STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055918	A. Building B. Wing	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Del Sol Post Acute	16910 Woodruff Ave. Bellflower, CA 90706

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 51860 Based on observation, interview, and record review, the facility failed to ensure one of the five sampled residents (Resident 67) had a call light within reach. This failure had the potential to result in a delay or inability for the resident to obtain necessary care and services. Findings: During a review of Resident 67's Admission Record (Face Sheet), the Admission Record indicated the facility admitted Resident 67 on 8/20/2024 with diagnoses including but not limited to nontraumatic intracerebral hemorrhage (a bleed in the brain not caused by an injury), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (partial weakness) following cerebral infarction (loss of blood flow to a part of the brain). During a review of Resident 67's Minimum Data Set (MDS, a resident assessment tool) dated 2/17/2025, the MDS indicated the resident had impairment of lower extremity abilities of both legs. During an observation on 4/1/2025 at 12:23p.m., Resident 67 was in bed sitting in a Fowler's (head of bed elevated between 45 and 60 degrees) position. The call light was on the wall behind the bed. Resident 67 stated if he does not have a call light within reach and needs a nurse he will call out loudly nurse. During a concurrent observation and interview at Resident 67's beside on 4/1/2025 at 12:25 p.m. with Certified Nurse Assistant (CNA) 3, CNA 3 observed the call light behind Resident 67's headboard, against wall, and out of reach of Resident 67. CNA 3 stated having the call light within reach was important for a resident to have access to in case of emergencies and needing assistance. During an interview on 4/03/2025 at 1:03 p.m. with Licensed Vocational Nurse (LVN) 4, LVN 4 stated, the call light has to be within reach of a resident, clipped on sheet, or placed where resident wants it, as long as it was close to resident. LVN 4 stated having the call light within reach was important so residents can call if they need help with anything. During an interview on 4/4/2025 at 10:24 a.m., with Registered Nurse (RNS) 1, RNS 1 stated a call light should be within reach of a resident because if the call light was not within reach and the resident soiled, if staff are unable to get to the resident timely, that can lead to skin breakdown. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Call Lights: Accessibility and Timely Response dated 12/19/22, the P&P indicated Staff will ensure the call light is within reach of resident and secured, as needed. and The call system will be accessible to residents while in their bed or other sleeping accommodations within the resident's room.

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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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49573 Based on interview and record review, the facility failed to ensure one out of three sampled residents (Resident 70) had their Level 1 Preadmission Screening and Resident Review ([PASARR], a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care) completed accurately. This deficient practice had the potential to delay care for Resident 70 and had the potential Resident 70 would not receive the proper level of care or services required. Findings: During a review of Resident 70's Admission Record, the Admission Record indicated Resident 70 was originally admitted to the facility on [DATE] with diagnoses including depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), bipolar disorder (mood swings that range from the lows of depression to elevated periods of emotional highs), anxiety disorder (a group of mental health conditions that cause fear, dread and other symptoms that are out of proportion to the situation), and mood affective disorder (a group of mental health conditions characterized by persistent changes in mood, emotions, and behavior). During a review of Resident 70's history and physical (H/P) dated 9/28/2024, the H/P indicated Resident 70 does not have the capacity to understand and make decisions. During a review of Resident 70's Minimum Data Set ([MDS], a resident assessment tool) dated 2/11/2025, the MDS indicated Resident 70 was moderately impaired in cognitive (thinking process) skills and required setup or clean up assistance (helper sets up while resident completes the activity or assist only prior to or following the activity) in self-care abilities such as eating, required moderate assistance (helper does less than half the effort to complete the task) in self-care abilities such as oral hygiene, toileting and personal hygiene, upper and lower body dressing, putting on and taking off footwear and required maximum assistance with showers and bathing. The MDS also indicated Resident 70 was set up or clean up assistance on mobility such as rolling left and right, sit to lying position, toilet transfers, and required supervision (helper provides verbal cues as resident completes the activity) with lying to sitting position, sit to stand position, bed to chair transfers, shower transfers, and walking 10 to 150 feet. The MDS indicated Resident 70 was taking high risk medications such as antipsychotic (medications that treat mental illness) and antidepressant (treat deprresion) medications. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 70's PASARR level 1 screening dated 10/14/2024, the PASARR Level 1 screening indicated it was negative, and a Level 2 screening was not required. The reason noted for Resident 70's negative PASARR Level 1 screening was due to no serious mental illness. The PASARR indicated Resident 70 did not have a serious diagnosed mental disorder such as Depressive Disorder, Anxiety Disorder (a mental disorder that causes excessive worrying and fear), Panic Disorder (unexpected and extreme episodes of intense fearfast hear rate, and shortness of breath), Schizophrenia/Schizoaffective Disorder (mental illness that causes a breack with reality), or symptoms of Psychosis (symptoms of a break with reality), Delusions (hearing, seeing or belieivng something that is not based on reality) and/or Mood Disturbance. During a concurrent interview and record review on 4/3/2025 at 1:21 p.m., with Medical Records staff (MR), Resident 70's Level 1 PASARR Screening dated 10/14/2024 was reviewed. The MR stated the PASARR was a preadmission screening before residents get admitted to the facility. The MR stated residents need to be evaluated for mental health services before being admitted to the facility. The MR stated if Level 1 PASARR was not done accurately, the Level 2 PASARR screening would not be triggered. The MR stated residents would be not getting the services and consults they would need if Level 1 PASARR was not done correctly. During an interview on 4/4/2025 at 12:10 p.m., with the Director of Nursing (DON), the DON stated the importance of a PASARR was so the facility would know the level and kind of care needed for the residents. The DON stated another Level 1 PASARR should have been done for Resident 70. The DON stated if residents were positive for Level 2 PASARR, the facility would develop a plan of care, provide consultants and recommendations from the Level 2 PASARR list of services residents needed. During a review of the facility's policy and procedure titled, Resident Assessment-Coordination with PASARR Program, revised 12/18/2023, indicated, the facility coordinates assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs all applicants to this facility will be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with the State's Medicaid rules for screening. PASARR Level 1 - initial pre-screening that is completed prior to admission. Negative Level 1 Screen - permits admission to proceed and ends the PASARR process unless a possible serious mental disorder or intellectual disability arises later if a resident who was not screened due to an exception above and the resident remains in the facility longer than 30 days, the facility must screen the individual using the State's Level I screening process and refer any resident who has or may have MD (mental disorder), ID (intellectual disorder) or a related condition to the appropriate state-designated authority for Level 2 PASARR evaluation and determination, the Level 2 resident review must be completed within 40 calendar days of admission the Social Services Director or designee shall be responsible for keeping track of each resident's PASARR screening status, and referring to the appropriate authority.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49573 Based on observation, interview and record review, the facility failed to develop and implement a comprehensive care plan for two of five sampled residents (Resident 2 and Resident 80) when the facility failed to update and implement a comprhensive care plan for: 1. Oral care and hygiene and refusal of the activity of daily living (ADL, basic tasks that enable people to care for themselves and live independently include eating, dressing, bathing, using the toilet, and moving around) for Resident 2. 2. When there was a change in condition that required resident to need a one-on-one feeder and diet change from regular texture to puree texture for Resident 80. This deficient practice had the potential to negatively affect the quality of life and wellbeing for Resident 2 and Resident 80 to prevent them from achieving their highest practical well-being. Findings: 1.During a review of Resident 2's Admission Record, the Admission Record indicated Resident 2 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including multiple sclerosis ([MS]- a chronic, progressive disease involving damage to the nerve cells in the brain and spinal cord), neuropathy (disease or dysfunction of one or more nerves, typically causing numbness or weakness in the hands and feet), seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), and functional quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury). During a review of Resident 2's history and physical (H/P) dated 2/18/2024, the H/P indicated Resident 2 had fluctuating capacity to understand and make decisions. During a review of Resident 2's Minimum Data Set ([MDS], a resident assessment tool) dated 3/28/2024, the MDS indicated Resident 2 was severely impaired in cognitive (thinking process) skills and was dependent (helper does all of the effort while the resident does none of the effort to complete the task) for self-care abilities such as eating, oral hygiene, toileting hygiene, personal hygiene, shower/bathe, upper and lower body dressing, and putting on and taking off footwear. The MDS also indicated Resident 2 was dependent with mobility such as rolling left and right, sit to lying position, lying to sitting on side of bed, and chair/bed to chair transfers. During a review of Resident 2's comprehensive care plan, dated 12/20/2023, the comprehensive care plan did not indicate any oral care and hygiene nor any oral care and hygiene refusal. (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 observation and interview on 4/1/2025 at 11:57 a.m., with Resident 2 in his room, Resident 2 was sitting up in bed. When Resident 2 opened his mouth there were food particles on his lips and white and orange material on his teeth. Resident 2 had partial dentures (a wearable plate holding artifical teeth) at the bedside. Resident 2 nodded his head NO when asked if he wore them during mealtimes. Resident 2 nodded his head NO when asked if his teeth was brushed every day. During an interview on 4/3/2025 at 12:12 p.m., with Licensed Vocational Nurse (LVN) 4, LVN 4 stated a care plan was a plan of care for residents. LVN 4 stated if residents had any change of condition, anything specific to the resident, there should be a care plan to ensure the facility will meet the resident's needs. LVN 4 stated the care plan should be updated as needed and if the problem had not been taken care of, the facility would continue with the care plan or make changes as needed. LVN 4 stated there should be a care plan in place for when a resident refused any type of treatment and/or care like oral care and hygiene. 2. During a review of Resident 80's Admission Record, the Admission Record indicated Resident 80 was admitted to the facility on [DATE] with diagnoses including malignant neoplasm of central portion of left breast (breast cancer, is a disease where cells in the breast tissue grow uncontrollably and form tumors) that metastasizes (spread to other sites in the body) to the bone, brain and lung, seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), urinary tract infection ([UTI]- an infection in the bladder/urinary tract), and muscle weakness. During a review of Resident 80's H/P dated 2/22/2025, the H/P indicated Resident 80 could make needs known but can not make medical decisions. During a review of Resident 80's MDS dated [DATE], the MDS indicated Resident 80 was moderately impaired in cognitive skills and was dependent on self-care abilities such as eating, oral hygiene, toileting and personal hygiene, shower/bathe, upper and lower body dressing and putting on and taking off footwear. The MDS also indicated Resident 80 was dependent on mobility functions such as rolling left and right and sit to lying position. During a review of Resident 80's comprehensive care plan dated 2/22/2025, the comprehensive care plan did not indicate Resident 80's change in condition requiring a one-on-one feeder and diet change from regular texture to puree (food processed not to require any chewing) texture. During an observation on 4/3/2025 at 12:34 a.m., of Resident 80 in her room, Resident 80 was sitting up in bed having lunch. There was a one-on-one feeder, a certified nursing assistant, feeding Resident 80 her puree lunch. Resident 80 was taking little bites of her food, needing time in between bites to swallow. During an interview on 4/3/2025 at 12:22 p.m., with LVN 4, LVN 4 stated there should have been a care plan for the one-on-one feeder for Resident 80. LVN 4 stated there should also have also been a care plan for the different food texture specific to the resident. LVN 4 stated Resident 80 was having a hard time with regular texture food, so the diet was changed to puree texture. LVN 4 stated the care plan was the plan of care for resident, and what type of care will be provided for them. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/4/2025 at 12:10 p.m. with the Director of Nursing (DON), the DON stated the importance of a care plan was that it was a tool the facility utilized to personalize each resident's care and to provide the care and services to the residents. The DON stated there should have been a care plan for Resident 2 for oral care and hygiene and if Resident 2 refused any care or treatment, there should have been a care plan for that too. The DON stated there should have been a care plan for Resident 80 when the diet changed from the regular texture to puree texture and should have been revised when Resident 80 had a change in condition where she was not able to eat on her own anymore and needed a one-on-one feeder. During a review of the facility's policy and procedure (P/P) titled, Comprehensive Care Plans, dated 12/19/2022, indicated, the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment the comprehensive care plan will describe, at a minimum, the following: the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being .the comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45777 49573 Based on observation, interview, and record review, the facility failed to maintain good oral hygiene for one of two samples residents (Resident 2) when there were white and orange material on Resident 2's lips and teeth. This deficient practice resulted in Resident 2's care needs not being met and had the potential to result in psychological harm, tooth decay and infection. Findings: During a review of Resident 2's Admission Record, the Admission Record indicated Resident 2 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including multiple sclerosis ([MS]- a chronic, progressive disease involving damage to the nerve cells in the brain and spinal cord), neuropathy (disease or dysfunction of one or more nerves, typically causing numbness or weakness in the hands and feet), seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), and functional quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury). During a review of Resident 2's history and physical (H/P) dated 2/18/2024, the H/P indicated Resident 2 had fluctuating capacity to understand and make decisions. During a review of Resident 2's Minimum Date Set ([MDS], a resident assessment tool) dated 3/28/2024, the MDS indicated Resident 2 was severely impaired in cognitive (thinking process) skills and was dependent (helper does all of the effort while the resident does none of the effort to complete the task) for self-care abilities such as eating, oral hygiene, toileting and personal hygiene, shower/bathe, upper and lower body dressing, and putting on and taking off footwear. The MDS also indicated Resident 2 was dependent with mobility such as rolling left and right, sit to lying position, lying to sitting on side of bed, and chair/bed to chair transfers. During a review of Resident 2's nurses progress notes for January 2025 to April 2025, there was no documentation of oral care provided nor the refusal of oral care documented in the nurses' progress notes. During a concurrent observation and interview on 4/1/2025 at 11:57 a.m. with Resident 2 in his room, Resident 2 was sitting up in bed. Resident 2 opened his mouth when asked by surveyor. There were food particles on the lips and white and orange material on his teeth. Resident 2 had partial dentures at the bedside but Resident 2 nodded his head NO when asked if he wore them during mealtimes. Resident 2 also nodded his head NO when asked if his teeth was brushed every day. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/3/2025 at 11:39 a.m. with Certified Nurse Assistant (CNA) 6, CNA 6 stated if residents refused activity of daily living (ADL, basic tasks that enable people to care for themselves and live independently include eating, dressing, bathing, using the toilet, and moving around) such as personal hygiene care and oral care, CNA 6 stated staff are to notify the Licensed Vocational Nurse (LVN) and the Director of Staff Development (DSD) of the refusal so it can be documented. CNA 6 stated the importance of providing ADL such as grooming, personal hygiene and oral care to residents every day was to prevent infection and keep the residents clean. During an interview on 4/3/2025 at 12:12 p.m. with LVN 4, LVN 4 stated if residents refused any type of ADL, there should be documentation of the refusal in the resident's chart. LVN 4 stated the CNAs report to the LVNs the resident's refusal of ADL and the LVN would document the refusal and notify the medical doctor and the responsible party of the refusal. LVN 4 stated family would be involved to try and help the residents get the ADLs task done. LVN stated the CNA reported to LVN that resident refused ADLs, and document the refusal in progress notes but there was no documentation of the refusal. LVN stated if there was no documentation, no oral care was provided and no refusal of the oral care done. During a concurrent interview and record review on 4/4/2025 at 12:10 p.m. with Director of Nursing (DON), the nurses progress notes were reviewed. DON stated CNAs should be providing oral care for residents daily and if residents refused ADL, it should be documented in their chart. DON stated CNAs should be encouraging residents to do and assist in their ADLs and involve family to help if after encouraging residents alone was not enough. DON stated CNAs should be rounding on residents every 2 hours to make sure all residents are clean. DON stated Resident 2 had been refusing oral care and had to have a few teeth removed due to pain and oral decay. DON stated if there was no documentation of the oral care or the refusal of oral care, it was not provided and not done. During a review of the facility's policy and procedure (P/P) titled, Oral Care, dated 12/19/2022, indicated, it is the practice of this facility to provide oral care to residents in order to prevent and control plaque-associated oral diseases. During a review of the facility's P/P titled, Activities of Daily Living (ADLs), dated 9/2/2022, indicated, care and services may consist of the following activities of daily living: bathing, dressing, grooming and oral care a resident who is unable to carry out activities of daily living will receive the necessary services 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50144 Based on observation interview and record review the facility failed to position one out of six residents (Resident 78) in an upright position when assisting with feedings This deficient practice had the potential to cause the resident to have difficulty in swallowing and aspirate (accidental inhalation of food liquid or other materials in the lungs) resulting in hospitalization . Findings: During a review of Resident 78's Admission Record, the Admission Record indicated Resident 78 was admitted to the facility on [DATE], with diagnoses including dysphagia oropharyngeal phase (difficulty in the transfer of food or liquid from the mouth to the esophagus [a muscle that connects the throat to the stomach]), gastro-esophageal reflux disease without esophagitis (when the stomach acid flow into the food pipe and irritates the lining causing heartburn [a burning discomfort in the chest], but without damage to the lining of the stomach), and muscle weakness. During a review of Resident 1's History and Physical (H&P), dated 1/29/2025, the H&P indicated, Resident 78 did not have the capacity to understand and make decisions. During a review of Resident 78's Minimum Data Set (MDS- a resident assessment tool) dated 3/5/2025, the MDS indicated Resident 78 was dependent (Resident does none of the effort to complete the activity) with activities of daily living such as eating, toilet hygiene, shower/ bathe self, upper and lower body dressing. During a record review of the Clinical admissions Orders dated 4/1/2025, the Clinical admissions Orders indicated an order for regular diet pureed (food that has been ground, pressed or strained to resemble pudding) textured, thin consistency (a fluid or food that is watery and easily pours, like water or juice) , fortified food (vitamins and minerals are added). Assist with feeding. During a record review of the Care Plan Report, dated 1/28/2025, the Care Plan Report indicated to maintain the head of the bed at 30-45 degrees upright during feeding. During an observation and interview on 4/2/2025 at 12:06 p.m., in resident 78's room with Certified Nursing Assistant 5 (CNA 5), CNA 5 was feeding Resident 78 in his bed. Resident 78 was lying on his left side with the head of the bed in a low 20-degree position . CNA 5 stated Resident 78 was not in a good feeding position and should have been placed in a upright position of at least 60 degrees. CNA 5 stated placing a resident in an upright sitting position can prevent them from choking. During an interview on 4/3/2025 at 12:30 p.m., the Licensed Vocational Nurse 2 (LVN 2) stated it was not recommended to feed a resident in a low side-lying position as they cannot intake the food well, have problems swallowing and possibly aspirate. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/4/2025 at 11:15 a.m., the Director of Nursing (DON) stated when feeding a resident in bed they should be placed at 45 degrees for safety to prevent a resident from choking or aspiration. During a review of the facility's policy and procedure (P&P) titled, Accidents and Supervision, [dated reviewed, revised 12/19/2022] the P&P indicated, the resident's environment will remain as free of accidents hazards as possible. Each resident will receive adequate supervision and assistive devices to prevent accidents . This includes implementing interventions to reduce hazards (s) risks (s).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055918	A. Building B. Wing	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Del Sol Post Acute	16910 Woodruff Ave. Bellflower, CA 90706

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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 - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45777 Based on observation, interview and record review, the facility failed to follow up with the Pain Management Doctor (PMD) for one out of three residents (Resident 46) when the PMD had ordered pain medication that Resident 46 was allergic too. This deficient practice had the potential for Resident 46's pain to go untreated. Findings : During a review of Resident 46's Admission Record, the Admission Record indicated Resident 46 was initially admitted to the facility on [DATE], with diagnoses including hypertensive disease (issues that develop during high blood pressure) without heart failure (the heart doesn't pump blood as it should), hyperlipidemia (unhealthy fat in the blood), and malignant neoplasm of the pancreas (rare cancer that starts as a growth of cell in the pancreas [an organ in the stomach]). The Admission Record indicated Resident 46 was allergic to Aspirin (a medication that reduces pain, fever, inflammation, and blood clotting) and Acetaminophen (medication used for low to moderate pain). During a review of Resident 1's History and Physical (H&P), dated 2/22/2025, the H&P indicated, Resident 46 could make needs known but could not make medical decisions. During a review of Resident 46's Minimum Data Set (MDS a resident assessment tool) dated 5/5/2025, the MDS indicated, Resident 46, required partial/moderate (helper does less than half the effort) assist with eating, was dependent (resident does none of the effort to complete the activities) with toilet hygiene, upper and lower body dressing shower/ bathe self. During a record review of Resident 46's Nurses Progress Notes (NPN) dated 3/31/2025 at 10:18 a.m., the NPN indicated a Pain Management Doctor (PMD) had ordered Tylenol 650 mg every 6 hours for pain, Phycians Order dated 3/31/2025. The Nurses Progress Notes indicated Resident 46 was allergic to Tylenol, therefore the order was not carried out, and the pain management doctor was notified that Resident 46 was allergic to Tylenol. During an interview on 4/2/2025 at 12:30 p.m., with Resident 46's family member (FM 1), FM 1 stated his mother had stomach pain sometimes. FM 1 stated the PMD told him (FM 1) she would order pain medication for Resident 46 in case she needed it. During a record review and interview on 4/3/2025 at 12:03 p.m., with Licensed Vocational Nurse (LVN) 2, Resident 46's Nurses Progress Notees dated 3/31/2025 at 10:18 was reviewed, LVN 2 stated she could see where the notes indicated a message was left for the PMD, but [NAME] had followed up for 3 days. LVN 2 stated facility staff must follow up on the resident's pain medication three times within 24 hours. LVN 2 stated if the PMD did not respond the facility staff must contact Resident 46's primary doctor. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and record review on 4/3/20205 with Registered Nurse 1 (RN 1), RN 1 stated the doctor was called on 3/31/2025 and no one followed up for 3 days. RN 1 stated the nurse should have followed up on calling the doctor three times if the doctor does not respond we then call Resident 46's attending doctor. RN 1 stated it is important to follow up in getting a different pain medication because pain can affect your appetite you cannot eat, and we want the residents pain managed. During an interview on 4/4/2025 at 11:16 a.m., with the Director of Nursing (DON), the DON stated if the resident is allergic to a pain medication a doctor has ordered the nurse should inform the doctor who prescribed the medication to change for something different. The DON stated if the doctor does not call back then the nurse can utilize the Medical Director. During a review of the facility's policy and procedure (P&P) titled, Change in a Residents Condition or Status , (revised April 2011] the P&P indicated, Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in resident's medical/mental condition and/or status (e.g. , changes in level of care, billing/ payments, residents rights, etc.,).

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 44055 Based on interview and record review the facility failed to ensure performance reviews for two of two Certified Nurse Assistants (CNA 1 and 2) were completed at least once every 12 months. The deficient practice had the potential to result in poor resident care and health outcomes. Findings: During an interview and record review with the Director of Staff Development (DSD) on 4/3/2025 at 11:42 a. m. CNA 1 and 2's personnel files were reviewed and the files did not indicate performance evaluations were completed in 2024 or annually. During an interview with the Director of Nursing (DON) on 4/4/2025 at 11:34 a.m. , the DON stated performance evaluations should be completed upon hire, 90 days after hire, and then annually thereafter. During a review of the facility's Facility Assessment tool, reviewed 2/27/2025, the tool indicated the facility will validate skills and competencies upon hire and regularly thereafter. The tool indicated the facility will follow regulations when assuring staff competency.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40994 (Cross-reference F760) Based on observation, interview, and record review, the facility failed to ensure that its medication error rate was less than five percent (%). Six medication errors out of 34 total opportunities contributed to an overall medication error rate of 17.65 % affecting two of five residents observed for medication administration (Residents 25 and 35.) The medication errors noted were as follows: 1. Late administration of magnesium oxide (a mineral supplement) to Resident 25. 2. Late administration of aspirin (a medication used to prevent blood blots) to Resident 25. 3. Late administration of vitamin C (a vitamin supplement) to Resident 25. 4. Late administration of multivitamins (a vitamin supplement) to Resident 25. 5. Late administration of gabapentin (a medication used to treat pain) to Resident 25. 6. Administered the incorrect formulation of guaifenesin (a medication used to treat cough) to Resident 35. The deficient practice of failing to administer medications in accordance with the physician's orders increased the risk that Residents 25 and 35 may have experienced medical complications possibly resulting in hospitalization . Findings: During an observation of medication administration on 4/2/25 at 8:02 AM with the Licensed Vocational Nurse (LVN 1), LVN 1 was observed preparing the following medications for Resident 25 by crushing and mixing them with a small amount of water for preparation to administer via gastrostomy tube (g-tube - a tube surgically inserted into the stomach for administration of medication and nutrition): 1.One tablet of metformin (a medication used to control blood sugar) 1000 milligrams (mg - a unit of measure for mass.) 2.One tablet of metoclopramide (a medication used to treat nausea) 10 mg. During a concurrent observation and interview on 4/2/25 at 8:09 AM, LVN 1 stated Resident 25 also requests a medication to treat mild pain. LVN 1 was observed preparing the following medication additionally: 3.Two tablets of acetaminophen (a medication used to treat mild pain) 325 mg. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 4/2/25 at 8:23 AM, LVN 1 was observed administering the three medications listed above to Resident 25 via the g-tube. LVN 1 stated these three are the only medications due to be administered to Resident 25 at this time but there will be others due later. During a review of Resident 25's Admission Record (a document containing diagnostic and demographic information), dated 4/3/25, the Admission Reocrd indicated Resident 25 was admitted to the facility on [DATE] with diagnoses including neuropathy (pain that is shooting, stinging, or burning in quality.) During a review of Resident 25's History and Physical (H&P - a record of a comprehensive physician's assessment), dated 2/20/2025, the H&P did not indicate whether Resident 25 had the capacity to understand and make decisions. During a review of Resident 25's Order Summary Report (a monthly summary report of all active physician orders), dated 4/3/25, indicated Resident 25 was also prescribed the following medications to be given via g-tube during the 9:00 AM medication administration: 1. Two tablets of magnesium oxide 400 mg. 2. One tablet of aspirin 81 mg chewable. 3. Five milliliters (ml - a unit of measure for volume) of vitamin C 500 mg/ 5 ml liquid. 4. Fifteen ml of multivitamin liquid. 5. One capsule of gabapentin 300 mg. During an interview on 4/2/2025 at 11:19 AM, with LVN 1, LVN 1 stated she came back later to administer the missing medications listed above at 10:34 AM. LVN 1 stated these medications were prescribed to be given at 9:00 AM and the latest they could be given to be considered on time would be 10:00 AM. LVN 1 stated she doesn't usually split Resident 25's medication pass into two different passes but made a mistake doing it today because she was nervous. LVN 1 stated if she had given the five missing medications during the first pass they would have been given on time, but since they were given later than 10:00 AM, they are considered late. LVN 1 stated giving medications later than prescribed could cause medical complications. LVN 1 stated giving gabapentin too close to the next dose could cause breathing difficulties or other medical complications which could result in hospitalization . During an observation of medication administration on 4/2/2025 at 10:31 AM, with LVN 2, LVN 2 was observed preparing 10 ml of Geri-Tussin DM (a cough medication formulation containing guaifenesin 200 mg and dextromethorphan [DM - a cough suppressant] 20 mg per 5 ml.) During an observation on 4/2/25 at 10:32 AM, Resident 35 was observed taking the Geri-Tussin DM by mouth. During a review of Resident 35's Admission Record, dated 4/3/2025, the Admission Record indicated Resident 35 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD - a medical condition resulting in difficulty breathing.) (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 35's H&P, dated 3/28/2025, the H&P indicated Resident 35 had the capacity to understand and make decisions. During a review of Resident 35's Order Audit Report (a report showing physician order details for a discontinued medication), dated 4/3/2025, the Order Audit Report indicated Resident 4 was prescribed guaifenesin 100 mg/5 ml oral liquid to give 10 ml by mouth every 4 hours as needed for cough between 3/19/25 to 4/2/2025 at 11:55 AM. During an interview on 4/2/2025 at 11:24 AM, with LVN 2, LVN 2 stated she administered the wrong formulation of cough medicine to Resident 35. LVN 2 stated the version she gave to Resident 35 has 200 mg of guaifenesin and 20 mg of DM per 5 ml versus 100 mg/5 ml of guaifenesin only as the physician order stated. LVN 2 stated if the product and the order do not match, she should have called the doctor to clarify the order prior to administering the medication. LVN 2 stated checking to ensure the order matches the product administered is critical to ensuring medications are given safely. LVN 2 stated if medications are given without double checking the order, there is a risk of residents receiving the wrong medication or wrong dose of medication which could lead to medical complications. During a review of the facility's policy (P&P) Medication Administration, dated 12/19/22, the P&P indicated Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice . Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, route, and time Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician .

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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 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** 40994 (Cross-reference F759) Based on interview and record review, the facility failed to ensure its residents were free from significant medication errors by A. Administering gabapentin (a medication used to treat pain) later than allowed by the physician's order on 4/2/25 in one of five residents observed for administration (Resident 25.) The deficient practice of failing to administer gabapentin in accordance with the physician order's time frame increased the risk that Resident 25 may have had complications related to gabapentin being dosed too frequently including drowsiness, dizziness, or difficulty breathing possibly resulting in hospitalization . B. The facility failed to hold blood pressure medication for Resident 46 and Resident 81 when blood pressure was lower than the ordered parameters (standards to measure set by physician, before administering medication). These deficinet practices had the potential for Resident's 46 and Resident 8's blood pressure to drop causing dizziness, weakness or other medical emergencies. 45777 51860 A. During an observation of medication administration on 4/2/25 at 8:02 AM with the Licensed Vocational Nurse (LVN 1), LVN 1 was observed preparing the following medications for Resident 25 by crushing and mixing them with a small amount of water for preparation to administer via gastrostomy tube (g-tube - a tube surgically inserted into the stomach for administration of medication and nutrition): 1.One tablet of metformin (a medication used to control blood sugar) 1000 milligrams (mg - a unit of measure for mass.) 2.One tablet of metoclopramide (a medication used to treat nausea) 10 mg. During a concurrent observation and interview on 4/2/25 at 8:09 AM, LVN 1 stated Resident 25 also requests a medication to treat mild pain. LVN 1 was observed preparing the following medication additionally: 3.Two tablets of acetaminophen (a medication used to treat mild pain) 325 mg. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 4/2/25 at 8:23 AM, LVN 1 was observed administering the three medications listed above to Resident 25 via the g-tube. LVN 1 stated these three are the only medications due to be administered to Resident 25 at this time but there will be others due later. During a review of Resident 25's Admission Record (a document containing diagnostic and demographic information), dated 4/3/2025, the Admission Record indicated Resident 25 was admitted to the facility on [DATE] with diagnoses including neuropathy (pain that is shooting, stinging, or burning in quality.) During a review of Resident 25's History and Physical (H&P - a record of a comprehensive physician's assessment), dated 2/20/2025, the H&P did not indicate whether Resident 25 had the capacity to understand and make decisions. During a review of Resident 25's Order Summary Report (a monthly summary report of all active physician orders), dated 4/3/2025, the Order Summary Report indicated Resident 25 was also prescribed the following medications to be given via g-tube during the 9:00 AM medication administration: 1. Two tablets of magnesium oxide 400 mg. 2. One tablet of aspirin 81 mg chewable. 3. Five milliliters (ml - a unit of measure for volume) of vitamin C 500 mg/ 5 ml liquid. 4. Fifteen ml of multivitamin liquid. 5. One capsule of gabapentin 300 mg. During an interview on 4/2/25 at 11:19 AM with LVN 1, LVN 1 stated she came back later to administer the missing medications listed above at 10:34 AM. LVN 1 stated these medications were prescribed to be given at 9:00 AM and the latest they could be given to be considered on time would be 10:00 AM. LVN 1 stated she doesn't usually split Resident 25's medication pass into two different passes but made a mistake doing it today because she was nervous. LVN 1 stated if she had given the five missing medications during the first pass they would have been given on time, but since they were given later than 10:00 AM, they are considered late. LVN 1 stated giving medications later than prescribed could cause medical complications. LVN 1 stated giving gabapentin too close to the next dose could cause breathing difficulties or other medical complications due to adverse effects which could result in hospitalization . B. During a review of Resident 46's Admission Record, the Admission Record indicated Resident 46 was initially admitted to the facility on [DATE], with diagnoses including hypertensive disease (issues that develop due to high blood pressure) without heart failure (the heart doesn't pump blood as it should), hyperlipidemia (fat in the blood), and malignant neoplasm of the pancreas (rare cancer that starts as a growth of cell in the pancreas [an organ in the stomach]). During a review of Resident 1's History and Physical (H&P), dated 2/22/2025, the H&P indicated, Resident 46 could make needs known but could not make medical decisions. (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 46's Minimum Data Set ([MDS] a resident assessment tool) dated 5/5/2025, the MDS indicated, Resident 46 required partial/moderate (helper does less than half the effort) assist with eating, was dependent (resident does none of the effort to complete the activities) with toilet hygiene, upper and lower body dressing shower/ bathe self. During a record review of Resident 46's Order Summary Report dated 2/10/2025, the Order Summary Report indicated amlodipine besylate (medication to lower blood pressure) oral tablet five mg (mg - unit of measure) to give one tablet by mouth one time a day for hypertension (high blood pressure), hold if systolic (measure of the pressure in blood vessels when the heart circulates blood) pressure is below 110 (reference range; less than 120 millimeters/mercury (mm - a unit of measure/ Hg-mercury]). During a review of Resident 46's Care Plan Report titled, Resident 46 has hypertension (HTN) dated 2/2/2024, the Care Plan goals indicated the resident would maintain a blood pressure within the following parameters (a specific set of guidelines or measures set by the physician to check before or after giving medication) through the review date with interventions to give anti-hypertensive medications as ordered. The Care Plan interventions included to observe blood pressure and or pulse (heart rate) monitoring parameters, prior to medication administration, monitor for side effects such as orthostatic hypotension (low blood pressure may cause dizziness which can be caused by standing up), increased heart rate and effectiveness. During an interview and record review on 4/3/2025 at 2:30 p.m., with Licensed Vocational Nurse (LVN) 2, Resident 46's Medication Administration Record was reviewed. The Medication Administration Record indicated amlodipine besylate 5 mg was given on 3/16/2025 at 09:00 a.m., to Resident 46 systolic blood pressure was 95 and on 3/17/2025 at 09:00 a.m., Resident 46 systolic blood pressure was 95. LVN 2 stated the check mark according to the MAR indicates the medication was given to Resident 46 both days. LVN 2 stated the parameter was not to give amlodipine if the systolic blood pressure was below 110. LVN 2 stated facility staff must hold the medication. LVN 2 stated if the amlodipine was given when the resident already had a low systolic blood pressure this could drop the blood pressure lower resulting in the nurse calling 911 . During an interview on 4/4/2025 at 10:07 a.m., with the Registered Nurse (RN), RN indicated when blood pressure is low nurses are to hold the blood pressure medication. The RN stated if it is given while the residents blood pressure is already low it can continue to lower the blood pressure causing the resident to have blurry vision becoming dizzy and falling. During an interview on 4/4/2025 at 11:06 a.m., with the Director of Nursing (DON), the DON stated if a resident's blood pressure is below a parameter, the blood pressure medication must be held, the nurse must call the doctor and the nurse must chart the medication was not given. The DON stated if the medication was given and the blood pressure is low the residents blood pressure can drop lower and could cause the resident to be transferred to the hospital which could have all been preventable if the medication was held. C.During a review of Resident 81's physician's order dated 3/18/2025 indicated Lisinopril (a blood pressure medication) 40 milligrams (mg, a unit of weight), one tablet by mouth daily for hypertension (HTN, high blood pressure), hold for systolic < 110 and Amlodipine (a blood pressure medication) 10 milligrams (mg, a unit of weight), one tablet by mouth daily for HTN, hold for systolic < 110. (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 81's electronic medication administration record (eMAR) dated 3/25/25 at 9:00 a. m. indicated Lisinopril and Amlodipine were administered when Resident 81's blood pressure reading was 101/63. During a review of Resident 81's Admission Record (Face Sheet), the Admission Record indicated the facility admitted Resident 81 on 2/28/2025 with diagnoses including but not limited to metabolic encephalopathy (a condition where the brain's function is impaired to an underlying chemical disturbance), hypertensive heart disease (heart issues that develop due to long-term high blood pressure) without heart failure, peripheral vascular disease (PVD - a slow progressive narrowing of the blood flow to the arms and legs), bacteremia (bacteria in the blood steam), type 2 diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing) with peripheral angiopathy with gangrene (a condition when reduced blood flow to the extremities leads to tissue death), pressure ulcer of the sacral region (localized damage to the skin and/or underlying tissue usually over a bony prominence, in this case the lower spine area). During a review of Resident 81's Minimum Data Set (MDS, a resident assessment tool) dated 3/21/2025, the MDS indicated the resident had impaired cognition (thought process) and lower extremity functional ability on one side, was helper-dependent with assistance for eating, personal hygiene, dressing. During a concurrent interview and record review with Licensed Vocational Nurse (LVN) 1 on 4/03/2025 at 10:45 a.m. at the nurse's station, Resident 81's eMAR was reviewed. LVN 1 stated Resident 81's blood pressure on 3/25/2025 was 101/63. LVN 1 stated Lisinopril and Amlodipine were given at 9:00 a.m. on 3/25/2025 when the systolic blood pressure was within the parameters to hold. LVN 1 stated the blood pressure can go down if blood pressure medications were given. LVN 1 stated a resident can have headache, nausea, dizziness, or fatigue if the blood pressure drops further. A review of the facility's policy Medication Administration, dated 12/19/22, indicated Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice . Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, route, and time Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician . A review of the facility's policy and procedure (P&P) titled, Medication Administration, revised on 12/19/22, indicated Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner . and Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medications for those vital signs outside the physician's prescribed parameters.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40994 Based on observation, interview, and record review, the facility failed to remove one expired fluticasone/salmeterol (a medication used to treat breathing problems) inhaler from the medication cart affecting Resident 17 in one of two inspected medication carts (Middle Medication Cart.) The deficient practice of failing to remove and replace Resident 17's expired fluticasone/salmeterol inhaler from the cart increased the risk that it could have been ineffective when used to treat or prevent breathing problems possibly leading to health complications resulting in hospitalization or death. Findings: During a review of Resident 17's Admission Record (a document containing diagnostic and demographic information), dated [DATE], the Admission Record indicated she was admitted to the facility on [DATE] with diagnoses including asthma (a medical condition characterized by episodic periods of difficulty breathing.) During a review of Resident 17's History and Physical (H&P - a record of a comprehensive physician's assessment), dated [DATE], the H&P indicated she had the capacity to understand and make decisions. During a review of Resident 17's Order Summary Report (a monthly summary report of all active physician orders), dated [DATE], the Order Summary Report indicated she was prescribed fluticasone/salmeterol , d+[DATE] micrograms (mcg - a unit of measure for mass) to inhale one puff by mouth every 12 hours for asthma. During a concurrent observation and interview on [DATE] at 11:52 AM of Middle Medication Cart with the Licensed Vocational Nurse (LVN 3), the following medications were found either expired, stored in a manner contrary to their respective manufacturer's requirements, or not labeled with an open date as required by their respective manufacturer's specifications: 1.One opened fluticasone/salmeterol inhaler labeled with an open date of [DATE]. According to the product labeling, open salmeterol/fluticasone inhalers should be used or discarded within one month after removal from the protective foil pack. LVN 3 stated the inhaler for Resident 17 expired on [DATE] and should have been removed from the cart at that time. LVN 3 stated she did not know that the inhaler expired one month after removing it from the cart. LVN 3 stated giving expired fluticasone/salmeterol to Resident 17 could increase the risk that it was ineffective at preventing asthma attacks, possibly resulting in hospitalization . (continued on next page)

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	055918	A. Building B. Wing	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Del Sol Post Acute	16910 Woodruff Ave. Bellflower, CA 90706

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy Medication Storage, dated [DATE], indicated It is the policy of this facility to ensure all medications housed on our premises will be stored in the . medication rooms according to the manufacturer's recommendations . all medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, defective, or deteriorated medications . These medications are destroyed in accordance with facility policy .

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38740 Based on observation, interview and record review, the facility failed to ensure the standardized recipes for lunch menu was followed and provide residents a variety of food option on 4/1/2025 when: One resident (Resident 60) who was vegetarian and on minced and moist diet did not receive the vegetarian option and vegetarian menu was not prepared. Resident 60 who was on minced and moist texture diet (food modified to texture where biting is not required, and minimal chewing required the pieces of food can fit through the gap between the prongs of a standard dinner fork) received chopped carrots instead of minced and moist carrots. This deficient practice had the potential to result in inadequate nutrition status, meal dissatisfaction and increased choking and aspiration risk for resident 60 who is on minced and moist diet texture. Findings: According to the facility lunch menu for the regular diet on 4/1/2025, the following items will be served on the regular diet: Crunchy Fish Fillet 3 ounces (oz.) lemon and tartar sauce; scalloped corn 1/2 cup; seasoned spinach 1/2 cup; bread or roll with butter 1 each. Fish Alternative menu: chicken and dumplings 1/2 cup Spinach alternative menu: steamed carrots. Vegetarian menu: A select Vegetarian item to serve instead of Crunchy Fish Fillet. Minced and Moist menu: lemon baked fish minced and moist with sauce of choice combined with fish 1/2 cup; mashed potatoes with gravy 1/2 cup; pureed seasoned spinach 1/2 cup; pureed bread. During an observation of tray line service for lunch (a system of food preparation, in which trays move along an assembly line) on 4/1/2025 at 12:15 p.m., one resident (Resident 60) who was vegetarian and minced and moist texture diet, the cook (cook1) did not have a vegetarian alternative protein item prepared and served steamed carrots as a replacement for the fish. During the same observation cook1 removed 1/2 cup of steamed carrots and chopped them into smaller pieces and served along with pureed spinach, pureed bread and mashed potato. The steamed carrots were soft when pressed with fork but chopped into pieces and not minced or moist. During a dining observation on 4/1/2025 at 1:10 p.m., Resident 60 was in the dining room and RNA 1 assisting Resident 60 with food. Resident completed the pureed bread and pureed mashed potatoes. The chopped pieces of carrots were remaining on the plate. A review of resident meal ticket indicated resident is vegetarian with minced and moist diet texture. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview with RNA (RNA1) on 4/1/2025 at 1:15p.m., RNA1 stated Resident 60 ate all the pureed items, RNA1 stated the carrots are chopped. RNA1 stated I mash them with fork and mix with the tomato soup for resident to be able to eat the carrots. RNA1 stated resident received mashed potato, pureed spinach, pureed bread, tomato soup, chopped carrots and pudding for dessert. RNA1 stated all the food is pureed except for carrots and it has to be mashed for resident to eat. During the same observation resident refused the carrots and the desert and asked for ice cream. During an interview with Dietary Supervisor (DS) on 4/1/2025 at 2:30 p.m. DS stated residents who are vegetarian facility can offer tofu, vegetable patty and other vegetarian options. When asked if there was any vegetarian alternative meal on the menu today, DS stated she did not know. During the same interview, DS stated minced and moist food is blended into a very small pieces almost like ground. DS stated Minced and moist is soft and moist with gravy. When asked if the carrots served for resident 60 was the right texture for a minced and moist diet, DS stated she did not notice. During a dining observation on 4/2/2025 at 1:05 p.m. Resident 60 was in the dining room and speech therapist (ST) was assisting resident with feeding. Resident 60 meal consisted of minced and moist shrimp (shrimp was chopped into small pieces mixed with gravy) and mashed potato. A review of resident 60 meal ticket next to her tray, indicated resident 60 is vegetarian with minced and moist diet texture. During a concurrent observation and interview with ST and DS on 4/2/2025 at 1:10 p.m. DS looked at Resident 60 meal and stated kitchen served her shrimp and they shouldn't because Resident 60 prefers vegetarian. DS stated cooks should have prepared something else for the vegetarian diet and they didn't. During the same interview ST stated today Resident 60 has received minced and moist shrimp. ST while feeding Resident, stated the minced and moist shrimp should be moister and shrimp smaller in size, it seems a little dry today and resident has to drink lots of water to swallow the food. ST stated that is why I am sitting next to resident to assist in feeding and to make sure resident drinks water after each bite. ST stated resident 60 tends to eat fast and needs to be reminded to eat slow. ST stated resident 60 posture is also a potential risk for aspiration because it is difficult to sit upright and the head is dropped down and to the right side. ST stated today the food should be more moist and smaller in size. ST stated will in-service staff on how to prepare texture modified diets. A review of Resident 60 Admission Record, the admission record indicated the facility initially admitted Resident 60 on 6/4/2024 and readmitted on [DATE] with diagnosis including, but not limited to Parkinson's Disease (a progressive neurological disorder affects movement, causing symptoms like tremors, slowness, stiffness and balance problems), Dysphagia Oropharyngeal phase (difficulty swallowing due to problems with the transfer of food from the mouth to the esophagus) and abnormal Posture. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 60 speech therapy SLP evaluation and plan of treatment record dated 3/22/2025 indicated, resident with new onset of coughing/choking during oral intake, pocketing food during intake, prolonged mastication with solids, risk for aspiration, risk for weight loss. Resident is anxious and requires supervision during mealtime. A review of facility policy titled Standardized Menus (revised 12/19/2022) indicated, Menus are revised by the RD and DS based on resident food preferences, reasons for change should be documented. A review of facility policy titled Texture-Modified Diets (dated 2024) indicated, Texture modified diets are prepared and served as prescribed by the physician .Minced and moist food texture is described as soft, tender, moist foods with no thin liquid leaking from food. Food should be no greater than 1/8 inch by 1/2 inch. All food from pureed are acceptable at this level. Biting is not required; minimal chewing is required. Food holds its shape on a spoon and falls off easily if spoon is tilted. Must not be firm or sticky.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38740 Based on observation, interview and record review, the facility failed to ensure safe and sanitary food storage and preparation practices in the kitchen when: 1.Previously cooked Ham with a use by date of [DATE] was stored in the walk-in refrigerator. 2.One can opener blade was worn and dented with the potential to harbor harmful bacteria. Stove and oven were dirty with dried food debris, sticky and greasy residue on the range (stove) and inside the oven. The knobs on the range (stove and oven) had dried brown and red color residue. The shelf under food preparation counter had crumbs and food debris. 3.TCS foods- texture modified fish was held on the steam table during lunch service with a temperature of 125F (TCS Time/Temperature Control for safety Food formerly potential hazardous food). (Bacterial growth and/or toxin production can occur if time/temperature control for safety food remains in the temperature Danger Zone of 5oC to 57oC (41oF to 135oF) too long). 4.Food contact surfaces were not sanitized with adequate amount of sanitizer solution per manufactures guidelines. Sanitizers and disinfectants are used on food contact surfaces to prevent cross contamination and food borne illness. Cook1 used the towel stored in a sanitizer solution that was not affective to clean and wipe food contact surfaces such as the counters and around the steam table. These deficient practices had the potential to result in harmful bacteria growth that could lead to food borne illness in 77 out of 84 residents who received food from the facility. Findings: During an observation in the kitchen on [DATE] at 8:45 a.m. there was one large tray of previously cooked ham with a use by date of [DATE] expired and stored in the walk-in refrigerator. During a concurrent observation and interview with Dietary Supervisor (DS), DS stated the previously cooked ham has exceeded storage date and should have been discarded. DS stated old ham can cause illness. During a review of facility policy titled, Food safety and Food Storage (revised [DATE]) indicated, Refrigerated Storage-Labeling, dating and monitoring refrigerated food, including, but not limited to leftovers, so it is used by its use-by date, or frozen/discarded . A review of the 2022 U.S. Food and Drug Administration Food Code titled Ready to Eat, Time/Temperature control for safety food, Date Marking Code#,d+[DATE].17, indicated, Ready to eat, time temperature control for safety food prepared and packaged by food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed, sold, or discarded. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation in the kitchen on [DATE] at 9:00 a.m. the stove and oven was dirty. There was dried food debris inside the oven and dried food stains on the stove. The oven knobs and handles had dried red color stains and greasy residue. The shelf under the food preparation counter was dirty with food crumbs. During a concurrent observation and interview with Cook1 and DS, DS stated the cooks are supposed to clean the range (stove and oven) on daily basis. Deep cleaning is done once a week. Cook1 stated yes, he cleans the oven daily. DS stated the oven, and stove does not look clean. DS stated there are food debris and food debris on the shelves under the counters. DS asked cook1 to clean the shelves and the range. DS stated food debris can attract pests to the kitchen area. During the same observation in the kitchen food preparation area on [DATE] at 9:05 a.m. one can opener blade was noted to be worn, the blade was nicked and not smooth. During a concurrent observation and interview, DS verified that here is only one can opener in the kitchen. DS said the can opener blade has a dent and will be replaced for infection control. A review of facility sanitation assessment report done by facility Registered Dietitian (RD) (dated [DATE]) indicated work areas: shelves clean-no food debris- improvement needed, if oven clean and good repair-improvement needed A review of facility policy titled Sanitation inspection (dated [DATE]) indicated, all food service areas shall be kept clean, sanitary, free from litter .inspection will be conducted to .main production area, food preparation area. A review of the 2022 U.S. Food and Drug Administration Food Code, ,d+[DATE].15 Can Openers. Indicated, Once can openers become pitted or the surface in any way becomes uncleanable, they must be replaced because they can no longer be adequately cleaned and sanitized. Can openers be designed to facilitate replacement. 3.During an observation of the tray line service for lunch (a system of food preparation, in which trays move along an assembly line) on [DATE] at 11:34 a.m., cook1 checked the temperatures of lunch items on the steam table (food holding table before service) using facility thermometer. The temperature of the texture modified-Minced and Moist and soft and bit size fish (cut fish mixed with gravy moist) was 125F. During the same observation and interview, cook1 stated the temperature is good and recorded the temperature of the fish on the log. Cook1 moved on to take the temperature of other items. During a concurrent observation and interview on [DATE] at 11:40 a.m. cook1 stated we will start serving at 12:00 p.m. cook1 stated the temperature of the minced and moist fish dropped because after cooking it was mixed and stirred with gravy. Cook1 stated after mixing with gravy he placed it directly on the steam table. Cook1 stated the holding temperature of hot food on the steam table is 140 degrees Fahrenheit (F) to prevent germs growing and for infection control. He stated he didn't think to return the fish back in oven earlier because it was thoroughly cooked and will get dry. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the same interview Dietary Supervisor (DS) stated the holding temperatures for hot food is 135 F pointing to a reminder sticker on the steam table that indicated hot food is 135 and up for the potential hazardous food. DS returned the fish back to the oven. A review of cook's job description indicated to monitor temperature of hot and cold foods through food preparation and service to ensure that established temperature goals are met prior to steamtable transfer and maintained throughout meal service. A review of facility policy titled, Record of Food Temperatures (revised [DATE]) indicated, Hot foods will be held at 135 degrees Fahrenheit or greater. If the food temperature falls into an unsafe range, immediately follow procedures for reheating. A review of the 2022 U.S. Food and Drug Administration Food Code, ,d+[DATE].16 Time/Temperature Control for Safety Food, Hot and Cold Holding. Indicated, Bacterial growth and/or toxin production can occur if time/temperature control for safety food remains in the temperature Danger Zone of 5oC to 57oC (41oF to 135oF) too long 4.During an observation in the kitchen on [DATE] at 1:00 p.m. Cook1 picked up a kitchen towel stored in a bucket of sanitizer solution and started wiping down the food service and food preparation counters after lunch service. An observation of the sanitizer solution in the bucket was brown in color, dirty and there were food debris inside the bucket. Cook1 stated the kitchen cloths are stored in the sanitizer solution with quaternary sanitizer (a type of sanitizer used in the kitchen) and its used to clean and sanitize surfaces and counters. Cook1 was asked to test the effectiveness of the sanitizer solution in the red bucket. Cook1 stated the sanitizer solution test is not going to be good because the solution is dirty, and it has been used throughout the day. Cook1 immersed a test strip in the red bucket and compared the color change to the test strip container. The test strip resulted in sanitizer not effective. Cook1 stated when the test strip results in sanitizer not effective it means there is no sanitizer, and the counters are not sanitized. Cook1 stated the solution needs to be changed. A review of facility policy titled Sanitizer use concentrations for Food Service and Food Production facilities (dated 2020) indicated, All surfaces and equipment should be washed with a sanitizing solution, Dietary should change these buckets at least three times a day and test with the appropriate strips each time the solution is changed to ensue accurate levels of sanitizer. Sanitizing cloths should be placed in the sanitizing buckets to be used for sanitizing all work surfaces and equipment Sanitation buckets must be established with appropriate sanitizing solution generally, for quaternary solution (a type of sanitizer) is ,d+[DATE] PPM.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 50144 Based on interview and record review, the facility's Quality Assessment and Assurance committee ([QAA] a group of facility staff who identifies, evaluates, and implements measures to improve the quality care and life for the residents in the facility) and Quality Assurance Performance Improvement ([QAPI] a group who takes a systemic, interdisciplinary, comprehensive, and data driven approach to maintaining and improving safety and quality in nursing homes while involving residents and families, and all nursing home caregivers in practical and creative problem solving) committee failed to ensure effective oversight of the facility's plan of correction (POC) of the deficient practices identified during the previous recertification survey (4/12/2024) thereby affecting 84 of 84 residents. This deficient practice resulted in the facility having repeat deficiencies in quality of care, including medication error rate of five percent or more, food and nutrition services, and antibiotic stewardship program. The deficient practices placed the residents at risk for not receiving the quality treatment necessary to adequately meet their highest practicable well-being. Findings: During a review of the facility's Statement of Deficiencies for the 2024 Recertification Survey, the Statement of Deficiencies indicated the following repeat deficiencies were identified: medication error rate of five percent or more, food and nutrition services, and antibiotic stewardship program. During a concurrent interview and record review on 4/4/2025 at 12:34 p.m., with the Administrator (ADM), the ADM stated the following systemic issues identified were not active QAPI issues being managed by the QAA committee: a. Medication Administration to decrease the medication error rate b. Food and nutrition services including managing therapeutic diets as ordered c. Antibiotic Stewardship program. The ADM stated these topics were part of the QAPI plan after the previous survey as part of the previous POC, but are no longer considered high focused topics. The ADM stated identifying issues and implementing a QAPI plan is important for keeping safe, improve quality care, and prevent negative resident outcomes. During a review of the facility's policy and procedure (P&P), titled QAPI Plan, undated, the P&P indicated the QAPI plan includes the polices and procedures used to: identify and use data to monitor the facility's performance, establish goals and thresholds for the facility's performance measurement, utilize resident, staff and family input, identify and prioritize problems and opportunities for improvement, systematically analyze underlying causes of systemic problems and adverse events, and develop corrective action or performance improvement activities. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(Cross Reference F759, F803, and F881)

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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 - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45777 46537 51860 Based on observation. interview and record review, the facility failed to implement infection control measures by failing to: A. Ensure Legionella (a type of bacteria that is naturally found in [NAME] environments, such as lakes and streams) water testing was done annually per the facility's policy and procedure. B.Ensure Resident 57's visitors wore personal protective equipment (PPE, clothing and equipment worn or used to provide protection against hazardous substances and/or environments) while visiting Resident 57, who was on enhanced barrier precaution (EBP, infection control intervention using gown and gloves during high contact with a resident, designed to reduce transmission of multi-drug resistant organisms). This failure had the potential to result in compromised infection control measures to prevent the potential spread of infection among residents, staff, and visitors. Findings: A.During a concurrent interview and record review on 4/3/2025, at 9:03 a.m., with the Infection Preventionist Nurse (IPN), the facility's Water Management Program Binder, dated from 1/2024 to 4/2025, was reviewed. The Water Management Program Binder indicated, there was no Legionella testing results for year 2024 and 2025. The Water Management Program Binder indicated, there was the testing schedule letter from contracted testing company on 3/15/2024 for 4/23/2024, at 11 a.m. appointment. IPN stated, she was not sure if the testing should be done annually, and she was not very familiar with the policy and procedure regarding Legionella water testing. IPN stated, she did not know why previous Administrator cancelled the Legionella testing. IPN stated, the testing for 2025 was done on 4/1/2025 and she did not receive the result yet. IPN stated, routine monitoring was important to reduce the risk of Legionella infection. During a phone interview on 4/3/2025, at 9:23 a.m., with Contracted Testing Company [NAME] President of Sales (CTCVP), CTCVP stated, he sent the letter on 3/15/2024 to inform the facility regarding scheduled testing on 4/23/2024 at 11 a.m., but previous Administrator cancelled the testing. CTCVP stated, he reminded him regarding water management program indicated annual testing even though it was not mandatory per Center for Medicare and Medicaid Services (CMS- the federal agency that provides health coverage to more than 160 million through Medicare, Medicaid, the Children's Health Insurance Program, and the Health Insurance Marketplace). CTCVP stated, most of the facilities did testing every three to six months with minimum of yearly testing for infection control surveillance (close observation) purpose. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 4/3/2025, at 9:32 a.m., with Maintenance Supervisor (MS), MS stated, Legionella testing should be done annually, but it was not done in 2024 because previous Administrator told him that it was not necessary and asked him to do risk assessment instead. MS stated, he believed the risk assessment could not replace actual Legionella water testing. MS stated, he checked and documented water temperature in log, but he forgot to document PH (a measure of how acidic or basic a substance or solution is) in log. MS stated, monitoring water quality was important to prevent infection and to protect the residents. During an interview on 4/4/2025, at 11:18 a.m., with Director of Nursing (DON), DON stated, the staff should follow the policy and procedure for water management policy. DON stated, Legionella testing should have been done annually as water management program indicated. DON stated, water quality would be affecting everybody, and it was important to ensure to maintain it for safety. During a review of the facility's Policy and Procedure (P&P) titled, Water Management Program, revised 12/19/2022, the P&P indicated, Policy: It is the policy of this facility to establish water management plans for reducing the risk of legionellosis and other opportunistic pathogens in the facility's water systems based on nationally accepted standards . 2. The Maintenance Director maintains documentation that describes the facility's water system. A copy is kept in the water management program binder . 6. Control measures will be applied to address potential hazards at each control point. A variety of measures may be used, including physical controls, temperature management, disinfectant level control, visual inspections, or environmental testing for pathogens. The measures shall be specified in the water management program action plan . 9. The effectiveness of the water management program shall be evaluated no less than annually. Routine infection control surveillance data, water quality data, and rounding data shall be utilized to validate the effectiveness. During a review of the facility's Policy and Procedure (P&P) titled, Legionella Water Management Program, dated 1/2/2024, the P&P indicated, Control Points: Areas to be monitored and tested .Quarterly and Annually: 1. CDC elite Legionella testing will be performed annually. The result report will be added to the water management binder . Control Point Monitoring: 8. The CDC Elite Legionella test, required by CMS, is a 14-day process. B.During review of Resident 57's Admission Record (Face Sheet), the Admission Record indicated the facility admitted Resident 57 on 2/26/2025 with a diagnoses including but not limited to hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness on one side of the body) following a cerebral infarction (loss of blood flow to a part of the brain the death of brain tissue), urinary tract infection (UTI, an infection in the bladder/urinary tract), dysphagia (difficulty swallowing), gastrostomy tube (G-tube, a surgical opening fitted with a device to allow feedings to be administered directly to the stomach, common for people with swallowing problems), type 2 diabetes mellitus (DM, a disordered characterized by difficulty in blood sugar control and poor wound healing), hypertension (HTN, high blood pressure), and severe sepsis (a life-threatening blood infection). During a review of Resident 57's Minimum Data Set (MDS - a resident assessment tool) dated 3/1/2025, the MDS indicated Resident 57 was helper-dependent (needing staff assistance) with eating, personal hygiene, dressing, and mobility. (continued on next page)

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	055918	A. Building B. Wing	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Del Sol Post Acute	16910 Woodruff Ave. Bellflower, CA 90706

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of Resident 57's Order Summary Report, undated, the Order Summary Report indicated a physician order for Enhanced Barrier Precautions. EBP for Resident 57's due to G-tube and Foley catheter (a thin, flexible tube inserted into the bladder through the urethra to drain urine) use. During an observation and interview on 4/03/2025 at 3:30 p.m. inside Resident 57's room, four visitors were noted to not have PPE when touching the resident. The visitors were observed holding Resident 57's hands, rubbing Resident 57's legs, hugging Resident 57, sitting on Resident 57's bed and bedding, and having purses lay on Resident 57's bed. During an interview with Resident 57's family member (FM), the FM stated awareness of EBP. Resident 57's FM was able to identify where the PPE items were located on the isolation cart and verbalized when to use hand sanitizer. During an interview and observation on 4/03/2025 at 3:35 p.m. with Licensed Vocational Nurse (LVN) 1, outside Resident 57's room, LVN 1 observed visitors in the room without PPE. LVN 1 stated enforcing EBP was important to minimize potential for transmission of bacteria to and from a resident, as well as to prevent transmission of pathogens to other residents and staff in facility. During an interview on 4/04/2025 at 8:31a.m. with the Infection Preventionist (IPN), IPN stated for EBP precautions, any staff member had the responsibility of educating visitors and remind them when a resident was on EBP. The IPN stated EBP protective measures prevent transmission and keeps patient safe. A review of facility's policy and procedure (P&P) titled, Enhanced Barrier Precautions, revised on 2/23/2024, indicated, It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms, .Implementation of Enhanced Barrier Precautions .Provide education to residents and visitors. During a review of the facility's Policy and Procedure (P&P) titled, Job Description: Infection Prevention Coordinator, dated, the P&P indicated, The primary purpose of your job position is to supervise and coordinate the multiple facets of the Infection Prevention Program serving under the Director of Nursing Services. Assure a high quality of resident care by: o Eliminating infection risks to residents and personnel through surveillance of multiple activities and practices. o implementing monitoring and surveillance programs in an effort to identify and reduce infection hazards in the facility.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46537 Based on interview and record review, the facility failed to implement the antibiotic stewardship program (the effort to ensure that [antibiotics - medicines that fight bacterial infections in people and animals] are used only when necessary and appropriate) for two of eight sampled residents (Resident 60 and Resident 69) as evidenced by: A. Failing to identify the indication (reason) for use and assess antibiotic time out (an active reassessment of an antimicrobial prescription 48-72 hours after first administration) of Bactrim (a prescription drug that's used to treat or prevent certain infections) for Resident 60. B. Failing to assess, monitor, and evaluate adverse reaction (an undesired effect of a drug) and side effects of prophylactic (preventative) Bactrim (a medicine or course of action used to prevent disease) use for Resident 69. This deficient practice had the potential for Resident 69 to develop antibiotic resistance (medication no longer effective to treat the infection) due to unnecessary or inappropriate antibiotic use. Findings: A. During a review of Resident 60's Admission Record, the Admission Record indicated, Resident 60 was initially admitted to the facility on [DATE] and last re-admission was on 3/8/2025 with diagnoses including acute(sudden onset) cystitis (an infection of the bladder), peritoneal (inside lining of the abdomen) abscess (a collection of infected fluid that is surrounded by inflamed tissue inside the belly) and bacteremia (the presence of bacteria in the blood). During a review of Resident 60's History and Physical (H&P), dated 3/11/2025, the H&P indicated, Resident 60 was confused with poor insight (a deep understanding of a person or thing) to her illness. During a review of Resident 60's Minimum Data Set (MDS - a resident assessment tool), dated 3/25/2025, the MDS indicated Resident 60 was dependent and required assistance (helper does more than half the effort) from two or more staff for toilet hygiene, shower/bathe, dressing, personal hygiene, bed mobility, and maximal assistance (helper does all of the effort) from one staff for eating. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 4/3/2025, at 9:42 a.m., with the Infection Preventionist Nurse (IPN), Resident 60's document titled, Antibiotic Time-Out, dated 3/24/2025 was reviewed. The Antibiotic Time-Out indicated, Resident 60 was on Cephalexin (a medication to treat certain infections caused by bacteria) 500 milligram (mg) tablet by mouth every eight hours due to intra-abdominal infection (infection within the abdomen) with no adverse reaction or any change in vital signs (the measurements of the body's most basic functions) noted. The Antibiotic Time Out indicated, continue with therapy based on General Acute Care Hospital (GACH) laboratory results and no new laboratory test ordered. The IPN stated, Cephalexin changed to Bactrim on 4/1/2025, but she did not do an Antibiotic Time-Out for Bactrim. The IPN stated, she was not sure what the indication was for Bactrim use, but she was guessing it was ordered for Resident 60's intra-abdominal infection. The IPN stated, she reviewed the physician's notes but there was no documentation regarding the indication to use Bactrim. The IPN stated, she should have followed up with the physician and made sure the antibiotic (Bactrim) order met Loeb's or McGeer's Criteria (criteria used to determine appropriate use of antibiotics). The IPN stated, there was no laboratory test done to see if Resident 60 needed to take Bactrim before it was prescribed. During a concurrent interview and record review on 4/4/2025, at 10:02 a.m., with Registered Nurse Supervisor (RNS) 1, Resident 60's Order Summary Report (OSR), dated 4/3/2025 was reviewed, the OSR indicated, give Bactrim 400-80 mg one tablet by mouth one time a day for intra-abdominal infection, ordered on 3/31/2025. The OSR indicated, Bactrim start date was on 4/1/2025, but there was no end date (to indicate how long Resident 60 would be taking the Bactrim). RNS 1 stated, all antibiotics should have a start date and an end date. RNS 1 stated, there should be documentation regarding the indication to use and the duration which was usually between seven to 14 days for antibiotic therapy. RNS 1 stated, Antibiotic Time-Out should have been done before antibiotic (Bactrim) was started to prevent unnecessary use of antibiotics. During a review of Resident 60's Nurses Progress Note, dated 4/3/2025, the Nurses Progress Note indicated, the IPN spoke to the physician regarding lack of documentation of an indication for the use of Bactrim and the physician referred to surgeon's report. The Nurses Progress Note indicated, there was no indication documented in surgeon's note and she left the message to surgeon's office. B. During a review of Resident 69's Admission Record, the Admission Record indicated, Resident 69 was initially admitted to the facility on [DATE] and last re-admission was on 7/15/2024 with diagnoses including multiple myeloma (a cancer that forms in a the blood), and anemia (a condition where the body does not have enough healthy red blood cells [components of blood]). During a review of Resident 69's H&P, dated 7/23/2024, the H&P indicated, Resident 69 had the capacity (ability) to understand and make decisions. During a review of Resident 69's MDS dated [DATE], the MDS indicated Resident 69 required moderate assistance (Helper does less than half the effort) from one staff for hygiene, dressing, bed mobility, and setup or clean-up assistance (Helper sets up or cleans up) from one staff for eating. During a review of Resident 69's Care Plan (CP), dated from 3/2025 to 4/2025, the CP indicated, there was no care plan for use of Bactrim. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 4/3/2025, at 9:52 am, with the IPN, Resident 69's Antibiotic Time-Out, dated 3/6/2025 was reviewed. The Antibiotic Time-Out indicated, Bactrim 800-160 mg one tablet by mouth every Monday, Wednesday, and Friday was ordered for prophylaxis with an indefinite end date and it did not meet criteria for Loeb's or McGeer's Criteria. The IPN stated, Bactrim was ordered on 3/3/2025 and the last antibiotic time out was done on 3/6/2025. The IPN stated, there was no follow up laboratory testing or evaluation done for Bactrim use. The IPN stated, she should have suggested to the physician an order for testing to see if there were any changes in Resident 69's status. The IPN stated, she could not find any documentation indicating Resident 69 was being monitored for adverse reactions or sign and symptoms of infection. During a concurrent interview and record review on 4/3/2025, at 10:12 a.m., with RNS 1, Resident 69's Nurses Progress Notes dated from 3/3/2025 to 4/3/2025 were reviewed. The Nurses Progress Notes indicated, there was no documentation regarding monitoring side effects and adverse reaction of Bactrim use. RNS 1 stated, the staff should have documented their assessment and monitoring for Bactrim in their progress notes. RNS 1 stated, it was important to monitor and document to identify possible side effects and adverse reactions during the course of treatment. RNS 1 stated, she realized there was no care plan for Bactrim use in Resident 69's medical records. During an interview on 4/4/2025, at 11:18 a.m., with the Director of Nursing (DON), the DON stated, all antibiotics should be assessed, monitored, and evaluated for the indication and duration of the therapy to prevent unnecessary use of antibiotics that could develop into resistance and cause the resident to unnecessarily suffer from adverse reaction and side effects. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's Policy and Procedure (P&P) titled, Antibiotic Stewardship Program, revised 12/19/2022, the P&P indicated, Policy: It is the policy of this facility to implement an Antibiotic Stewardship Program as part of the facility's overall infection prevention and control program. The purpose of the program is to optimize the treatment of infections while reducing the adverse events associated with antibiotic use. Policy Explanation and Compliance Guidelines: 4. The program includes antibiotic use protocols and a system to monitor antibiotic use. a. Antibiotic use protocols: 1. Nursing staff shall assess residents who are suspected to have an infection and complete an SBAR form prior to notifying the physician. ii. Laboratory testing shall be in accordance with current standards of practice. iii. The facility uses the (CDC's NHSN Surveillance Definitions, updated McGeer criteria, or other surveillance tool) to define infections. iv. The Loeb Minimum Criteria may be used to determine whether to treat an infection with antibiotics. v. All prescriptions for antibiotics shall specify the dose, duration, and indication for use. b. Monitoring antibiotic use: i. Monitor response to antibiotics, and laboratory results when available, to determine if the antibiotic is still indicated or adjustments should be made (e.g., antibiotic time-out). ii. Antibiotic orders obtained upon admission, whether new admission or readmission, to the facility shall be reviewed for appropriateness. iii. Antibiotic orders obtained from consulting, specialty, or emergency providers shall be reviewed for appropriateness .Nursing will monitor the initiation of antibiotics on residents and conduct an antibiotic timeout within 48-72 of antibiotic therapy to monitor response to the antibiotic and review laboratory results and will consult with the practitioner to determine if the antibiotic is to continue or if adjustments need to be made based on the findings. 6. New or changed orders for antibiotics based on the antibiotic timeout recommendations will be obtained from the practitioner .9. Documentation related to the program is maintained by the Infection Preventionist, including, but not limited to: a. Action plans and/or work plans associated with the program. b. Assessment forms. c. Antibiotic use protocols/algorithms. d. Data collection forms for antibiotic use, process, and outcome measures. e. Antibiotic stewardship meeting minutes. f. Feedback reports. g. Records related to education of physicians, staff, residents, and families. h. Annual reports.