STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055910	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2025
NAME OF PROVIDER OR SUPPLIER: Country Manor LA Mesa Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 5696 Lake Murray Blvd LA Mesa, CA 91942	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46235 Based on observation and interview, the facility failed to maintain a resident's electric fan filled with gray dust for one of 18 residents reviewed for home like environment. (Resident 57) This failure had the potential to affect the resident's self-esteem living in an unkempt environment and the risk for respiratory issues from inhaling dust from the electric fan. Findings: Resident 57 was admitted to the facility on [DATE] with diagnoses including hemiplegia (total or partial paralysis of one side of the body) and hemiparesis (muscle weakness on one side of the body) following cerebral infarction (stroke) according to the facility's Admission Record. During an interview and observation on 1/13/25 at 9:20 A.M., Resident 57 was in bed with a cell phone and speaker on top of the overbed table. A tall and round electric fan on the floor was turned on at the left side of the bed facing Resident 57. The electric fan was observed with thick, gray dust on the blades and on the grill covers. Resident 57 stated nobody had cleaned the electric fan but did not want to complain about it. During a review of Resident 57's Minimum Data Set (MDS-a clinical assessment tool) dated 11/11/24, the MDS indicated a Brief Interview of Mental Status (BIMS) score of 15, cognitively intact. A joint interview and observation on 1/14/25 at 2:06 P.M. with the infection preventionist (IP) was conducted. The electric fan was observed to be on and with thick, gray dust on the blades and on the grill covers. The IP stated the electric fan facing Resident 57 was dirty and needed cleaning. The IP stated the electric fan should be cleaned to prevent Resident 57 from inhaling dirt into Resident 57's lungs. The IP further stated the electric fan should have been checked by housekeeping staff and the nursing staff during daily rounds. An interview with the Maintenance Director (MN) was conducted on 1/16/25 at 9:23 A.M. The MN stated each nursing station had a deep cleaning schedule which included cleaning of bed frames, mattresses, windows, electric fans, vents, TV, and the wall perimeter. The MN stated the cleaning of resident 57's electric fan was missed. The MN stated it was important to clean resident equipment such as an electric fan to provide a sanitary and homelike environment for the resident. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055910	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2025

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing (DON) on 1/16/25 at 2 P.M., the DON stated residents' electric fans should be free of dust, cleaned every week and appropriate for use for a home like environment. A review of the facility's policy and procedure (P&P) titled, Homelike Environment, dated February 2021 was conducted. The P&P indicated, .The facility staff and management maximizes .the characteristics of the facility that reflect a personalized homelike setting. These characteristics include .a. clean, sanitary and orderly environment .

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46235 Based on observation, interview, and record review, the facility failed to ensure three of six residents, who were unable to carry out activities of daily living (ADL-self- care activities such as grooming, bathing, and toileting), received assistance with nail care (cleaning, trimming and/or filing of nails) and shaving. (Resident 21, 57 and 67) This failure resulted in residents having long, dirty fingernails, a thick beard and moustache which had the potential to negatively impact the residents' self-esteem and comfort. Findings: 1. Resident 21 was admitted to the facility on [DATE] with diagnoses including hemiplegia (a total or partial paralysis of one side of the body) and hemiparesis (muscle weakness on one side of the body) following unspecified cerebrovascular disease (stroke) according to the facility's Admission Record. An observation and interview was conducted with Resident 21 on 1/13/25 at 9:51 A.M. Resident 21 was in bed and was observed with fingernails that were long. Resident 21 showed both hands with long fingernails and with black debris under the fingernails. Resident 21 stated he would like his fingernails to be trimmed because he was unable to trim them himself. A concurrent observation and interview with licensed nurse (LN) 1 was conducted on 1/14/25 at 2:14 P.M. in Resident 21's room. Resident 21 showed his fingernails to LN 1 and stated they were long, dirty, and needed trimming. LN 1 stated it was her expectation for Certified Nurse Assistants (CNAs) to provide nail care and shaving every Sunday and as needed upon admission to the facility. LN 1 stated Resident 21's fingernails have not been trimmed weekly. LN 1 further stated Resident 21's fingernails should be trimmed and cleaned because Resident 21 used his hands to eat and the dirt may cause infection. During a review of a care plan for Resident 21, the care plan revised on 5/10/24 indicated, .ADL maintenance as manifested by .Personal hygiene [Extensive] with [1] staff .Interventions .assist to wash face, brush teeth, comb hair, shave, apply lotion, etc . 2. Resident 57 was admitted to the facility on [DATE] with diagnoses including hemiplegia (total or partial paralysis of one side of the body) and hemiparesis (muscle weakness on one side of the body) following cerebral infarction (stroke) according to the facility's Admission Record. During an interview and observation on 1/13/25 at 9:20 A.M., Resident 57 was in bed with a cell phone and speaker on top of the overbed table. Resident 57 stated he was not able to open his left hand due to a stroke. Resident 57 showed his left hand which was closed and with long fingernails. A concurrent observation and interview was conducted on 1/14/25 at 2:12 P.M. with the Infection Preventionist (IP) in Resident 57's room. Resident 57 showed the IP his long fingernails. The IP stated it was a daily routine for staff to check resident's grooming to promote resident's well-being. The IP stated Resident 57's fingernails were missed for trimming. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of a care plan for Resident 57, the care plan revised on 9/22/24 indicated, .Interventions . ADL maintenance as manifested by .personal hygiene [E-extensive] with [1] staff .revision 6/29/21 . encourage increase participation with ADL. Assist as needed .Date initiated 6/13/21 . 3. Resident 67 was admitted to the facility on [DATE] with diagnoses including encounter for palliative care (medical care focused on providing relief from pain and other symptoms of a serious illness) and paraplegia (inability to voluntarily move the lower parts of the body), unspecified according to the facility's Admission Record. An observation and interview was conducted with Resident 67 on 1/13/25 at 10:17 A.M. Resident 67 was observed in bed watching TV. Resident 67 was observed with a thick beard and moustache. Resident 67 stated he needed his shaver adjusted because he would like his beard and moustache trimmed. Resident 67 stated his moustache was growing into his nose and it was uncomfortable. An interview and joint observation was conducted with Certified Nurse Assistant (CNA) 1 on 1/14/25 at 2:01 P.M. CNA 1 stated grooming for residents were completed twice a week during showers and as needed. Resident 67 stated his moustache was so long that it was entering his nostrils and showed his fingernails to CNA 1. CNA 1 stated resident should have been assisted with moustache and fingernail trimming. During a review of a care plan for Resident 67, the care plan revised on 11/30/24 indicated, .ADL maintenance as manifested by .personal hygiene [supervision] with [1-] staff .Interventions .assist to wash face, brush teeth, comb hair, shave, apply lotion, etc . An interview was conducted on 1/16/25 at 2 P.M. with the Director of Nursing (DON). The DON stated staff needed to ensure residents' nails were trimmed every Sunday and shaved during shower days. The DON stated it was important to increase residents' self-esteem with the expectation for residents to be presentable and well-groomed. A review of the facility's policy and procedure (P&P) titled, Activities of Daily Living [ADL], Supporting, dated March 2018 was conducted. The P&P indicated, .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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46235 Based on observation, interview and record review, the facility failed to ensure two of three residents (Resident 26 and 46) reviewed for Trauma Informed Care (TIC - an intervention and organization approach that focuses on how trauma may affect an individual's life and his or her response to behavioral health), received care and services in accordance with professional standards when Resident 26's and 46's diagnosis of PTSD (Post-traumatic stress disorder - a disorder that may occur in people who have experienced or witnessed a traumatic event) were not identified and addressed by the facility. This failure resulted in the facility's inability to identify possible triggers that could result in re-traumatization (the reactivation of trauma symptoms via thoughts, memories, or feelings related to the past traumatic experience) that could lead to severe psychosocial harm and affect the resident's quality of life. Findings: 1. Resident 26 was admitted to the facility on [DATE] with diagnoses including hemiplegia (total or partial paralysis of one side of the body) and hemiparesis (muscle weakness on one side of the body) following cerebral infarction (stroke) and PTSD according to the facility's Admission Record. During a review of psychiatry evaluation for Resident 26 dated 4/28/23 indicated diagnoses including depression and PTSD. During an observation and interview on 1/15/25 at 8:37 A.M. Resident 26 was in bed with the head of bed elevated, his left arm on his chest with his left hand closed. Resident 26 stated he was not able to move his left arm and hand. Resident 26's speech was slurred and stated he was in the Vietnam war and had been diagnosed with PTSD. Resident 26 stated he felt stressed when war movies were shown in the activity room. An interview was conducted on 1/15/25 at 8:57 A.M. with Certified Nurse Assistant (CNA) 2. CNA 2 stated Resident 26 knew his name, the place, and his situation. CNA 2 stated she was not sure if Resident 26 had PTSD but knew that Resident 26 was in the Vietnam war because Resident 26 talked about it. During an interview on 1/15/25 at 3:10 P.M. with Licensed Nurse (LN) 2, LN 2 stated he has been the regular afternoon nurse for hall four (which included Resident 26's room) for three years. LN 2, however stated he was not sure which residents in his hall had PTSD. LN 2 stated it was important to know who had PTSD and the triggers for PTSD to prevent residents from getting aggressive. During an interview on 1/15/25 at 3:16 P.M. with CNA 3, CNA 3 stated there were no residents in hall four who had PTSD. CNA 3 stated staff needed to know residents' past experiences to understand residents' behaviors. (continued on next page)

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F 0699

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

An interview was conducted on 1/15/25 at 3:24 P.M. with the Social Service Director (SSD). The SSD stated a social service resident assessment was completed prior to care conference or during care conference. The SSD stated information regarding PTSD was documented in the resident's care plan which flowed to the CNA's Kardex (electronic medical record for CNAs with resident information). The SSD further stated it was expected for all staff to know the triggers for residents with PTSD.

A concurrent record review and interview with the Director of Staff Development (DSD- a licensed nurse certified for staff training) was conducted on 1/15/25 at 3:45 P.M. The DSD showed the Kardex for Resident 26 on a small tablet used by the CNAs. The Kardex did not list Resident 26 as having a diagnosis of PTSD. The DSD stated it was important for staff to know who had a diagnosis of PTSD to know triggers and understand resident's behaviors.

2. Resident 46 was admitted to the facility on [DATE] with diagnoses including PTSD and major depressive disorder according to the facility's Admission Record.

During a review of the physician's history and physical (H&P) for Resident 46 dated 11/30/22, the H&P indicated Resident 26 had a diagnosis of PTSD.

A review of social service assessment dated [DATE] indicated Resident 46 experienced trauma during active military service in Vietnam, experienced racism in the military and with significant exposure to death and violence.

During observation and interview on 1/15/25 at 8:33 A.M., Resident 46 was in bed and stated he just finished breakfast. Resident 46 stated he was in the military and was in the war.

An interview was conducted on 1/15/25 at 8:57 A.M. with Certified Nurse Assistant (CNA) 2. CNA 2 stated Resident 46 was independent with activities of daily living (ADL) except for toileting and transfers out of bed. CNA 2 stated Resident 46 was oriented to his name, place, and his situation. CNA 2 stated Resident 46 was a veteran but was unsure if Resident 46 had the diagnosis of PTSD.

During an interview on 1/15/25 at 3:10 P.M. with Licensed Nurse (LN) 2, LN 2 stated he has been the regular afternoon nurse for hall four (which included Resident 46's room) for three years. LN 2 however stated he was not sure which residents in his hall had PTSD. LN 2 stated it was important to know who had PTSD and the triggers for PTSD to prevent residents from getting aggressive.

During an interview on 1/15/25 at 3:16 P.M. with CNA 3, CNA 3 stated there were no residents in hall four who had PTSD. CNA 3 stated staff needed to know residents' past experiences to understand residents' behaviors.

An interview was conducted on 1/15/25 at 3:24 P.M. with the Social Service Director (SSD). The SSD stated a social service resident assessment was completed prior to care conference or during care conference. The SSD stated information regarding PTSD was documented in the resident's care plan which flowed to the CNA's Kardex (electronic medical record for CNAs with resident information). The SSD further stated it was expected for all staff to know the triggers for residents with PTSD.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A concurrent record review and interview with the Director of Staff Development (DSD- a licensed nurse certified for staff training) was conducted on 1/15/25 at 3:45 P.M. The DSD showed the Kardex for Resident 46 on a small tablet used by the CNAs. The Kardex did not list Resident 46 as having a diagnosis of PTSD. The DSD stated it was important for staff to know who had a diagnosis of PTSD to know triggers and understand resident's behaviors. An interview was conducted on 1/16/25 at 2 P.M. with the Director of Nursing (DON). The DON stated all staff must be aware of triggering factors for residents with PTSD to avoid past experiences. The DON stated residents with PTSD must be approached in a calm manner and staff must explain procedures prior to care. During a review of the facility's policy and procedure (P&P) titled Trauma Informed Care, dated March 2019, the P&P indicated, .Purpose .To guide staff in appropriate and compassionate care specific to individuals who have experienced trauma .All staff are provided in-service training about trauma, its impact on health, and post-traumatic stress disorder . Trauma-informed care is culturally sensitive and person-centered . Caregivers are taught strategies to help eliminate, mitigate or sensitively address a resident's triggers . Resident-Care Strategies .As part of the comprehensive assessment, identify history of trauma or interpersonal violence .Identify past trauma or adverse experiences .

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40610 Based on interview and record review, the facility failed to indicate the appropriate indication for the use of anticoagulant (blood thinner) medication for one of three residents (Resident 51) reviewed for unnecessary medications. This failure had the potential for unnecessary medication use and had the potential to negatively impact the resident's well-being. Findings: A review of Resident 51's Admission Record indicated Resident 51 was admitted to the facility on [DATE], with diagnoses which included atrial fibrillation (A-fib, irregular and rapid heartbeat). On 1/13/25, a review of Resident 51's physician order dated 9/30/23 indicated the following order: - Apixaban (blood thinner medication) for blood thinner. On 1/15/25 at 11:59 A.M., a concurrent review of Resident 51's clinical record and an interview with Licensed Nurse (LN) 11 was conducted. LN 11 stated there was a physician's order of Apixaban for Resident 51 on 9/30/23 and the indication for its use was for blood thinner. LN 11 stated there should be a clear indication for the use of Apixaban for Resident 51 like A-fib. LN 11 stated the LNs should have verified with the attending physician what was the Apixaban intended for. On 1/15/25 at 3:40 P.M., an interview with the Director of Nursing (DON) was conducted. The DON stated the expectation was for every medication, there should be the right diagnosis and the right indication. A review of the facility's policy titled, Administering Medication, revised April 2019, was conducted. The policy did not indicate verification of indication of the medication.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40610 Based on observations, interviews, and record review, the facility failed to indicate the appropriate and measurable target behavior of antipsychotic (medication used to treat the symptoms of mental illness) medication and psychotropic (mind-altering medications) medication for two of six residents reviewed for unnecessary psychotropic medication use (Resident 6 and Resident 52). This failure had the potential for unnecessary psychotropic medication use, its side effects, and a decline for residents psychological and mental well-being. Findings: 1. A review of Resident 6's Admission Record indicated Resident 6 was readmitted to the facility on [DATE] with diagnoses which included psychosis (mental illness). A review of Resident 6's physician order dated 7/9/24 indicated the following order: - Risperidone tablet for psychosis. AEB [sic, as evidenced by]: repetitive health concern. On 1/14/25 at 2:26 P.M., an interview was conducted with Certified Nursing Assistant (CNA) 11, outside Resident 6's room. CNA 11 stated she was familiar with Resident 6. CNA 11 stated Resident 6 was unable to communicate her needs, no behaviors, and no behavioral monitoring that was relayed to the staff to observe. On 1/15/25 at 10:43 A.M., a concurrent review of Resident 6's clinical record and an interview was conducted with Licensed Nurse (LN) 11. LN 11 stated Resident 6 had a period of confusion and forgetfulness. LN 11 stated Resident 6 had a physician's order of risperidone and was indicated for psychosis. LN 11 stated the target behavior indicated for risperidone was to monitor Resident 6' repetitive health concern. LN 11 stated there should be a specific target behavior for the use of risperidone. LN 11 stated the care plan, and the target behavior should match the behavior being monitored for Resident 6. On 1/15/25 at 3:40 P.M., an interview with the Director of Nursing (DON) was conducted. The DON stated the expectation was to indicate the target behavior being monitored for the use of psychotropic medications. The DON stated the target behavior should be measurable and should match what the resident manifested. The DON stated these were important to identify if the resident still needed the medication. A review of the facility's policy, titled Psychotropic Medication Use, revised July 2022, indicated, Residents will not receive medications that are not clinically indicated to treat a specific condition .2. Drugs in the following categories are considered psychotropic medications and are subject to .monitoring, and review requirements specific to psychotropic medications: .a. Anti-psychotics . (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. A review of Resident 52's Admission Record indicated Resident 52 was readmitted to the facility on [DATE] with diagnoses which included major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). A review of Resident 52's physician order dated 5/15/24 indicated the following order: - Divalproex Sodium 3 capsules one time a day for feeling happy and upbeat to feeling sad and impulsiveness. - Divalproex Sodium 5 capsules at bedtime for feeling happy and upbeat to feeling sad and impulsiveness. - Monitor behaviors of feeling happy and upbeat to feeling sad and impulsiveness every shift. On 1/13/25 at 10:12 A.M., an observation of Resident 52 was conducted in her room. Resident 52 laid in bed and did not respond to her name. On 1/14/25 at 1:49 P.M., a follow up observation and an interview of Resident 52 was conducted in her room. Resident 52 was watching TV, was making incomprehensible sounds and was unable to express herself. On 1/14/25 at 2:32 P.M., an interview was conducted with Certified Nursing Assistant (CNA) 11. CNA 11 stated Resident 52 was unable to converse, and she talked to the television. CNA 11 stated Resident 52 would pinch, grab, and scratch the staff while staff provided care to Resident 52. CNA 11 stated the Licensed Nurses (LNs) measured the number of behaviors the resident exhibited. On 1/15/25 at 12:07 P.M., a concurrent review of Resident 52's clinical record and an interview was conducted with Licensed Nurse (LN) 11. LN 11 stated Resident 52 barely reacted to people and that Resident 52 easily screams. LN 11 stated Resident 52 was on divalproex sodium and the target behavior for the staff to monitor was for feeling happy and upbeat to feeling sad and impulsiveness. LN 11 stated she was confused as to what was the specific behavior Resident 52 exhibited. LN 11 stated there should be specific behavior the resident manifested to indicate if the resident still needed the medication. On 1/15/25 at 3:40 P.M., an interview with the Director of Nursing (DON) was conducted. The DON stated the expectation was to indicate the target behavior being monitored for the use of psychotropic medications. The DON stated the target behavior should be measurable and should match what the resident manifested. The DON stated these were important to identify if the resident still needed the medication. A review of the facility's policy, titled Psychotropic Medication Use, revised July 2022, indicated, Residents will not receive medications that are not clinically indicated to treat a specific condition 1. A psychotropic medication is any medication that affects the brain activity associated with mental processes and behavior .2. Drugs .are considered psychotropic medications and are subject to .monitoring, and review requirements specific to psychotropic medications .

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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. 38542 Based on observation and interview, the facility failed to ensure the kitchen staff followed a recipe during food preparation. As a result, there was a potential the taste of the food was affected. Findings: On 1/14/25 at 10:53 A.M., a concurrent observation of pureed (liquidized/crushed) food preparation, interview, and recipe review was conducted with [NAME] (CK) 1. A review of the recipe for the lunch menu indicated CK 1 was supposed to add 1/8 teaspoon (tsp) of margarine to the pureed food. CK 1 was observed to have used the 1/4 tsp measuring spoon to add the margarine. CK 1 stated she just used less than the 1/4 tsp to measure the margarine. CK 1 stated the recipe needed to be followed. On 1/14/25 at 11:09 A.M., an interview with the Dietary Manager (DM) was conducted. The DM stated if the staff did not follow the recipe, it can affect the taste of the food. Per the facility's policy and procedure titled, Standardized Recipes revised April 2007, Policy Statement Standardized recipes shall be .used in the preparation of foods.

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NAME OF PROVIDER OR SUPPLIER Country Manor LA Mesa Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5696 Lake Murray Blvd LA Mesa, CA 91942	

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46235 Based on observation, interview, and record review the facility failed to ensure provision of hospice services (a special kind of care that focuses on a person's quality of life and dignity as they near the end of their life) for one of two residents (Resident 67) reviewed for hospice when: 1. The facility did not have documentation of hospice staff visits, 2. There was no schedule when a resident will be visited by hospice staff, 3. The facility did not have an agreement with the hospice agency. This failure had the potential to put Resident 67 at risk for uncoordinated medical care between the facility and the hospice agency. In addition, Resident 67's ADL need for grooming was not met. Findings: Resident 67 was admitted to the facility on [DATE] with diagnoses including chronic respiratory failure with hypercapnia (a condition where there is not enough oxygen or too much carbon dioxide in the body) according to the facility's Admission Record. 1. During a review of Resident 67's physician's orders for January 2025, the physician's orders indicated, Admit to .Hospice ., dated 11/25/24. An observation and interview was conducted with Resident 67 on 1/13/25 at 10:17 A.M. Resident 67 was observed in bed watching TV. Resident 67 was observed with a thick beard and moustache. Resident 67 stated he needed his shaver adjusted because he would like his beard and moustache trimmed. Resident 67 stated his moustache was growing into his nose, it was uncomfortable, and nobody had offered to trim it. Resident 67 stated he had hospice services, but he was not sure why he was on hospice. A concurrent record review and interview on 1/14/15 at 1:50 P.M. with Licensed Nurses (LN) 1 and LN 2 was conducted. LN 1 showed the hospice binder for Resident 67. LN 1 stated there was a hospice nurse who visited Resident 67 on 1/13/25 but have not seen any home health aides (HHA) or certified nurse assistants. LN 2 stated he had not seen any hospice staff visit Resident 67. LN 1 stated there was no documentation in the hospice binder or the nursing progress notes that a hospice nurse visited Resident 67 on 1/13/25. LN 1 stated there was only a LN documentation for 1/6/24 and a chaplain's visit on 1/9/25. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A phone interview was conducted on 1/14/25 at 3:11 P.M. with the Hospice Licensed Nurse (HLN). The HLN stated she was familiar with Resident 67 and had visited Resident 67 yesterday, 1/13/25. The HLN stated a LN and HHA visited Resident 67 twice a week and documented their visits on the hospice electronic medical record (EMR). The HLN stated there were communication sheets with documentation by the LN and/or the HHA in the hospice binder for the facility to review. The HLN stated she did not document on the communication sheet regarding the 1/13/25 visit for Resident 67. The HLN stated documentation was missed if there was no documentation of the visits in Resident 67's hospice binder. The HLN further stated it was important to communicate hospice care provided to Resident 67. 2. During a concurrent record review and interview on 1/14/15 at 1:50 P.M. with Licensed Nurse (LN) 1, LN 1 showed the hospice binder for Resident 67. LN 1 showed a December 2024 calendar which indicated signatures on 12/4/24, 12/17/24, 12/18/24 and 12/25/24. The bottom of the calendar had a handwritten month of January 2025 and signatures for 1/8/25 and 1/9/25. LN 1 stated the signatures indicated the dates hospice staff visited Resident 67. LN 1 stated the calendar only indicated the hospice staff visited once a week or less. During a phone interview on 1/14/25 at 3:11 P.M. with the Hospice Licensed Nurse (HLN), the HLN stated the hospice binder for Resident 67 had a calendar which outlined the expected days hospice staff were going to visit Resident 67. The HLN stated a LN and HHA visited Resident 67 twice a week and documented their visits on the hospice electronic medical record (EMR). The HLN stated for changes in schedule, the hospice staff would communicate to the facility staff and make the change on the calendar. 3. During a review of the survey entrance records for hospice agreements, there was no agreement found for Resident 67's hospice service. During a concurrent record review and interview on 1/14/15 at 1:50 P.M. with Licensed nurse (LN) 1, LN 1 showed the hospice binder for Resident 67 and there was no hospice agreement in the binder. An interview with the Director of Nursing (DON) was conducted on 1/16/25 at 2 P.M. The DON stated it was important to have collaboration of care with hospice services. The DON stated her expectation was to be in on the same page with hospice, collaborate the plan of care and to provide comfort for the resident. The DON stated a schedule of visits on a calendar and documentation of care provided to the resident should be completed. The DON further stated the facility should have an agreement with hospice agreeing to care for the resident, monitor, observe, implement procedures, and follow facility policies. A review of the facility's policy and procedure (P&P) titled, Hospice Program, dated July 2017 was conducted. The P&P indicated, .Hospice providers who contract with this facility .must have a written agreement with the facility outlining [in detail] the responsibilities of the facility and the hospice agency .Our facility has designated [this area was blank] .to coordinate care provided to the resident by our facility staff and the hospice staff .He or she is responsible for .Collaborating with hospice representatives and coordinating facility staff participation in the hospice care planning process for residents receiving these services .Communicating with hospice representatives and other healthcare providers participating in the provision of care .to ensure quality of care for the residents and family .Obtaining the following information from the hospice .The most recent hospice plan of care specific to each resident .

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. 43518 Based on interview and record review the facility's Quality Assessment and Assurance Committee (QAA-facility group that monitors concerning trends in a facility) failed to identify and include in the facility's Quality Assurance Performance Improvement plan (QAPI-plan developed by QAA to help improve conditions in the facility) deficient trends found by surveyors during the recertification survey concerning grooming/hygiene and the management of residents with Post Traumatic Stress Disorder (PTSD- a mental health condition that's caused by an extremely stressful or terrifying event - either being part of it or witnessing it). This failure had the potential for facility to overlook trends in resident care that might have affected residents' health and quality of life. Cross Reference: F677, F699 Findings: On 1/16/25 at 1:32 P.M., a concurrent interview with the Administrator (ADM), the Infection Preventionist (IP) and the Director of Nursing (DON) and a review of QAPI program was conducted. The ADM stated that the main areas that the QAPI team were monitoring were falls, pressure ulcers and infection control monitoring of hand hygiene and PPE usage. During the recertification survey, deficient trends in basic grooming (nailcare and beard care) and the staff's lack of knowledge about caring for Post Traumatic Stress Disorder residents were found. The ADM stated that neither of these trends had been identified by the QAA Committee and/or included in the QAPI plan. On 1/16/25 at 1:40 P.M., an interview with the ADM was conducted. The ADM stated that the expectation was the QAA Committee should have identified the trends that were identified by the surveyors. In addition, the ADM stated the deficient trends should have been included in the QAPI plan. The ADM stated the importance of QAA Committee identifying deficient trends and including them in the QAPI plan was to promote the highest standard of care for their residents. On 1/16/25 at 1:50 P.M., an interview with the DON was conducted. The DON stated that the expectation was that the QAA Committee should have identified the trends identified by surveyors. In addition, the DON stated the deficient trends should have been included in the QAPI plan. The DON stated the importance of QAA Committee identifying trends was to maintain residents' dignity (for grooming/hygiene) and to promote the highest standard of care for their residents with PTSD. Review of facility policy titled Quality Assurance and Performance Improvement dated February 2020 indicated .The objectives of the QAPI Program are to 1. Provide a means to measure current and potential indicators for outcomes of care and quality of life. 2. Provide a means to establish and implement performance improvement projects to correct identified negative or problematic indicators. 3. Reinforce and build effective systems and processes related to the delivery of quality care and services. 4. Establish systems through which to monitor and evaluate corrective actions .The QAPI plan describes the process for identifying and correcting quality deficiencies. Key components of this process include: .C. Identifying and prioritizing quality deficiencies

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40610 Based on observations, interview, and record review the facility failed to ensure infection control procedures were followed when a Licensed Nurse (LN) 12 did not wear a gown for Resident 55 with enhanced barrier precautions (EBP - involves gown and glove use during high-contact resident care activities for residents [example: residents with medical devices]), and perform hand hygiene (the practice of cleaning hands to remove germs, dirt, or other harmful substances) consistently after removing his gloves while passing medication (med/s) during med pass observation. These failures had the potential for cross contamination, spread of infection and Resident 55's decline of health. Findings: A review of Resident 55's Admission Record indicated Resident 55 was admitted to the facility on [DATE], with diagnoses which included Resident 55 had a gastrostomy tube (g-tube, a surgical opening fitted with a device to allow feedings/ meds to be administered directly to the stomach common for people with swallowing problems). On 1/15/25 at 8 A.M., an observation and an interview were conducted with Licensed Nurse (LN) 12 while preparing medications for Resident 55. There was an EBP sign attached to Resident 55's door. LN 12 stated he will check Resident 55's vital signs. LN 12 checked Resident 55's vital signs without putting a gown. On 1/15/25 at 8:12 A.M., another observation of LN 12 was conducted. LN 12 went back to Resident 55's room and checked Resident 55's g-tube placement without putting a gown. On 1/15/25 at 8:36 A.M., an observation was conducted of LN 12 while preparing Resident 55's medications. LN 12 put gloves on, removed a gown from the wall, took out the gown from the plastic package, placed the plastic package in the trash bin with his gloves, opened the trash bin with gloved hands, put the gown to himself, moved the trash bin with gloved hand, did not remove his gloves, went to Resident 55's room and proceeded to give the medications to Resident 55. LN 12 instilled medication drops to Resident 55's eyes then gave the medications to Resident 55 via the g-tube. On 1/15/25 at 12:30 P.M., an interview was conducted with LN 12. LN 12 stated when providing care to residents with EBP, staff were required to wear PPE, such as giving meds, checking residents' vital signs and peri care to prevent cross contamination. LN 12 stated any direct contact to residents with EBP required PPE use. LN 12 stated he forgot to wear a gown when he checked Resident 55's vital signs and g-tube placement. LN 12 stated he did not realize he did not perform hand hygiene and changed gloves when he touched the trash bin and gave Resident 55 his medications. LN 12 stated the trash bin was considered dirty. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/15/25 at 3:40 P.M., an interview with the Director of Nursing (DON) was conducted. The DON stated the expectation was for the staff to follow the procedures on EBP, to perform hand hygiene and changed gloves when gloves were contaminated to prevent infection because residents were prone to getting an infection. A review of the facility's policy titled, Enhanced Barrier Precautions, revised August 2022, indicated, .1. Enhanced barrier precautions (EBP) are used as an infection prevention and control interventions to reduce the spread of multi-drug resistant organisms (MDROs) to residents. 2. EBPs employ targeted gown and glove use during high contact resident care activities .3. Examples of high-contact resident care activities . include .g. device care or use (.feeding tube .) . A review of the facility's policy titled, Handwashing/ Hand Hygiene, revised October 2023, indicated, The facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections . Indications for hand hygiene .e. after touching the resident's environment .