers shift was posted daily on 2/11/2025 and on 2/13/2025 as indicated in the facility's policy and procedure (P&P) on Staffing, Sufficient and Competent Nursing. This deficient practice had the potential to keep residents and visitors unaware of the total number of staff and the actual hours worked by staff in the facility. Findings: During an observation, interview, and concurrent record review with the Director of Staff Development (DSD) on 2/11/2025 at 2:50 p.m., observed the facility's document California Department of Public Health (CDPH) form titled Census and Direct Care Service Hours Per Patient Day (DHPPD) dated 2/11/2025, posted prominently in the facility's Nursing Station 1 counter. The DSD stated that the posted document is the facility's nursing projected hours. The DSD stated the hours are projected, not actual. The DSD stated they will not have the actual hours until the payroll department calculates the hours the following day. During an observation, interview, and concurrent record review with the Director of Staff Development (DSD) on 2/12/2025 at 2:45 p.m., observed the facility's document titled Census and Direct Care Service Hours Per Patient Day (DHPPD) dated 2/12/2025, posted prominently in the facility's Nursing Station 1 counter. The document contained a typed number for Projected hours and a number written in for Actual Hours. The document indicated a decrease in the number in the census for the 7 a.m. to 3 p.m. shift. The DSD stated they wrote in the number for Actual Hours after the shift had started because there was an adjustment in staffing. During an observation, interview, and concurrent record review with the Director of Staff Development (DSD) on 2/13/2025 at 10:15 a.m., the DSD observed the facility's document titled Census and Direct Care Service Hours Per Patient Day (DHPPD) dated 2/13/2025. There was a blank by the space for Actual Hours. The DSD stated they thought that they only had to post the projected hours because the CDPH Form 612 indicated the Actual Direct Care Service Hours must be completed at the end of each 24-hour patient day. During a concurrent interview and record review with the Director of Nurses (DON) on 2/13/2025 at 11:05 a.m., reviewed Form 612, dated 2/11/2025. The DON stated that the actual posting numbers are documented on Actual Hours after the stand-up meeting and the DSD knows which staff is present in the facility. The DON stated this should be posted by 11 a.m. The DON stated there should be the actual hours indicated on the form. During a review of the facility's policy and procedure titled, Staffing, Sufficient and Competent Nursing, last reviewed 1/30/2025, indicated direct care daily staffing numbers (the number of nursing personnel responsible for providing direct care to residents) are posted in the facility for every shift.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 49947 Based on interview and record review, the facility failed to maintain accurate clinical records in accordance with accepted professional standards and practices by failing to ensure all medications administered to residents were documented in their medication administration record (MAR, a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for two of five sampled residents (Resident 22, 10) being investigated under the care area of unnecessary medications for: a. Resident 22's Xanax (controlled [a medication's use and distribution are tightly controlled because of their abuse potential or risk] medication for anxiety [feelings of fear, dread, and uneasiness]) and tramadol (controlled medication used for pain). b. Resident 10's Percocet (narcotic, controlled medication used for pain). This deficient practice had the potential to result in medication error and/or drug diversion (illegal distribution or abuse of prescription drugs). Findings: a. During a review of Resident 22's Admission Record, the Admission Record indicated the facility admitted Resident 22 on 6/15/2024 with diagnoses that included, but not limited to repeated falls, depression (persistent feelings of sadness and hopelessness) and anxiety disorder. During a review of Resident 22's Physician's Progress Note, dated 1/17/2024, the Physician's Progress Note indicated Resident 22 does have the capacity to understand and make decisions. During a review of Resident 22's Minimum Data Set (MDS - an assessment and care screening tool) dated 1/21/2025, the MDS indicated the resident was able to understand others and make himself understood. The MDS indicated Resident 22 needed partial assistance from staff for bathing, dressing, and toileting. The MDS further indicated Resident 22 was on a scheduled pain medication regimen and received as needed (PRN) pain medication. During a review of Resident 22's Physician's Orders, the Physician's Orders indicated the following orders: 1. Alprazolam (generic name for Xanax) 0.5 milligrams (mg, metric unit of measurement, used for medication dosage and/or amount), give one tablet by mouth every 12 hours as needed (PRN, or pro re nata, Latin for as needed) for anxiety ordered on 2/16/2025. 2. Tramadol 50 mg, give 1 tablet by mouth every 12 hours PRN pain level 6-10 (numeric pain scale in which a resident's pain is indicated with zero being no pain and 10 for the worst pain imaginable) ordered on 1/16/2025 (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 22's Care Plan for Chronic Pain, initiated 1/27/2025, the care plan indicated the resident will not have an interruption in normal activities due to pain through the review date. The care plan indicated the following: - Administer analgesia (pain medication) as per orders. - Evaluate the effectiveness of pain intervention. During a review of Resident 22's Care Plan for use of anti-anxiety medications, initiated 1/27/2025, the care plan indicated the resident will be free from discomfort or adverse reactions (unwanted or undesirable effects) through the review date. The care plan indicated the following: -Give anti-anxiety medications as per orders. -Monitor/document side effects and effectiveness. During a review of Resident 22's Controlled Drug Record (CDR - record of all resident's controlled medications; the licensed nurse must sign once medication is removed from supply) the document indicated: 1. Xanax was removed from the blister pack (or called bubble pack, a card that packages doses of medication within small, clear, plastic bubbles [or blisters] that is punched out to administer to a resident) on 2/9/2025 at 8:20 a.m. 2. Tramadol was removed from blister pack on 2/9/2025 at 8:30 a.m. During a review of Resident 22's MAR for the month of 1/2025 and 2/2025, the MAR did not indicate Resident 22 was given Xanax or tramadol on 2/9/2025. During a concurrent interview and review of the Nursing Staffing Assignment and Sign-In Sheet on 2/11/2025 at 11:10 a.m. with the Director of Staff Development (DSD), the DSD confirmed Licensed Vocational Nurse (LVN) 2 used the medication cart (Cart 1) on 2/9/2025 from 7:00 a.m. - 3:30 p.m. The DSD further stated the initials in the CDR for Xanax and Tramadol on 2/9/2025 at 8:20 a.m. and then 8:30 a.m. belonged to LVN 2. The DSD stated LVN 2 would not be into work until the upcoming weekend and provided his phone number. During a phone interview on 2/12/2025 at 2:44 p.m. with LVN 2, LVN 2 stated when a controlled drug is removed from the bubble pack, the licensed nurse is to sign the controlled drug record, give the medication to the resident, and then sign the MAR. LVN 2 explained once the medication is signed in the MAR, the MAR prompts a re-evaluation task 1 hour from when the medication is given. LVN 2 stated he was unsure why the medications were not signed in the MAR but that it is very important to prevent extra doses and important for re-evaluation of anxiety and pain. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review with the Assistant Director of Nurses (ADON) on 2/11/2025 at 11:34 a.m., reviewed Resident 22's Xanax and Tramadol CDR and 2/2025 MARs. The ADON confirmed the entries on the CDR for Xanax on 2/9/2025 at 8:20 a.m., and Tramadol 2/9/2025 at 8:30 a.m. had no corresponding entries in Resident 22's 2/2025 MAR. The ADON stated the licensed nurses need to sign both the CDR and MAR to ensure all the licensed nurses know when the next dose is due, to prevent medication error, and to reassess the effectiveness of the medications. During a review of the facility provided Policy and Procedure (P&P) titled, Preparation and General Guidelines: Controlled Medications, last reviewed 1/30/2025, indicated when a controlled medication is administered, the licensed nurse administering the medication must immediately enter in the medication administration record (MAR): 1. Date and time of administration 2. Amount administered 3. Signature of the nurse administering the dose on the accountability record at the time the medication is removed from the supply 4. Initials of the nurse administering the dose on the MAR after the medication is administered. During a review of the facility provided P&P titled, Charting Errors and/or Omissions, last reviewed 1/30/2025, indicated accurate medical records shall be maintained by this facility. 34659 b. During a review of Resident 10's Admission Record (front page of the chart that contains a summary of basic information about the resident), the document indicated the resident was admitted to the facility on [DATE] and readmitted [DATE] with diagnoses that included chronic pain syndrome (a condition characterized by persistent or recurring pain that lasts for more than 3 months). During a review of Resident 10' s Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 1/15/2025, the MDS indicated Resident 10 was cognitively (the process of acquiring knowledge and understanding through thought, experience, and the senses) intact with skills required for daily decision making. The MDS indicated Resident 10 required setup or clean-up assistance for eating and moderate assistance (helper does less than half the effort) for oral hygiene and personal hygiene. During a review of Resident 10's Physician's Orders, the Physician Orders indicated the following orders: oxycodone with acetaminophen tablet (brand name is Percocet, a narcotic pain medication) 5-325 milligrams (mg, metric unit of measurement, used for medication dosage and/or amount), give one tablet by mouth every six hours as needed (PRN, or pro re nata, Latin for as needed) for pain 4-10, (numeric pain scale in which a resident's pain is indicated with zero being no pain and 10 for the worst pain imaginable), dated 9/15/2024. During a review of Resident 10's Care Plan for Chronic Pain, initiated 3/16/2023, the care plan indicated the resident will not have an interruption in normal activities due to pain through the review date. The care plan indicated the following: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Administer analgesia (pain medication) as per orders. - Evaluate the effectiveness of pain intervention. During a review of Resident 10's CDR, the document indicated the medication Percocet was removed from the blister pack (or called bubble pack, a card that packages doses of medication within small, clear, plastic bubbles [or blisters] that is punched out to administer to a resident) on the following dates: 1/21/2025 1:10 a.m. 1/31/2025 1:45 a.m. 2/01/2025 2 a.m. During a review of Resident 10's MAR for the month of 1/2025 and 2/2025, the MAR did not indicate Resident 10 was given Percocet on the above dates. During a medication cart observation and concurrent record review with Licensed Vocational Nurse 5 (LVN 5) on 2/12/2025 at 2:04 p.m., observed the contents of Medication Cart 2. Reviewed Resident 10's CDR for Percocet which indicated Percocet was signed out to be given to Resident 10 on 1/21/20025 at 1:10 a.m., 1/31/2025 at 1:45 a.m., and 2/01/2025 at 2 a.m. However, there was no corresponding entry in Resident 10's 1/2025 and 2/2025 MARs. LVN 5 stated the process is that when a controlled drug is removed from the bubble pack, the licensed nurse is to sign the controlled drug record, give the medication to the resident, and then sign the MAR. LVN 5 stated the licensed nurse should have signed the MAR after giving the medication. LVN 5 stated this process is important so that a resident's physician knows how much medication is being given and will indicate whether a resident's pain relief is achieved. During a concurrent interview and record review with the Director of Nurses (DON) on 2/12/2025 at 4:34 p.m. , reviewed Resident 10's Percocet CDR and Resident 10's 1/2025 and 2/2025 MARs. The DON confirmed the entries on the CDR for 1/21/2025 at 1:10 a.m., 1/31/2025 at 1:45 a.m. and 2/01/2025 at 2 a.m. had no corresponding entries in Resident 10's 1/2025 and 2/2025 MARs. The DON stated the licensed nurses need to sign both the CDR and MAR to ensure the licensed nurses know when the next dose is due, to prevent medication error, to provide pain relief and ensure licensed nurses gave the medication and there was no possibility of drug diversion. During a concurrent interview and record review with LVN 7 on 2/13/2025 at 7:17 a.m., reviewed Resident 10's Percocet CDR, 1/2025 MAR, and 2/2025 MAR. LVN 7 confirmed that they signed Resident 10's Percocet CDR for 1/21/2025, 1/31/2025, and 2/01/2025. LVN 7 stated there may have been an emergency that interrupted them from signing the MAR and forgot to return later to sign the MAR. LVN 7 stated if the MAR is not signed the licensed nursing staff will know not know what level the resident's pain is or if it was relieved by the medication. LVN 7 stated if the MAR is not signed then the next licensed nurse may give the pain medication too soon. During a review of the facility's policy and procedure titled, Controlled Medications, last reviewed 1/30/2025, the document indicated the following: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	When a controlled medication is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and the medication administration record (MAR): 1) Date and time of administration. 2) Amount administered. 3) Signature of the nurse administering the dose on the accountability record at the time the medication is removed from the supply. 4) Initials of the nurse administering the dose on the MAR after the medication is administered.

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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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 47883 Based on interview and record review, the facility failed to monitor a resident for side effects of Trazadone (an antidepressant medication) and Xanax (an antianxiety medication) for one (Resident 72) out of five sampled residents investigated under the care area of unnecessary medications. This deficient practice had the potential to place Resident 72 t at increased risk of taking an unnecessary medication and experiencing adverse side effects. Findings: During a review of Resident 72's Admission Record, the Admission Record indicated that the facility initially admitted Resident 72 on 5/7/2024 and readmitted the resident on 1/17/2025 with diagnoses including infection and inflammatory reaction to prosthetic devices (bacteria have entered the body around a surgical implanted device, causing the body's immune system to react with swelling, pain redness at the implant site), acute hematogenous osteomyelitis (a bacterial infection of the bone that spreads through the bloodstream), cellulitis (a deep skin infection that can be painful and cause swelling). During a review of Resident 72's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 1/27/2025, the MDS indicated that the resident had mildly impaired cognition (a slight decline in mental abilities, memory and completing complex tasks). The MDS further indicated that Resident 72 required maximal assistance from staff with most activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). And clean -up assistance with eating and oral hygiene. During a review of Resident 72 History and Physical (H&P), dated 1/20/2025, the H&P indicated Resident 72 had the capacity to understand and make decisions. During the review of Resident 72's Physician Order Report, dated 2/1/2025, the Physician Order Report indicated the following physician orders for: 1. Trazadone 50 milligram (mg - unit of measurement) at bedtime for depression manifested by inability to sleep, dated 1/25/2025. 2. Xanax 0.5 milligram (mg - unit of measurement) every 8 hours as needed for anxiety as needed, dated 1/23/2025. 3. Monitor for side effects for antianxiety medication Xanax every shift dated, 1/23/2025. 4. Monitor for side effects for antidepressant medication Trazadone per shift dated, 1/23/2025. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 12/11/2024 at 4:19 p.m., reviewed Resident 72's Medication Administration Record (MAR - a report detailing the drugs administered to a patient by a healthcare professional at a treatment facility) with the Minimum Data Set Nurse (MDSN). The MDSN stated the resident received Trazadone 50 mg on 01/31/2025, at 9 PM and Xanax 0.5 mg on 02/01/2025, at 5:30 AM. When asked to provide documentation that the licensed nurses were monitoring for side effects for Trazadone and Xanax, MDSN stated she could not find any documentation indicating that the nurses were monitoring for side effects on 2/1/2025 from 7 AM to 3 PM . On 2/12/2025 at 4:46 p.m., during an interview, the Director of Nursing (DON) stated it was important to monitor for side effects of psychotropic medications to determine if the dosage needed to be adjusted. The DON stated nurses needed to monitor for adverse side effects so it could be reported to the physician and necessary changes could be made to the dosage. The DON stated if the nurses did not monitor for either of these, then the resident may possibly be receiving an unnecessary medication. During a review of the facility's policy and procedure titled, Psychotherapeutic Medication Use last reviewed on 1/30/2025, the policy indicated: Resident receiving psychotropic medications are monitored for adverse consequences . If psychotropic medications are identified as possibly causing or contributing to adverse consequences, the prescriber will determine the medication should be continued, and document the rationale for this decision.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47883 Based on observation, interview, and record review, the facility failed to ensure residents were free from any significant med errors for three of six sampled residents (Resident 72, Resident 70, and Resident 83) reviewed for unnecessary medications by failing to: 1. Administer Resident 72's Morphine Sulfate Contin (a medication used to control pain) 30 milligrams (mg-metric unit of measurement, used for medication dosage and/or amount) on 2/1/2025 as ordered by the physician. This deficient practice resulted in the resident not receiving the medication as scheduled, which can potentially lead to increased pain. 2. Hold parameters for midodrine (a medication to elevate blood pressure for those with low blood pressure) as ordered by the physician for Resident 70 and Resident 83. This deficient practice had the potential to cause complications such as high blood pressure that could require hospitalization . Findings: 1. During a review of Resident 72's Admission Record, the Admission Record indicated that the facility initially admitted Resident 72 on 5/7/2024 and readmitted the resident on 1/17/2025 with diagnoses including infection and inflammatory reaction to prosthetic devices (bacteria have entered the body around a surgical implanted device , causing the body's immune system to react with swelling , pain redness at the implant site), acute hematogenous osteomyelitis (a bacterial infection of the bone that spreads through the bloodstream), cellulitis (a deep skin infection that can be painful and cause swelling), and chronic pain syndrome() During a review of Resident 72's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 1/27/2025, the MDS indicated that the resident had mildly impaired cognition (a slight decline in mental abilities, memory and completing complex tasks). The MDS further indicated that Resident 72 required maximal assistance from staff with most activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). And clean -up assistance with eating and oral hygiene. During a review of Resident 72 History and Physical (H&P), dated 1/20/2025, the H&P indicated Resident 72 had the capacity to understand and make decisions. During a review of Resident 72's Physician's Orders Summary, it indicated an order for Morphine Sulfate Contin oral tablet 30 mg, give one tablet by mouth one time a day for pain, dated 01/23/2025. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 02/11/25 at 4:19 p.m., with Minimum Data Set Nurse (MDSN), Resident 72's Medication Administration Record (MAR) was reviewed. The MDSN stated the MAR indicated that on 2/1/2025 at 9 a.m. Morphine Sulfate Contin was not administered to Resident 72. The MDSN reviewed the nursing assignment for Resident 72 on 2/1/2025 and stated that it was Licensed Vocational Nurse (LVN) from the registry who was assigned to Resident 72 on 2/1/2925. The MDSN stated the LVN from the registry is on vacation right now and could not be reached at this time. The MDSN stated that medication should have been administered to Resident 72 according to the physician order. During a concurrent record review and interview on 2/13/2025 at 2:05 p.m. with Licensed Vocational Nurse 6 (LVN 6), Resident 72's antibiotic or controlled drug record was reviewed. LVN reviewed controlled drug record from 1/30/2025 to 2/13/2025 and stated the record indicated than Morphine Sulfate Contin was not given to Resident 72 on February 1, 2025. During an interview with the DON on 2/13/2025 at 2:36 p.m., the DON stated the Morphine Sulphate Contin should be administered according to physician order. The DON stated not giving Resident 72 the medication as ordered by the physician placed the resident at risk for increased pain. 34659 2.a. During a review of Resident 83's Admission Record (front page of the chart that contains a summary of basic information about the resident), the Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included hypertension (HTN, high blood pressure) and systolic and diastolic heart failure (systolic heart failure occurs when the heart can't contract effectively, while diastolic heart failure occurs when the heart can't relax properly). During a review of Resident 83's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 1/17/2025, the MDS indicated Resident 83 was severely impaired in cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) with skills required for daily decision making. The MDS indicated Resident 83 needed setup or clean-up assistance (helper sets up or cleans us) with eating and moderate assistance (helper does less than half the effort) for oral hygiene. During a review of Resident 83's Physician's Orders, it indicated an order for midodrine oral tablet 10 milligrams (mg- metric unit of measurement, used for medication dosage and/or amount) give one tablet by mouth three times a day for hypotension, hold if systolic blood pressure (SBP - the pressure in the arteries when the heart contracts and pumps blood throughout the body, normal reference range is less than or equal to 120 millimeters of mercury [mm Hg]) is greater than (>) 120 mm Hg. During a review of Resident 83's Care Plan for Altered Cardiovascular Status, initiated 1/23/2025, it indicated a goal that the resident will be free from signs or symptoms of complications of cardiac problems through the review date. The care plan indicated an intervention to take vital signs every shift and to notify physician of any abnormal findings. During a review of Resident 83's 1/2025 MAR, the document indicated Resident 70 was given midodrine when the SBP was > 120 mm Hg for the following dates: 1/11/2025 5 p.m. 122/60 mm Hg. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1/13/2025 5 p.m. 132/68 mm Hg. 1/16/2025 5 p.m. 137/77 mm Hg. 1/19/2025 9 a.m. 132/78 mm Hg. 1/19/2025 1 p.m. 128/76 mm Hg. 1/24/2025 9 a.m. 126/71 mm Hg. 1/24/2025 1 p.m. 126/71 mm Hg. 1/25/2025 5 p.m. 126/71 mm Hg. 1/29/2025 5 p.m. 126/70 mm Hg. 1/31/2025 5 p.m. 137/62 mm Hg. During a review of Resident 83's 2/2025 MAR, covering the dates 2/01/2025 through 2/12/2025, the document indicated Resident 70 was given midodrine when the SBP was > 120 mm Hg for the following dates: 2/01/2025 9 a.m. 123/77 mm Hg. 2/02/2025 9 a.m. 127/72 mm Hg. 2/02/2025 1 p.m. 123/72 mm Hg. 2/02/2025 5 p.m. 126/62 mm Hg. 2/03/2025 5 p.m. 124/60 mm Hg. 2/04/2025 5 p.m. 134/70 mm Hg. 2/07/2025 1 p.m. 124/68 mm Hg. During a concurrent interview and record review with Licensed Vocational Nurse 4 (LVN 4) on 2/11/2025 at 5:06 p.m., reviewed Resident 83's 1/2025 and 2/2025 MARS. LVN 4 confirmed that LVN 4 signed that the midodrine was given to Resident 83 on the following dates and times: 1/11/2025 5 p.m. 122/60 mm Hg. 1/13/2025 5 p.m. 132/68 mm Hg. 1/16/2025 5 p.m. 137/77 mm Hg. 1/29/2025 5 p.m. 126/70 mm Hg. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2/02/2025 5 p.m. 126/62 mm Hg. 2/03/2025 5 p.m. 124/60 mm Hg. 2/04/2025 5 p.m. 134/70 mm Hg. LVN 4 stated LVN 4 could not remember for the January dates if LVN 4 gave the medication or not. LVN 4 stated LVN 4 held the medication for the February dates but marked as given by mistake. LVN 4 stated when Resident 83's blood pressure is above 120 mm Hg., midodrine should be held. LVN 4 stated this is important to follow the blood pressure parameters so Resident 83's blood pressure will not be too high. During a concurrent interview and record review with LVN 3 on 2/11/2025 at 5:18 p.m., reviewed Resident 83's 1/2025 and 2/2025 MARs. LVN 3 confirmed that LVN 3 signed that the midodrine was given to Resident 83 on the following dates and times: 1/19/2025 9 a.m. 132/78 mm Hg. 1/24/2025 9 a.m. 126/71 mm Hg. 1/24/2025 1 p.m. 126/71 mm Hg. 1/25/2025 5 p.m. 126/71 mm Hg. 2/02/2025 1 p.m. 132/72 mm Hg. 2/07/2025 1 p.m. 124/68 mm Hg. LVN 3 verified they signed Resident 83's 1/2025 and 2/2025 MARS for the above dates. LVN 3 stated they could not remember if they gave Resident 83 the midodrine on the above dates or not. LVN 3 stated it is important to follow the blood pressure parameters so that Resident 83's blood pressure will not be elevated. During a concurrent interview and record review with the Director of Nursing (DON) on 2/12/2025 at 4:10 p.m. , reviewed Resident 83's 1/2025 MAR and 2/2025 MAR covering the dates 2/01/2025 through 2/11/2025. The DON stated midodrine should not have been given on the above dates and times. The DON stated Resident 83 could be at risk for elevated blood pressure and resulting complications. 2.b. During a review of Resident 70's Admission Record, the document indicated the resident was admitted to the facility on [DATE] with diagnoses that included HTN and hypotension (low blood pressure). During a review of Resident 70's MDS, dated [DATE], the MDS indicated Resident 70 was severely impaired in cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) with skills required for daily decision making. The MDS indicated Resident 70 was dependent on staff for oral hygiene, toileting, dressing, and personal hygiene. The MDS indicated Resident 70 had a diagnosis of hypertension, orthostatic hypotension (a condition where blood pressure drops significantly upon standing up from a sitting or lying position) and syncope (fainting). (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 70's Physician's Orders, the document indicated an order for midodrine oral tablet 10 mg, give one tablet via gastrostomy tube (G-Tube, a plastic tube to allow feedings to be administered directly to the stomach for those with swallowing problems) every eight hours for hypotension, hold if SBP is greater than (>) 120 mm Hg. During a review of Resident 70's Care Plan for Altered Cardiovascular Status, initiated 6/21/2024, indicated a goal that the resident will be free from signs or symptoms of complications of cardiac problems through the review date. The care plan indicated an intervention to take vital signs every shift and to notify physician of any abnormal findings. During a review of Resident 70's 1/2025 MAR, the document indicated Resident 70 was given midodrine when the SBP was > 120 mm Hg for the following dates: 1/03/2025 10 p.m. 132/67 mm Hg. 1/09/2025 6 a.m. 126/78 mm Hg. 1/15/2025 6 a.m. 136/67 mm Hg. 1/18/2025 10 p.m. 122/67 mm Hg. 1/19/2025 2 p.m. 122/76 mm Hg. 1/22/2025 2 p.m. 133/65 mm Hg. During a concurrent interview and record review with the DON on 2/13/2025 at 1:36 p.m., reviewed Resident 70's 1/2025 MAR. The DON stated the midodrine should not have been given on the above dates and times. The DON stated Resident 70 could be at risk for elevated blood pressure and resulting complications. During a review of the facility's policy and procedure titled, Medication Administration - General Guidelines, last reviewed 1/30/2025, the policy indicated medications are administered in accordance with written orders of the attending physician.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 38469 Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices in the kitchen when a steel scoop was left inside a bin containing a thickener powder used for residents` pureed diet (a pureed diet is needed for people who have trouble chewing or swallowing). This deficient practice had the potential to place five residents who are receiving pureed diet, out of 91 residents at risk for foodborne illnesses (refers to illness caused by the ingestion of contaminated food or beverages). Findings: During a concurrent kitchen observation and interview on 2/10/2025 at 08:00 a.m., with Dietary Supervisor 1 (DS 1) in the facility`s kitchen, observed a container bin with transparent cover containing whitish powder. DS 1 stated the powder is a thickener used for pureed diets. Observed a stainless scoop inside the container bin with the handle buried in the thickener powder. DS 1 stated the scoop should not have been left inside the bin per facility`s policy and to avoid contaminating the contents of the container bin. DS 1 stated that contaminating the thickener powder can place the residents on pureed diet at risk for foodborne illnesses.  During a review of the facility`s policy and procedure, titled Recommended Storage Practices, last reviewed on 1/30/2025, the policy indicated in the procedure to Do not store scoops in food containers .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47883 Based on observation, interview, and record review, the facility failed to: 1. Implement policies on transmission based precautions (TBP-a set of infection control measures used to prevent the spread infections that are transmitted through contact with infected person, their bodily fluids, or contaminated surfaces or objects) by failing to provide trash cans inside resident's rooms for used Personal Protective Equipment (PPE - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) for one of five (5) sampled residents (Resident 72) reviewed for infection control. 2. Observe infection control guidelines when LVN 6 was observed leaving a resident's room during a medication pass observation while still wearing an isolation gown and gloves for one (Resident 16) of five residents who were placed on enhanced barrier precautions (EBP - an infection control method that uses targeted gown and gloves to reduce the spread of multidrug-resistant organisms [MDROs - microorganisms, mainly bacteria, that are resistant to one or more classes of antimicrobial [a substance that kills microorganisms such as bacteria or mold, or stops them from growing and causing disease agents). This deficient practice had the potential to increase the risk of spreading infection to other residents. 3. Label with resident identifier (room and bed number) two (Resident 40 and Resident 188) plastic urinal (bottle for urination) and, ensure Resident 40's urinal was not hung on the trash bin for two of two sampled residents. These deficient practices had the potential to result in contamination of the resident's care equipment and risk of transmission of bacteria. 4. Provide a trash can inside a resident's room under contact isolation (used when a resident has an infectious disease that may be spread by touching either the resident or other objects the resident has handled) to doff (take off) Personal Protective Equipment (PPE-clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) for one of one sampled resident (Resident 54). 5. Ensure Medication room [ROOM NUMBER] was free from personal belongings. These deficient practices had the potential to increase the risk of spreading infection to other residents and staff members. Findings: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. During a review of Resident 72's Admission Record, the Admission Record indicated that the facility initially admitted Resident 72 on 5/7/2024 and readmitted the resident on 1/17/2025 with diagnoses including infection and inflammatory reaction to prosthetic devices (bacteria have entered the body around a surgical implanted device , causing the body's immune system to react with swelling , pain redness at the implant site), acute hematogenous osteomyelitis (a bacterial infection of the bone that spreads through the bloodstream), cellulitis (a deep skin infection that can be painful and cause swelling). During a review of Resident 72's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 1/27/2025, the MDS indicated that the resident had mildly impaired cognition (a slight decline in mental abilities, memory and completing complex tasks). The MDS further indicated that Resident 72 required maximal assistance from staff with most activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). And clean -up assistance with eating and oral hygiene. During a review of Resident 72 History and Physical (H&P), dated 1/20/2025, the H&P indicated Resident 72 had the capacity to understand and make decisions. During concurrent observation and interview on 2/10/1025 at 10:10 a.m., in Resident 72 room with the Assistant Director of Nursing (ADON), observed resident in her bed. The room had a signage which indicated Resident 72 was on contact precautions (steps taken to prevent the spread of germs from patient to other). The signage indicated to don a gown and gloves when entering the resident's room. There was no trash can observe in the resident's room for the staff to dispose of their used PPEs. The ADON stated there should have been a trash can in the resident's room for the staff to use when they discard their PPE's prior to exiting Resident 72's room. The ADON stated this deficient practice had the potential to spread infection to other residents. 2.During a review of Resident 16's Admission Record, the Admission Record indicated that the facility initially admitted Resident 16 on 1/9/2024 and readmitted the resident on 1/23/2024 with diagnoses including hemiplegia and hemiparesis (weakness or the inability to move on one side of the body, making it had to perform everyday activities like eating or dressing), gastrostomy (G-Tube- a tube inserted through the abdomen that delivers nutrition directly to the stomach), encephalopathy (the group of condition that cause brain dysfunction[can appear as confusion, memory loss and personality change). During a review of Resident 16's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 1/13/2025, the MDS indicated that the resident had severely impaired cognition (a severely damaged mental abilities, including remembering things, making decisions, concentrating, or learning). The MDS further indicated that Resident 16 was totally dependent on staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a review of Resident 16 History and Physical (H&P), dated 2/11/2025, the H&P indicated Resident 16 did not have the capacity to understand and make decisions. During a review of Resident 16's Order Summary Report dated February 2025, the Order Summary Report indicated physician orders for: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1.Eliquis (a medication used) 5 milligrams (mg-unit of measurement) via G-tube two times a day, dated 1/7/2025. 2. Vitamin C (supplement) 500 milligrams (mg- unit of measurement) via G-tube two times a day dated 7/8/2024. 3.Arginaid powder (nutritional supplement) give 1 packed via G-tube wo times a day with 6 ounces (oz-30 milliliters) of water, dated 11/15/2024. During a medication pass observation with LVN 6 on 2/12/2025 at 8:14 a.m., observed Resident 6's room with a signage which indicated Resident 6 was on EBP. The signage indicated to don (put on) a gown and gloves when performing high contact activity and use of G-tube. Observed the following medication administered to Resident 6 via g-tube: 1.Eliquis 5 mg 2. Vitamin C 500 mg 3.Arginaid powder After LVN 6 gave the medications to Resident 6, LVN 6 exited Resident 16's room while still wearing an isolation gown. One of LVN 6's gowned arms touched the medication cart. When asked why LVN 6 was still wearing the isolation gown after exiting a resident's room on EBP precautions, LVN 6 stated she should have removed the isolation gown before exiting the room. LVN 6 then removed the isolation gown. LVN 6 stated it is important to follow EBP guidelines to prevent the spread of infection. During an interview on 2/12/2025 at 1:10 p.m., the Infection Preventionist (IP) stated staff providing care for residents who are on EBP and TBS should remove the isolation gown and gloves before leaving a resident's room. The IP stated that rooms with TBS and EBP should have trash cans for used PPE. The IP stated LVN 6 should have removed the gown before exiting Resident 16's room. The IP stated this was important to prevent the spread of infection. During a review of the facility policy named Isolation- Categories of Transmission-Based Precautions, last reviewed on 1/30/2025, the policy indicated: Staff and visitors wear a disposable gown upon entering the room and remove leaving the room and avoid touching potentially contaminated surfaces with clothing after gown is removed. During a review of the facility policy named Enhanced Barrier Precautions, last reviewed on 1/30/2025, the policy indicated: EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. Gloves and gown are applied prior to performing the high contact resident care activity. Personal protective equipment (PPE)is changed before caring for another resident .Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include .device use or care (central line, urinary catheter, feeding tube, tracheostomy/ventilator. etc.). 38469 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055906	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rinaldi Convalescent Hospital	16553 Rinaldi St Granada Hills, CA 91344

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During a review of Resident 40's Admission Record, the Admission Record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included but not limited to, hypertension (high blood pressure) and type 2 diabetes mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy.). During a review of Resident 40`s Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 01/27/2025, the MDS indicated the resident`s cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was intact and required partial/moderate assistance with toileting hygiene, shower, and dressing. During an observation on 02/10/2025 at 9:34 a.m., in Resident 40`s room, observed an unlabeled plastic urinal placed in the urinal holder hanging on the bed side rail. During a concurrent observation and interview on 02/10/2025 at 9:56 a.m., with the Director of Nursing (DON), in Resident 40s' room, the DON stated that Resident's 40s urinal did not have a label. The DON stated that urinals should be labeled with the resident`s name and room number to prevent inadvertent use by another resident. The DON stated that if the urinal is unlabeled there is a chance that it can be used by another resident which can result in cross contamination and place the residents at risk for infection. During a review of Resident 188's Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE], with diagnoses that included but not limited to, hypertension and depression (a common mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest in activities). During a review of Resident 188`s Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 01/22/2025, the MDS indicated the resident`s cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was intact and required substantial assistance from staff for toileting hygiene, shower, dressing and personal hygiene. During an observation and interview on 02/10/2025 at 09:34 a.m., in Resident 188's observed a plastic urinal without a label hanging on the trash bin next to the resident's bed. Resident 188 stated he does not know who placed the urinal in the trash bin. During a concurrent observation and interview on 02/10/2025 at 09:52 a.m., with the Director of Nursing (DON) in Resident 188's room, the DON stated Resident 188's unlabeled urinal was hanging on the trash bin. The DON stated urinals should be labeled with the resident`s name and room number to prevent inadvertent use by another resident. The DON stated urinals should be labeled and should not be hanging on the trash bins to prevent risk of cross contamination and spread of infection  During a review of the facility`s policy and procedure titled Disinfection of Bedpans and Urinals, last reviewed on 1/30/2025, the policy and procedure indicated that the policy provide guidelines for disinfection of bedpans and urinals .disposable bedpans and urinals are for single use only. [NAME] with the resident`s name and discard upon discharge . 44309 (continued on next page)

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	055906	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rinaldi Convalescent Hospital	16553 Rinaldi St Granada Hills, CA 91344

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. During a review of Resident 54's Admission Record (face sheet), the Admission Record indicated that the facility originally admitted the resident on 6/17/2022, and readmitted on [DATE], with diagnoses including seizure (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), unspecified dementia (a progressive state of decline in mental abilities), and muscle weakness. During a review of Resident 54's Minimum Data Set (MDS - a resident assessment tool) dated 2/4/2025, the MDS indicated that the resident`s cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated that Resident 54 was dependent to staff (helper does all the effort) for toileting hygiene, showering/bathing, lower body dressing, and putting on /taking off the footwear. During a review of Resident 54's physician order dated 1/31/2024, the order indicated that the resident was tested positive for Extended-Spectrum Beta-Lactamase (ESBL- enzymes produced by some bacteria that may make them resistant to some antibiotics) of urine. The physician order further indicated that Resident 54 was on contact isolation. During an observation on 2/10/2025 at 12:10 p.m., inside Resident 54`s room, surveyor was inside the resident`s room wearing a gown and gloves and was attempting to doff and exit the room. However, there was no trash can inside Resident 54 to discard the PPE. During a concurrent observation and interview on 2/10/2025 at 12:12 p.m., with the Administrator (ADM), observed a surveyor inside Resident 54`s room wearing a gown and gloves and unable to doff because there was no trash can available. The ADM stated that there is a sign for contact precaution at Resident 54`s door, and a closed lid trash can is required to be present inside the room for staff to be able to doff their PPE. The ADM stated the potential outcome of not providing trash can inside a resident`s room under contact isolation is the possibility of the staff exiting the room while having their gown and gloves on and spreading infection to other staff members and residents. During a review of the facility Policy and Procedure (P&P) titled Isolation- Categories of Transmission-Based Precautions (TBS-a set of infection control measures used to prevent the spread infections that are transmitted through contact with infected person, their bodily fluids, or contaminated surfaces or objects), last reviewed on 1/30/2025, the P&P indicated that contact precautions are implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environment surfaces or resident-care items in the resident`s environment. Staff and visitors wear a disposable gown upon entering the gown and remove before leaving the room and avoid touching potentially contaminated surfaces with clothing after gown is removed. During a review of the facility Policy and Procedure (P&P) titled Infection Control, last reviewed on 1/30/2025, the P&P indicated that the facility`s infection control policies and procedures are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections. The objectives our infection control policies and procedures are to establish guidelines for the availability and accessibility of supplies, and equipment necessary for standard and transmission-based precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5.During a concurrent observation and interview on 2/11/2025 at 8:15 a.m., with the Assistant Director of Nursing (ADON) inside Medication room [ROOM NUMBER], a black jacket was observed hanging on the storage shelf. The ADON stated that the black jacket belongs to one of the staff members and should not be present inside the medication room. During a concurrent observation and interview on 2/11/2025 at 8:20 p.m., inside Medication room [ROOM NUMBER] with Licensed Vocational Nurse 6 (LVN 6), LVN 6 stated that the black jacket belongs to her, and she should have not hung it inside the medication room. LVN 6 stated personal belongings are not allowed inside medication rooms because of infection control concerns. During a review of the facility Policy and Procedure (P&P) titled Isolation- Categories of Transmission-Based Precautions (TBS-a set of infection control measures used to prevent the spread infections that are transmitted through contact with infected person, their bodily fluids, or contaminated surfaces or objects), last reviewed on 1/30/2025, the P&P indicated that contact precautions are implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environment surfaces or resident-care items in the resident`s environment. Staff and visitors wear a disposable gown upon entering the gown and remove before leaving the room and avoid touching potentially contaminated surfaces with clothing after gown is removed. During a review of the facility Policy and Procedure (P&P) titled Infection Control, last reviewed on 1/30/2025, the P&P indicated that the facility`s infection control policies and procedures are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections. The objectives our infection control policies and procedures are to establish guidelines for the availability and accessibility of supplies, and equipment necessary for standard and transmission-based precautions.