STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055929	A. Building B. Wing	02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crystal Cove Care Center	1445 Superior Avenue Newport Beach, CA 92663

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49258 Based on interview, medical record review, and facility P&P review, the facility failed to provide the information regarding the rights to formulate the advance directives and/or failed to obtain and maintain the copies of advance directives for two of 22 final sampled residents (Residents 10 and 586). These failures had the potential for the residents' decisions regarding their healthcare and treatment options not being honored. Findings: Review of the facility's P&P titled Advance Directives (undated) showed the following: - Prior to or upon admission of a resident, the SSD or designee inquire of the resident, his/ her family members and/ or his or her legal representative, about the existence of any written advance directives; - The resident or representative is provided with the written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so; - If the resident or representative indicates that he or she has not established an advance directives, the facility staff will offer assistance in establishing an advance directives; and - If the resident or the resident's representative has executed one or more advance directive(s), or executes one upon admission, copies of these documents are obtained and maintained in the same section of the resident's medical record and are readily retrievable by any facility staff. 1. Medical record review for Resident 586 was initiated on 2/18/25. Resident 586 was admitted to the facility on [DATE]. Review of Resident 586's H&P evaluation dated 2/16/25, showed Resident 586 was in no acute distress and alert. Review of Resident 586's MDS assessment dated [DATE], showed Resident 586 had moderate cognitive impairment and no acute change in mental status. (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident 586's medical record failed to show documentation whether Resident 586 had an advance directive or not. On 2/18/25 at 1322 hours, an interview was conducted with Resident 586. Resident 586 stated she had no advance directive and was interested in having one. Resident 586 further stated no one in the facility had asked her if she already had an advance directive or explained to her how to formulate one. On 2/19/25 at 1449 hours, an interview and concurrent medical record review was conducted with the SSD. The SSD stated the social services department was responsible in obtaining information from the residents regarding the advance directives. The SSD stated when the resident was admitted in the facility, the social services staff should meet with the resident's family member within 48 hours and obtain the information if the resident had an advance directive. The SSD stated the facility's Advance Directive Acknowledgement document would be discussed with the resident. The SSD stated the document would indicate whether the resident had executed an advance directive for healthcare or not. The SSD stated if the resident had an advance directive, a copy would be requested from the resident. The SSD stated if the resident had not executed an advance directive for healthcare, the resident had an option to initiate one and the facility would provide assistance to the resident to formulate one, or the resident could also decline to initiate an advance directive. The SSD further stated the form should be signed by the resident and retained in the resident's medical record. The SSD verified the social services staff had not discussed the advance directive with Resident 586. On 2/24/25 at 1445 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 52251 2. Medical record review for Resident 10 was initiated on 2/18/25. Resident 10 was admitted to the facility on [DATE]. Review of Resident 10's POLST dated 1/8/25, showed the advance directive was not available. Review of Resident 10's Baseline Care Plan Person-Centered Care Planning -V3.1 dated 1/13/25, signed by the SSD, showed Resident 10 stated he had an advance directive and a copy was requested on 1/8/25. Review of Resident 10's Advance Directive Acknowledgement form dated 1/8/25, showed the resident had executed an advance directive for healthcare and a copy was requested. However, there was no copy of the advance directive in Resident 10's medical record at the time of the medical record review. On 2/19/25 at 0917 hours, an interview and concurrent medical record review for Resident 10 was conducted with the SSD. The SSD verified the above findings. The SSD further stated the copy of the advance directive should have been in Resident 10's medical record. Furthermore, the SSD stated she should have followed up within 48 hours of the initial request to obtain a copy of the advance directive for Resident 10's medical record. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/20/25 at 0750 hours, a follow-up interview and concurrent medical record review for Resident 10 was conducted with the SSD. The SSD verified the resident's Baseline Care Plan Person-Centered Care Planning dated 1/13/25, showed a copy of the advance directive was requested on 1/8/25; however, there was no documentation she had followed-up on obtaining the resident's advance directive and the SSD reaffirmed she should have followed-up on obtaining the copy of Resident 10's advance directive.

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F 0583 Level of Harm - Potential for minimal harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50967 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the privacy was provided for one of five final sampled residents (Resident 40) observed for medication administration. * The privacy curtain was not pulled to provide privacy during the GT medication administration for Resident 40. This failure had the potential to negatively affect the dignity of the residents and violate the residents' right to privacy. Findings: Medical record review for Resident 40 was initiated on 2/20/25. Resident 40 was readmitted to the facility on [DATE]. Review of Resident 40's MDS dated [DATE], showed Resident 40 had short and long-term memory problems. On 2/20/25 at 0830 hours, a medication administration observation was conducted with LVN 5. LVN 5 left the privacy curtain open on the left side of the bed facing the sliding door. The curtain of the sliding door was also left open, exposing Resident 40 to the outside patio and rooms across the patio. LVN 5 was observed pulling Resident 40's gown up and exposed Resident 40's stomach area to access the GT for the administration of the medications. Additionally, a portion of Resident 40's diaper was also exposed. LVN 5 was about to administer the medications via GT when LVN 5 was reminded of providing privacy to Resident 40. LVN 5 stated she should have provided privacy to Resident 40 by pulling the privacy curtain by the bed and the curtain of the sliding door prior to administering the medications. On 2/24/25 at 1513 hours, an interview was conducted with the DON. When asked about providing the residents privacy, the DON stated it was not only providing privacy to the resident during medication administration was important, but also the resident's right for privacy. The DON was informed and acknowledged the above findings.

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52251 Based on interview, medical record review, and facility P&P review, the facility failed to ensure the resident or the residents' representative was provided with a written or verbal notice of the facility's bed hold (holding or reserving a resident's bed while the resident in the acute care hospital) policy upon transfer to the acute care hospital for one of three residents (Resident 85) reviewed for closed records. This failure had the potential for the resident and the residents' representative to be unaware of their rights to return to the facility following a hospitalization . Findings: Review of the facility's P&P titled Bed-Holds and Returns dated 2001 showed the residents and/or representatives are informed (in writing) of the facility and state (if applicable) bed-hold policies. All the residents/representatives are provided written information regarding the facility and state bed-hold policies, which address holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave). Residents, regardless of payer source, are provided written notice about these policies at least twice: a. Notice 1: well in advance of any transfer (e.g., in admission packet); and b. Notice 2: at the time of transfer (or, if the transfer was an emergency, within 24 hours) Review of the Bed Hold Policy and Notification showed it is the policy of this facility to provide any resident that is transferred to a general acute care hospital the right to exercise the bed hold provision. Upon transfer to a general acute care hospital, the hospital, the resident, or resident's representative shall notify the facility within 24 hours after being informed of the right to have the bed hold, if the resident desires the bed hold. If the resident's attending physician notifies the facility in writing that the resident's stay in the general acute care hospital is expected to exceed seven days, the facility shall not be required to maintain the bed hold. Closed medical record review for Resident 85 was initiated on 2/24/25. Resident 85 was admitted to the facility on [DATE], and transferred to the acute hospital on 12/6/24 . Review of Resident 85' H&P examination dated 11/13/24, showed Resident 85 was alert and able to make her own decisions. Review of Resident 85's eINTERACT Change in Condition Evaluation form dated 12/6/24, showed Resident 85 was transferred to the acute care hospital. Review of Resident 85's Bed Hold Notification showed Resident 85's representative signed the form on admission, 11/11/24. Further review of the Bed Hold Notification form showed the sections for Confirmation of Transfer and Bed Hold Provision and 24-hour Notification were left blank. (continued on next page)

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of Resident 85's medical record failed to show documented evidence the resident or resident's representative was notified of the bed hold provision when the resident was transferred to the acute care hospital on 12/6/24. On 2/24/25 at 1330 hours, an interview and concurrent medical record review was conducted with the ADON. The ADON verified the above findings. The ADON stated the licensed nurses were responsible to notify the resident and/or their representative of the bed hold provision and complete the bed hold notification form at the time of transfer.

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F 0657 Level of Harm - Potential for minimal harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52238 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the plan of care for one of 22 final sampled residents (Resident 5) was revised to address the resident's specific care needs when the resident refused to wear the sling on RUE as ordered by the physician. This failure posed the risk of not providing the appropriate, consistent, and individualized care to the resident. Findings: Review of the facility's P&P titled Care Plans, Comprehensive Person-Centered dated 2001 showed a comprehensive, person-centered care plan that includes measurable objectives and timetable to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Further review of the facility's P&P showed assessments of residents are ongoing and care plans are revised as information about the residents and the residents' condition change. Medical record review for Resident 5 was initiated on 2/18/25. Resident 5 was admitted to the facility on [DATE], with diagnoses including unspecified fracture of the upper end of right humerus, subsequent encounter for fracture with routine healing. Review of Resident 5's Order Summary Report dated 2/20/25, showed a physician's order dated 12/22/24, for the resident to wear a sling to the RUE while out of bed. Review of Resident 5's H&P examination dated 12/23/24, showed the resident was alert and oriented, interactive, with normal speech. Review of Resident 5's Plan of Care showed a care plan problem dated 2/18/25, addressing the resident's risk for pain related to fracture of the upper end of right humerus. The interventions included to apply a sling to the RUE while out of bed. On 2/18/25 at 0925 hours, Resident 5 was observed in her room sitting in a wheelchair and not wearing a sling to her RUE. On 2/19/25 at 0821 hours, Resident 5 was observed in her room sitting in a wheelchair and not wearing a sling to her RUE. On 2/24/25 at 1414 hours, an observation and concurrent interview was conducted with Resident 5. Resident 5 was observed sitting up in bed. When asked about the fracture to her right upper arm, Resident 5 stated she fell at home on 11/19/24. When asked if Resident 5 was aware of the physician's order for a sling to be worn on her RUE when out of bed, Resident 5 stated she aware but had not been wearing the sling since the physician told her that she did not need to wear it and Resident 5 decided to stop wearing the sling. (continued on next page)

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F 0657 Level of Harm - Potential for minimal harm Residents Affected - Some	On 2/24/25 at 1453 hours, an interview and concurrent medical record review for Resident 5 was conducted with the ADON. The ADON verified the physician's order and the care plan for the resident to wear the sling to the RUE. The ADON had acknowledged Resident 5 should be using the sling to her RUE. However, the ADON stated Resident 5 had a tendency to remove it. The ADON verified Resident 5's plan of care should have been updated to show the resident's refusal to wear the sling.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453 Based on interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to ensure two of 22 final sampled residents (Residents 45 and 336) attained and maintained their highest practicable physical well-being. * The facility failed to monitor Resident 336's pacemaker. In addition, the facility failed to ensure Resident 336's skin assessments were accurate and complete. Furthermore, the facility failed to monitor Resident 336 after the removal of the staples on her back, obtain the physician's order before applying the Steri-Strips to Resident 336's surgical site, and develop a plan of care to monitor the surgical site and address the removal of the staples. * The facility failed to ensure the laboratory tests for CBC, Chem 7 blood panel and magnesium level ordered for Resident 45 were completed. In addition, the facility failed to monitor Resident 45's orthostatic blood pressure correctly. These failures had the potential to cause a delay in providing care to Residents 45 and 336, which would cause negative impact to the residents' well-being. Findings: 1. Review of the facility's P&P titled Pacemaker, Care of the Resident dated 2001 showed for each resident with a pacemaker, document the following in the medical record and on a pacemaker identification card upon admission: the name, address, and telephone number of the cardiologist, type of pacemaker, type of leads, manufacturer and model, serial number, date of implant, and paced rate. Medical record review for Resident 336 was initiated on 2/18/25. Resident 336 was admitted to the facility on [DATE]. Review of Resident 336's Nursing - Admission/ Readmission Evaluation/ Assessment - V4 dated 2/14/25, showed the following: - The Edema section showed a pacemaker was listed as a cardiac device, and indicated [NAME] inserted 03/2024. - The Skin Evaluation section showed the skin general appearance was discoloration, dry, pale and warm, and the resident did not have wounds or skin integrity concerns present on admission. - The Summary Note section showed, status-post thoracic to lumbar decompression with respiratory complications . with pacemaker requested corresponding documentation of pacemaker from home . a. Review of Resident 336's medical record did not show the resident's pacemaker was monitored. There was no documented evidence to show the resident's pacemaker information was followed up. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Review of Resident 336's initial admission assessment by RN 5 showed Resident 336 did not have wounds or there was no skin integrity concerns present on admission. However, Resident 336 was admitted with a surgical wound with staples. c. Review of Resident 336's Nursing - Comprehensive Skin Evaluation/ Assessment - V2 dated 2/15/25, showed Resident 336 was admitted with mid-back surgical site with staples. Further review of Resident 336's skin assessment by LVN 10 failed to show the complete assessment of Resident 336's surgical wound with staples. The assessment had no documentation to show how many staples were in Resident 336's mid-back surgical site. On 2/21/25 at 0937 hours, a wound treatment observation for Resident 336 and concurrent interview and medical record review was conducted with LVN 9. LVN 9 was observed applying the Steri-Strips to Resident 336's mid-back surgical site. Review of Resident 336's Order Summary Report showed a physician's order dated 2/15/25, for mid-back surgical site with staples, to clean with normal saline, pat dry and apply dry dressing daily for 14 days. d. Resident 336's physician's orders did not show an order to apply Steri-Strips to Resident 336's mid-back surgical staples after the removal of the staples. e. Review of Resident 336's Plan of Care did not show a care plan problem was developed to address Resident 336's mid-back surgical site upon admission, and the removal of the staples. f. Further review of Resident 336's medical record did not show Resident 336 was monitored after the removal of the staples to her surgical site. On 2/21/25 at 1002 hours, an interview and concurrent medical record review for Resident 336 was conducted with LVNs 9 and 10. LVNs 9 and 10 verified the above findings. LVN 9 stated Resident 336 came with a midback surgical site with 62 staples. When asked about Resident 336's skin assessment, LVN 9 stated she did the initial skin assessment and knew that Resident 336 had 62 staples because Resident 336 told her, but she did not physically count how many staples Resident 336 had. When asked about the removal of the staples, LVN 9 stated Resident 336 came back from her appointment with the staples removed at 1600 hours, yesterday (2/20/25). LVNs 9 and 10 verified there was no documented evidence to show Resident 336 was assessed or monitored after the removal of the staples nor followed up with the appointment clinic for further orders. When asked about the application of the Steri-Strips to the surgical site, LVN 10 stated there was no physician's order to apply the Steri-Strips to the surgical site. LVN 9 further stated per the resident, the surgeon did not want anything on the surgical site, but there was an opening, so I need to apply the Steri-Strips. LVN 9 verified she did not clarify with the physician if she could apply the Steri-strips to the surgical site or not. LVNs 9 and 10 verified Resident 336's plan of care did not show a care plan problem was developed to address Resident 336's mid-back surgical site upon admission and the removal of the staples. On 2/21/25 at 1338 hours, an interview and concurrent medical record review for Resident 336 was conducted with RN 4. RN 4 verified Resident 336's pacemaker was not monitored, and there was no documented evidence to show the facility followed up about Resident 336's pacemaker information. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Medical record review for Resident 45 was initiated on 2/18/25. Resident 45 was admitted to the facility on [DATE]. Review of Resident 45's Order Summary Report showed the following physician' s orders dated 2/6/25: - to perform CBC, Chem 7, and Magnesium tests every Monday; and - to monitor orthostatic blood pressure every day within three-minute intervals. a. Review of Resident 45's MAR for February 2025 showed the laboratory tests for CBC, Chem 7, and magnesium level were scheduled on 2/16/25, but the space to document the laboratory tests done was blank. Further review of the MAR showed the orthostatic blood pressures (sitting, lying and standing) were scheduled to be monitored every Sunday. However, the blood pressure readings for all positions (sitting, lying and standing) were the same as follows: - on 2/9/25, a blood pressure reading of 126/72 mmHg was documented for the sitting and standing positions; and - on 2/16/25, a blood pressure reading of 126/72 mmHg was documented for the lying, sitting, and standing positions. b. Further review of Resident 45's medical record did not show any laboratory results for the CBC, Chem 7, and magnesium level scheduled on 2/16/25. There was no followed up with the laboratory for the results nor any documentation if the laboratory tests were done or not. On 2/20/25 at 1400 hours, an interview and concurrent medical record review for Resident 45 was conducted with LVN 12. When asked about the laboratory tests for Resident 45, LVN 12 verified it was not signed in the MAR. LVN 12 was not able to show a requisition paper and the results for the laboratory test for CBC, Chem 7, and magnesium level as ordered by the physician. In addition, LVN 12 was not able to show documented evidence of a follow-up whether the laboratory tests were completed or not. When asked about the orthostatic blood pressure, LVN 12 stated the CNAs and the therapists assisted the resident to stand up and the LVN checked the blood pressure. LVN 12 verified same blood pressure results were documented for the standing, sitting, and lying positions for Resident 45.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49258 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the necessary care and services were provided to prevent the development of pressure injuries for one of two final sampled residents reviewed for high risk of developing pressure injuries (Resident 40). * The facility failed to ensure Resident 40's turning and repositioning interventions were implemented to prevent the development of the pressure injuries. This failure had the potential for the resident to develop pressure injuries or worsening of the existing pressure injuries. Findings: Review of the facility's P&P titled Repositioning (undated) showed the repositioning is the common, effective intervention for preventing skin breakdown, promoting circulation, and providing pressure relief. Residents who are in the chair should be on an every one hour repositioning schedule. Review of the facility's P&P titled Prevention of Pressure Injuries (undated) showed the following: - The nursing staff to inspect the skin daily when performing or assisting with personal care or ADL care: identify any signs of developing pressure injuries, inspect the pressure points (sacrum, heels, buttocks, coccyx, elbows, etc.), wash the skin after any episodes of incontinence, and reposition the resident as indicated on the care plan. - Keep the skin clean and hydrated; - Clean promptly after episodes of incontinence; and - Reposition all the residents with or at risk of pressure injuries on an individualized schedule, as determined by the interdisciplinary care team. Medical record review for Resident 40 was initiated on 2/18/25. Resident 40 was readmitted to the facility on [DATE]. Review of Resident 40's MDS assessment dated [DATE], showed Resident 40 had short and long-term memory problems and was dependent with mobility. Review of Resident 40's Plan of Care showed a care plan problem revised on 2/18/25, addressing Resident 40's risk for skin breakdown. The interventions included to assist Resident 40 with the turning and repositioning as indicated/tolerated, check the skin during the daily care provisions, and keep the skin clean and dry to the extent possible. On 2/19/25, multiple observations of Resident 40 were conducted for the following hours: - at 0745 hours, Resident 40 was observed sitting in the wheelchair and awake; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- at 0846 hours, Resident 40 was observed sitting in the wheelchair and sleeping; - at 0950 hours, Resident 40 was observed sitting in the wheelchair and still sleeping; - at 1045 hours, Resident 40 was observed sitting in the wheelchair and sleeping; - at 1107 hours, Resident 40 was observed sitting in the wheelchair and still sleeping; and - at 1145 hours, Resident 40 was observed awake, sitting and slightly sliding in the wheelchair with the left leg not resting on the foot rest, and Responsible Party 2 was observed placing a pillow at the back of Resident 40 to lift the upper body up; and - at 1146 hours, LVN 5 was called to assist Responsible Party 2 with Resident 40. LVN 5 stated they would put Resident 40 back to bed. On 2/19/25 at 1155 hours, an interview was conducted with CNA 4. CNA 4 stated she was the one who placed Resident 40 in the wheelchair. CNA 4 stated she did not transfer Resident 40 back to the bed because Responsible Party 2 usually wanted Resident 40 in the wheelchair. When asked if she knew what time Resident 40's responsible party would come in the morning, CNA 4 stated the responsible party would come in different times. CNA 4 stated the residents who were total care should be turned every two hours or as needed. CNA 4 stated for the residents who could not call, she would make sure to check and turn them every two hours. When asked how often she would check the residents if they were incontinent and soiled, CNA 4 stated she would check the residents who were incontinent if soiled every time she would turn or reposition them. When asked if she checked or cleaned Resident 40 since the time Resident 40 was placed in the wheelchair, CNA 4 stated she was not able to check Resident 40 if the resident needed diaper change or had soiled. On 2/19/25 at 1205 hours, an interview was conducted with LVN 5. LVN 5 stated she did not know Resident 40 was placed in the wheelchair early and usually the CNAs would ask her if they could already place Resident 40 in the wheelchair which happened around 1000 hours. LVN 5 stated the wheelchair was not a bariatric size wheelchair so she together with the PT would shift Resident 40 once. LVN 5 stated the shifting meant Resident 40 was slightly turned on her side and a wedge or pillow should be used to make sure the buttocks of the resident were lifted off from the surface. LVN 5 verified no wedge or pillow was placed at the side of Resident 40. LVN 5 further stated Resident 40 should be repositioned every two hours and should not be left in the wheelchair for a long period of time. On 2/19/25 at 1215 hours, an observation of LVN 6 with Resident 40 was conducted in the resident's room. LVN 6 was observed checking the sacral area of Resident 40. Resident 40 was observed with blanchable redness on the sacral area. Resident 40 was also observed with dry greenish fecal matter and the diaper was wet with light yellow colored urine. LVN 6 verified the findings and stated the fecal matter and wet diaper could have been there for a while. On 2/24/25 at 1435 hours, an interview was conducted with the DON. The DON stated the repositioning was to be done for those residents who required assistance with ADL care and could not move. The DON stated the repositioning should be done every two hours or as needed. The DON further stated there was no such thing as shifting for repositioning and it was impossible for the residents to be repositioned on their sides while in a wheelchair. The DON was informed and acknowledged the above findings for Resident 40.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453 Based on interview, medical record review, and facility P&P review, the facility failed to monitor the fluid intake for one of one final sampled resident (Resident 45) reviewed for hydration status. * The facility failed to ensure Resident 45's fluid intake from the dietary department and the total daily fluid intake were monitored. This failure had the potential for Resident 45 to have fluid overload, which had the potential to negatively impact the resident's well-being. Findings: Review of the facility's P&P titled Encouraging and Restricting Fluids dated 2001 showed the Restricting Fluids section includes the following: - Remove the resident's water pitcher and cup from the room; - Take the fluid container to the resident's room; - Encourage the resident to drink the fluid. Should the resident refuse, report such information to your supervisor; - Record the amount of fluid consumed on the intake side of the intake and output record. Record fluid intake in ml; and - Remove fluid container. Review of the facility's P&P titled Intake, Measuring and Recording dated 2001 showed the Documentation section showing the following information should be recorded in the resident's medical record per the facility's guidelines: - The date and time the resident's fluid intake were measured and recorded; - The name and title of the individual who measured and recorded the fluid intake; - The amount in ml of liquid consumed; - The type of liquid consumed (such as tea, milk, coffee, soup, etc.); - If the resident refused, the reason(s) why and the intervention taken; and - The signature and title of the person recording the data. On 2/18/25 at 0854 hours, and 12/19/25 at 0828 hours, Resident 45 was observed in bed with a water pitcher at the bedside. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medical record review for Resident 45 was initiated on 2/18/25. Resident 45 was admitted to the facility on [DATE]. Review of Resident 45's Order Summary Report showed the following physician's orders: - dated 1/31/25, for a fluid restriction order of 1500 ml/day as follows: the dietary department to provide a total of 720 ml with a breakdown of 240 ml in the day shift, 240 ml in the evening shift, and 240 ml in the NOC shift; and nursing department to provide a total of 1080 ml with a breakdown of 480 ml in the day shift, 360 ml in the evening shift, and 240 ml in the NOC shift. - dated 2/19/25, for a fluid restriction order of 1800 ml/day as follows: the dietary department to provide a total of 720 ml with a breakdown of 240 ml in the day shift, 240 ml in the evening shift, and 240 ml in the NOC shift; and nursing department to provide a total of 1080 ml with a breakdown of 480 ml in the day shift, 360 ml in the evening shift, and 240 ml in the NOC shift. a. Review of Resident 45's MAR for January and February 2025 showed the documentation of Resident 45's fluid intake from the nursing department. However, the MAR showed Resident 45's fluid intake from the dietary department was marked with an x, and did not show Resident 45's actual fluid intake from the dietary department or during the meals. Review of Resident 45's Documentation Survey Report v2 form for January and February 2025 did not show any documentation of Resident 45's fluid intake from the dietary department or during the meals. b. Further review of Resident 45's medical record did not show any documentation of Resident 45's fluid intake from the dietary department or during the meals. In addition, there was no documented evidence to show Resident 45's total daily fluid intake from the fluids consumed during the meals as recorded by the CNAs and the fluids consumed during the medication administration as recorded by the licensed nurses. On 2/20/25 at 1348 hours, an interview for Resident 45 was conducted with CNA 7. CNA 7 verified Resident 45 had a water pitcher at bedside. When asked about the documentation of Resident 45's fluid intake, CNA 7 stated there was no option in the Tasks in Resident 45's EHR to document her fluid intake. CNA 7 stated she did not report to the nurses on the amount of Resident 45's fluid intake during the meals. When asked if Resident 45 was on fluid restriction, CNA 7 answered no. On 2/20/25 at 1400 hours, an interview and medical record review for Resident 45 was conducted with LVN 6. When asked about the documentation of Resident 45's fluid intake, LVN 6 stated Resident 45's fluid intake from the nursing department which included the fluids offered by the nurses and CNAs during the shift and the fluids from the medication administration documented by the charge nurses in the MAR. LVN 6 also stated he did not know where the staff would document Resident 45's fluid intake from the dietary department which included the fluids from the meal trays. LVN 6 verified the MAR showed Resident 45's fluid intake from the nursing department only, and there were no documentation to show Resident 45's fluid intake from the dietary department or during the meals. LVN 6 also verified there was no documentation to show the total of Resident 45's daily fluid intake from both the nursing and dietary departments.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52238 Based on observation, interview, medical record review and facility P&P review, the facility failed to provide the necessary respiratory care and services for three of three final sampled residents (Residents 67, 336, and 686) reviewed for the respiratory care. * The facility failed to obtain a physician's order prior to the oxygen administration for Resident 686. * The facility failed to obtain a physician's order prior to the oxygen administration for Resident 336. The facility failed to place an Oxygen In Use sign outside the door of Resident 336's room as per the facility's P&P. In addition, the facility failed to develop a care plan problem to address Resident 336's oxygen use. Furthermore, the facility failed to administer oxygen as per the physician's order to Resident 336. * The facility failed to ensure Resident 67's nebulizer tubing was labeled with Resident 67's name and the date. These failures had the potential to negatively impact the residents' well-being. Findings: Review of the facility's P&P titled Oxygen Administration dated 2001 showed the following: - Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration; - Review the resident's care plan to assess for any special needs of the resident; and - Under the Steps in the Procedure section, to place an Oxygen in Use sign on the outside of the room entrance door and place an Oxygen in Use sign in a designated place on or over the resident's bed. 1. On 2/18/25 at 0907 hours, during the initial tour of the facility, Resident 686 was observed in bed using an oxygen via nasal canula at a rate of 4 liters per minute. Medical record review for Resident 686 was initiated on 2/18/25. Resident 686 was admitted to the facility on [DATE]. Further review of Resident 686's medical record failed to show for the physician's order for Resident 686's oxygen use. On 2/18/25 at 1211, 1238, and 1509 hours, a follow-up observation was conducted in Resident 686's room. Resident 686 was observed using the oxygen via nasal canula at a rate of 4 liters per minute. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/18/25 at 1513 hours, an observation and concurrent interview was conducted with LVN 6. LVN 6 verified Resident 686 was receiving a continuous oxygen via nasal canula at a rate of 4.5 liters per minute. On 2/18/25 at 1539 hours, a follow-up interview and concurrent record review was conducted with LVN 6. LVN 6 verified there was no physician's order for the use of oxygen in Resident 686's EHR or paper medical record. LVN 6 acknowledged if a resident was receiving the oxygen, the resident should have a physician's order. LVN 6 also acknowledged Resident 686 had been on a continuous oxygen therapy via nasal canula since the morning. 39453 2. On 2/18/25 at 0854 hours, during the initial tour of the facility, Resident 336 was observed lying in bed with continuous oxygen being administered at a rate of 2 liters per minute via nasal cannula. There was no Oxygen in Use sign posted outside of the room door. Medical record review for Resident 336 was initiated on 2/18/25. Resident 336 was admitted to the facility on [DATE]. a. Review of Resident 336's Order Summary Report did not show a physician's order to administer the oxygen. Review of Resident 336's Plan of Care did not show a care plan problem was developed to address Resident 336's use of oxygen. On 2/18/25 at 1531 hours, an observation, interview, and concurrent medical record review for Resident 336 was conducted with MDS Coordinator 2. MDS Coordinator 2 verified Resident 336's continuous oxygen was being administered at a rate of 2 liters per minute via nasal cannula, and there was no Oxygen In Use sign posted outside the resident's door. MDS Coordinator 2 also verified there was no physician's order to administer the oxygen to Resident 336, and there was no care plan developed to address Resident 336's oxygen use. b. On 2/21/25 at 1001 hours, a follow-up observation was conducted for Resident 336. Resident 336 was observed lying in bed with a continuous oxygen being administered at a rate of 2.5 liters per minute via nasal cannula. Further review of Resident 336's Order Summary Report showed a physician's order dated 2/18/25, to administer oxygen via nasal cannula at a rate of 2 liters per minute. On 2/21/25 at 1002 hours, an observation, interview, and concurrent medical record review was conducted with LVN 9. LVN 9 verified Resident 336's continuous oxygen was being administered at a rate of 2.5 liters per minute via nasal cannula. LVN 9 verified the physician's order showed to administer continuous oxygen via nasal cannula was at a rate of 2 liters per minute. 50787 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of the facility's P&P titled Administering Medications through Small Volume (Handheld) Nebulizer dated 2001 showed when the equipment is completely dry, to store in a plastic bag with the resident's name and date on it. On 2/18/25 at 1034 hours, during the initial tour of the facility, Resident 67's nebulizer mask and tubing were observed inside a plastic bag located on top of the nightstand without a resident's name and date labeled. Medical record review for Resident 67's was initiated on 2/19/24. Resident 67 was admitted to the facility on [DATE]. Review of Resident 67's Order Summary Report showed physician's order dated 3/27/25, for Pulmicort (a breathing treatment) Inhalation Suspension 0.5 mg/ml 2 ml inhale orally two times a day for shortness of breath. On 2/18/25 at 1130 hours, an observation and concurrent interview was conducted with LVN 4. LVN 4 verified Resident 67's bagged nebulizer mask and tubing had no resident's name and date labeled. LVN 4 acknowledged and stated she would have the nebulizer mask and tubing tubing replaced and labeled. On 2/24/25 at 1630 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49258 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the dialysis care was provided for one of two final sampled residents (Resident 70) reviewed for dialysis as evidenced by: * The facility failed to ensure the dialysis emergency kit was maintained at the bedside for Resident 70. In addition, the facility failed to ensure Resident 70's dialysis access site was assessed and monitored appropriately and consistently. The licensed staff failed to consistently assess Resident 70's dialysis access site prior to the resident being transported to the dialysis treatment center and upon returning from the dialysis center. In addition, the licensed staff documented Resident 70's dialysis access type as either catheter or left blank, instead of permacath. These failures had the potential for Resident 70 not being provided with the appropriate care and treatment, which could lead to medical complications related to the resident's dialysis access site. Findings: Review of the facility's P&P titled End-Stage Renal Disease, Care of a Resident with, revised 9/2010 showed for the staff caring for the residents with ESRD, including the residents receiving dialysis care outside the facility, shall be trained in the care and special needs of these residents. Education and training of staff includes, specifically, the type of assessment data to be gathered about the resident's condition on a daily or per shift basis, the signs and symptoms of worsening condition and/ or complications of ESRD, how to recognize and intervene in medical emergencies, how to recognize and manage equipment failure or complications, and the care of grafts and fistulas. Agreements between the facility and the contracted ESRD facility include all aspects of how the resident's care will be managed, including how information will be exchanged between the facilities. 1. Medical record review for Resident 70 was initiated on 2/19/25. Resident 70 was admitted to the facility on [DATE]. Review of Resident 70's H&P examination dated 12/20/24, showed Resident 70 had no capacity to make medical decisions. Review of the Order Summary Report showed the following physician's orders: - dated 12/18/24, to check permacath at the right upper chest for color, warmth, and edema. - dated 2/19/25, for the dialysis days and time of treatment every Monday, Wednesday, and Friday from 0530 hours to 0845 hours. Review of Resident 70's Care Plan initiated on 12/19/24, showed a care plan problem addressing Resident 70 requiring hemodialysis due to ESRD. The interventions included for the dialysis emergency kit to be maintained at bedside. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/20/25 at 1440 hours, an interview was conducted with LVN 5. LVN 5 stated Resident 70 had hemodialysis every Monday, Wednesday, and Friday. LVN 5 stated Resident 70 had the permacath access to the right upper chest for dialysis. LVN 5 was asked to show the dialysis emergency kit for Resident 70. LVN 5 failed to show the dialysis emergency kit was maintained at the bedside of Resident 70. LVN 5 stated it was very important to have the dialysis emergency kit at the bedside because if something happened to the dialysis access site, like accidental pulled out or bleeding, the treatment would not be delayed. LVN 5 stated it was the facility's protocol to provide a dialysis emergency kit to the resident who was on dialysis upon admission, and it should be always maintained at the resident's bedside. LVN 5 further stated it was the responsibility of the nurses to check the dialysis emergency kit be available in the resident's bedside. 2. Review of the Nursing Hemodialysis Communication Observation/Assessment showed the licensed staff did not assess Resident 70's dialysis access site prior to the resident being transported to the dialysis center and upon return from the dialysis center, and there were missing assessment from the dialysis center. For example: - On 12/20/24 and 1/27/25, there was no documentation of the assessment of the resident's dialysis access site completed prior to Resident 70 being transported to the dialysis center; - On 12/20/24, 12/27/24, 1/3, and 1/27/25, there was no documentation of the assessment of the resident's dialysis access site completed upon Resident 70's return from the dialysis center; - On 12/20/24 and 1/27/25, the assessment of the resident's dialysis access site completed at the dialysis center were not available in the medical record. - On 12/27/24, 1/3, 1/17, 1/20, 1/24, 1/29, 2/5, 2/7, 2/10, 2/12, 2/14, 2/17, and 2/19/25, the resident's dialysis access site was identified as either catheter or left blank. On 2/21/25 at 1044 hours, an interview and concurrent medical record review was conducted with LVN 5. LVN 5 stated it was important to assess the resident before transporting to the dialysis center to make sure the resident was stable to have dialysis treatment, and the dialysis access site had no complication. LVN 5 stated when the resident came back from the dialysis center, assessing the resident was important to make sure the resident did not have any post adverse reactions after the dialysis, and the dialysis access site remained intact and with no complications. LVN 5 stated the nursing hemodialysis communication form would be sent out with the resident for the dialysis nurse to fill up and the form should be returned with the resident. LVN 5 stated if the facility did not receive the communication form, the facility nurse should follow up with the dialysis center. On 2/24/25 at 1439 hours, an interview was conducted with the DON. The DON stated the dialysis emergency kit should be provided to the resident upon admission, it should always be with the resident during the transport to the dialysis center, and the expectation was for the charge nurse to check the dialysis emergency kit at the bedside when the resident came back to the facility. The DON stated in the event of an emergency, the supplies were ready for use, and it would not delay the treatment needed by the resident. The DON stated the timely and accuracy of the assessment of the resident and the resident's dialysis access type were important and it would avoid confusion. The DON was informed and acknowledged the above findings.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453 Based on observation, interview, and facility document review, the facility failed to ensure the competency of two of two licensed nurses (LVN 12 and the ADON) interviewed regarding bladder training and failed to ensure the annual performance evaluation was conducted for one of three licensed nurses (LVN 5) reviewed for the annual performance evaluation. * The facility failed to ensure LVN 12 and the ADON were able to demonstrate their competency on the bladder training for a resident with an indwelling urinary catheter. * The facility failed to provide the training materials used for the in-service trainings provided to the facility staff. * The facility failed to ensure the annual performance evaluation was completed for LVN 5. These failures had the potential to put the residents at risk for care not being provided in a safe and competent manner. 1. According to [NAME] and Wilkins' article titled Reducing CAUTIs with a Bladder Retraining Program dated 2013 showed the bladder retraining with a catheter involves a structured approach to help the residents regain the normal bladder function, particularly after surgeries or periods of catheterization. One common method is the clamping and unclamping technique which aims to gradually increase the bladder capacity and restore the sensation of fullness. This method has been utilized to reduce the CAUTIs by encouraging the natural bladder function and minimizing the continuous drainage. Medical record review for Resident 336 was initiated on 2/18/25. Resident 336 was admitted to the facility on [DATE]. Review of Resident 336's Order Summary Report showed the following physician's orders: - on 2/15/25, to monitor for proper placement, no kinking or compression that could obstruct the urine flow to gravity bag during the indwelling urinary catheter care every shift; and - on 2/16/25, for the indwelling urinary catheter 16 Fr/10 ml balloon for urinary retention, to check if intact/functioning every shift; and - on 2/21/25, for the indwelling urinary catheter care every shift. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 336's Progress Note showed a Nurse's Note dated 2/17/25 at 1234 hours, showed Responsible Party 1 was notified the resident's indwelling urinary catheter would be removed if there was no indication for it. The nurse's note showed Responsible Party 1 stated he did not want to have the indwelling urinary catheter removed and wanted a bladder training while the indwelling urinary catheter was inserted. The note further showed the nurse let Responsible Party 1 know the bladder training with the indwelling urinary catheter was not possible, and the facility could help with the toileting schedule if the indwelling urinary catheter was removed; however, Responsible Party 1 preferred to not have the indwelling urinary catheter removed and would like a follow-up with the urology. Further review of Resident 336's medical record did not show a bladder training was provided for Resident 336 while having the indwelling urinary catheter nor a urology consultation was followed up. On 2/21/25 at 1008 hours, an interview and concurrent medical record for Resident 336 was conducted with LVN 10. When asked about the bladder training for Resident 336, LVN 10 stated the process they followed in the facility included only to remove the indwelling urinary catheter, but there was no bladder training provided at the facility. LVN 10 stated the facility did not provide bladder training to Resident 336. LVN 10 stated if there was an order to remove the indwelling urinary catheter, the licensed nurses would removed the indwelling urinary catheter and scan the resident's bladder. LVN 10 further stated if the bladder scan showed more than 400 ml of urine in the resident's bladder, then they would do a straight catheterization. On 2/21/25 at 1416 hours, an interview and concurrent medical record for Resident 336 was conducted with the ADON. When asked about the bladder training for Resident 336, the ADON stated she told Responsible Party 1 the bladder training was not possible for a resident with an indwelling urinary catheter. When asked to elaborate, the ADON stated she meant the staff was not able to a bladder training in the facility. The ADON stated she was not sure why a bladder training for a resident with an indwelling urinary catheter was not done at the facility. The ADON further stated she worked at the facility for four years, and they had not done a bladder training for a resident with an indwelling urinary catheter. The ADON stated a toileting schedule was an option where the CNAs would assist the resident to void upon rising, and before and after meals. On 2/24/25 at 1352 hours, an interview and concurrent medical record review and facility document review for Resident 336 was conducted with the DON. The DON stated if there was a physician's order for a bladder training on a resident with an indwelling urinary catheter, then the nurses had to do it by clamping and unclamping the indwelling urinary catheter. The DON stated if the physician wanted to remove the indwelling urinary catheter without performing a bladder training, then they would explain that procedure to the resident. The DON stated the facility staff were given an in-service on the bladder training. Review of the facility's Education/Training Attendance Record for the Bowel and Bladder Training dated 2/5/25, showed LVN 12 had signed the attendance record. In addition, the record did not show the ADON was provided with the in-service training on Bowel and Bladder Training. The training documents included the facility's P&P for the Bowel and Bladder Training Program (undated). The facility's P&P for the Bowel and Bladder Training Program did not show the procedure on how to do a bladder training program for the residents with an indwelling urinary catheter. 49258 (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the facility's P&P titled In-Service Training, All Staff (undated) showed the primary objective of in-service training is to ensure the staff are able to interact in a manner that enhances the resident's quality of life and quality of care and can demonstrate competency in the topic areas of the training. Training methods and teaching materials are appropriate to the level of education and expected roles of those attending. On 2/24/25 at 0920 hours, an interview and concurrent facility document review was conducted with the DSD. Review of the In-Service Training Binder for January to December 2024 and January 2025 showed only the sign in sheets signed by the CNAs and licensed nurses who attended the trainings. Further review of the In-Service Training Binder failed to show the training materials for each in-services provided. The DSD verified there were no training materials for the in-services provided. The DSD stated the training matrials should be included because it would provide the teaching objectives, specific topics discussed, and how the staff would be assessed for their competency. On 2/4/25 at 1445 hours, an interview was conducted with the DON. The DON stated the in-service trainings should include the training materials because it would show what were discussed, the expectations from the staff, and how the competency would be assessed. The DON was made aware and acknowledged the above findings. 3. Review of the facility's P&P titled Performance Evaluations (undated) showed the performance evaluation would be completed on each employee at the conclusion of his/her 90-day probationary period, and at least annually thereafter. The performance evaluation meeting will occur at the same time as the employee's compensation review. On 2/24/25 at 0902 hours, an interview and concurrent facility personnel record review was conducted with the DSD. Review of LVN 5's personnel record showed LVN 5 was hired on 2/1/21. The personnel record showed LVN 5's last employee's performance appraisal was on 1/30/24. Further review of LVN 5's personnel record failed to show LVN 5 was evaluated one year after the last performance evaluation. The DSD verified the above findings. The DSD stated the licensed nurses would be evaluated either by a designated RN supervisor or the DON. On 2/4/25 at 1445 hours, an interview was conducted with the DON. The DON stated the performance evaluation should be done annually at the minimum. The DON stated the performance evaluation would be needed to determine the quality of the employee's work performance and to determine if the employee would need an improvement. The DON was informed and acknowledged the above findings.

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F 0730 Level of Harm - Potential for minimal harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 49258 Based on interview, facility document review, and facility P&P review, the facility failed to ensure the performance evaluations were completed every 12 months for one of two CNAs' (CNA 7) employee files reviewed. This failure had the potential for the staff to not maintain competencies to provide the residents with needed and appropriate care and services. Findings: Review of the facility's P&P titled Performance Evaluations (undated) showed the performance evaluation would be completed on each of the employee at the conclusion of his/her 90-day probationary period, and at least annually thereafter. The performance evaluation meeting will occur at the same time as the employee's compensation review. On 2/24/25 at 0902 hours, an interview and concurrent facility personnel record review was conducted with the DSD. Review of CNA 7's personnel record showed CNA 7 was rehired on 10/18/22. Further review of CNA 7's personnel record failed to show the performance evaluations were completed every 12 months for the past two years. The DSD verified the findings. The DSD stated it was the responsibility of the DSD to perform the annual evaluation for the CNAs. The DSD stated she started to work as the facility's DSD only last January 2025 and had not reviewed all the CNAs' personnel records. On 2/4/25 at 1445 hours, an interview was conducted with the DON. The DON stated the performance evaluations were done annually at the minimum. The DON stated the performance evaluations were needed to determine the quality of the employee's work performance and if the employees would need improvement. The DON was informed and acknowledged the above findings.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50787 Based on observation, interview, and medical record review, the facility failed to ensure one of five final sampled residents (Resident 67) reviewed for unnecessary drugs were free from unnessary drugs. * Resident 67 had duplicate medication orders with different dosages. This failure posed the risk of medication errors. Findings: Medical record review for Resident 67 was conducted on 2/19/25. Resident 67 was admitted to the facility on [DATE]. Review of Resident 67's H&P examination dated 3/28/24, showed Resident 67 had the capacity to understand and make decisions. Review of Resident 67's Order Summary Report showed the following physician's orders: - dated 8/16/24, to administer guaifenesin oral tablet 400 mg PO every six hours as needed for cough and congestion. - dated 1/2/25, to administer geri-tussin (a brand of cough and cold medicine that contains guaifenesin, an expectorant and helps relieve cough, chest congestion, and stuffy nose) oral liquid 100 mg/5 ml 10 ml PO every six hours as needed for cough and congestion. On 2/24/25 at 1025 hours, an interview was conducted with LVN 4. LVN 4 was asked about Resident 67's two guaifenesin PRN orders with different ordered dosages. When asked how she determined which order she would administer, LVN 4 stated it was depended on the condition of the resident. On 2/24/25 at 1320 hours, a telephone interview and concurrent medical record review was conducted with the Pharmacist. The Pharmacist was asked what the process was for a duplicate medication order received with different dosages. The Pharmacist stated they would call the facility and verify the orders. The Pharmacist reviewed Resident 67's guaifenesin order and stated the pharmacy received only one order of guaifenesin oral tablet 400 mg. The Pharmacist further stated they did not receive the order for the geri-tussin, it was a stock item. On 2/24/25 at 1356 hours, a telephone interview was conducted with Resident 67's attending physician regarding the two guaifenesin orders. Resident 67's attending physician stated, I only wanted one order, they must have forgotten to discontinue the previous order. On 2/24/25 at 1630 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453 Based on interview and medical record review, the facility failed to ensure two of five final sampled residents (Residents 1 and 336) reviewed for unnecessary medications was free from the unnecessary psychotropic medication. * The facility failed to ensure the informed consent for zolpidem (hypnotic medication) was signed by the physician. In addition, the facility failed to ensure the monitoring for hours of sleep related to the use of zolpidem matched the documentation of the episode when Resident 336 was unable to sleep. * The facility failed to ensure the informed consent for Resident 1's clonazepam (antianxiety medication) medication was renewed and the consent was obtained from the responsible party and signed by the physician. These failures had to potential to result in unnecessary use and ineffective monitoring for the use of psychotropic medication that could negatively affect Resident 336's well-being. Findings: 1. Medical record review for Resident 336 was initiated on 2/18/25. Resident 336 was admitted to the facility on [DATE]. Review of Resident 336's Order Summary Report showed the following physician's orders: - dated 2/14/25, to administer zolpidem 10 mg by mouth at bedtime for insomnia; - dated 2/17/25, to monitor for the hours of sleep related to the use zolpidem every evening and night shift; and - dated 2/17/25, to monitor the episodes of inability to fall asleep or stay asleep. a. Review of Resident 336's Informed Consent - Psychoactive Medication - V4 dated 2/17/25, did not show it was signed by the physician. b. Review of Resident 336's MAR for February 2025 showed Resident 336 was administered the zolpidem medication from 2/15 to 2/20/25 at 2100 hours. Further review of the MAR showed Resident 336 had zero hours of sleep on 2/20/25; however, there was also documentation showing Resident 336 had zero episode of not falling asleep on 2/20/25. On 2/21/25 at 1338 hours, an interview and concurrent medical record review for Resident 336 was conducted with RN 4. RN 4 verified the informed consent form for the zolpidem medication was not signed by the physician. RN 4 also verified the monitoring for hours of sleep related to the use of zolpidem medication did not match the documentation of the episode when Resident 336 was unable to sleep. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	50787 2. Review of the facility's P&P titled Psychoactive/Psychotropic Medication use dated 5/2024 showed the section for Renewals of Informed Consent showing the prescriber must renew the written informed consent every six months, providing any recommended dosage adjustments and the option for the resident to revoke consent as required by state specific regulations. According to the California Department of Public Health, All Facilities Letter (AFL) 24-07 dated 2/28/24, showed the facilities must obtain a resident's written informed consent for treatment using the psychotherapeutic drugs, and consent renewal every six months. The section for Renewals of Informed Consent showed the facilities must provide the resident with any recommended dosage adjustments and the option of revoking consent. If the resident decides to discontinue using the drug, the prescriber is responsible for planning any necessary, gradual dose reduction, as well as possible behavioral interventions. Review of Resident 1's medical record was conducted on 2/20/25. Resident 1 was admitted on [DATE]. Review of Resident 1's BIMS dated 2/1/25, showed a BIMS score summary of 12 (moderate cognitive impairment). Review of Resident 1's Order Summary Report showed a physician's order dated 2/4/25, for clonazepam 1.5 mg by mouth to be given every evening at 1700 hours, for anxiety m/b inability to relax. Review of Resident 1's MAR for February 2025 showed the following physician's orders: - dated 8/16/24, to administer clonazepam 1.5 mg PO in the evening at 1700 hours, for anxiety and verbalization of anxiousness, discontinued on 2/4/25; and - dated 2/5/25, to administer clonazepam 1.5 mg PO in the evening at 1700 hours, for anxiety m/b inability to relax. Further review of the MAR showed the clonazepam 1.5 mg medication was administered daily at 1700 hours, on 2/1 to 2/19/25. Review of Resident 1's Informed Consent-Psychoactive Medication dated 8/6/24, showed an initial consent for the use of clonazepam 2 mg in the evening for anxiety signed by Resident 1 and the physician. On 2/24/25 at 1435 hours, an interview and concurrent review of Resident 1's informed consent was conducted with RN 3. RN 3 verified and acknowledged Resident 1's latest clonazepam informed consent was obtained on 8/6/24. On 2/24/25 at 1630 hours, an interview was conducted with the DON. The DON was informed of Resident 1's clonazepam informed consent was obtained on 8/6/24. The DON verified the informed consent was not renewed as per the facility P&P and AFL. The DON acknowledged and verified the above findings.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50787 Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the medications were stored safely, securely and properly labeled. * The facility failed to ensure the single use dressings and discontinued topical medication were removed and discarded from the treatment cart. Furthermore, the facility failed to ensure the treatment cart was clean. * The facility failed to ensure the expired Covid testing kits were discarded. * The facility failed to ensure a medication with white pasty cream and a bottle of Adapt stoma powder (powder used to absorb moisture from broken skin around the stoma, which allows for better barrier adhesion to help protect the skin) were not kept at Resident 54's bedside. These failures had the potential to negatively impact the residents' wellbeing. Findings: Review of the facility's P&P titled Medication, Labeling and Storage (undated) showed the facility stores all the drugs and biologicals in a safe, secure, and orderly manner. 1. On [DATE] at 1058 hours, an inspection of the treatment cart and concurrent interview was conducted with LVN 9. The following was observed: - three opened and partially used Steri-Strips dressings (single use only), - two opened hydrocolloid (occlusive or semiocclusive dressings made of gelatin, pectin, polysaccharides or sodium carboxymethylcellulose), single use only dressings - one opened hydrofera blue (antibacterial wound dressing) dressing packet. The package description showed single use, sterile unless damaged or open. - one opened xeroform gauze (mesh dressing infused with petrolatum and 3% Bismuth Tribromophenate) packet, single use only - one opened and used Santyl ointment (a topical enzyme medication used for wound management) with no label - two drawers had dark brownish residue with dust like particles (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LVN 9 verified the opened packages of the steri-strips, hydrocolloid dressing, hydrofera blue, and xeroform gauze were single use only. LVN 9 stated if opened, the unused supply should have been discarded. LVN 9 further stated the used Santyl ointment belonged to a resident who was discharged , and it should have been discarded. LVN 9 acknowledged and confirmed the above findings. 2. On [DATE] 1200 hours, an inspection of the Covid testing kits and concurrent interview was conducted with RN 1. The following was observed: - nine boxes of Covid testing kits, lot #199236, expired on [DATE], with extension date of [DATE], - two boxes of Covid testing kits, lot #226204, expired on [DATE], with extension date of [DATE], - one box of Covid testing kit, lot #200883, expired on [DATE], with extension date of [DATE], and - one box of Covid testing kit, lot #205503, expired on [DATE], with extension date of [DATE]. RN 1 acknowledged and confirmed the Covid testing kits had expired. On [DATE] at 1125 hours, an interview was conducted with the DON. The DON stated she was not aware of the expired test kits in the nursing station drawer and acknowledged the above findings. 39453 3.a. On [DATE] at 0822 hours, during the initial tour of the facility, Resident 54 was observed awake and lying in bed. A medication cup with a white pasty cream was observed inside Resident 54's nightstand table. On [DATE] at 0834 hours, an observation and concurrent interview was conducted with CNA 8. CNA 8 verified a medication cup with a white pasty cream was inside Resident 54's nightstand table. CNA 8 stated it must be a leftover rash cream. When asked who applied the rash cream to Resident 54, CNA 8 stated the treatment nurse applied the rash cream, but the CNAs also applied it when they were asked to do so. b. On [DATE] at 0817 hours, Resident 54 was observed awake and lying in bed. A bottle of Adapt stoma powder (used to absorb moisture from broken skin around a stoma) was observed inside Resident 54's nightstand table. Medical record review for Resident 54 was initiated on [DATE]. Resident 45 was admitted to the facility on [DATE]. Further review of Resident 54's medical record did not show a physician's orders to apply a rash cream and Adapt stoma powder. On [DATE] at 1400 hours, an observation and concurrent interview was conducted with RN 6. RN 6 verified a bottle of Adapt stoma powder was observed inside Resident 54's nightstand table. RN 6 verified the above findings.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43119 Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the sanitary requirements were met in the kitchen as evidenced by: * The facility failed to ensure the kitchen utensils were clean and free of food particle or residue. * The facility failed to ensure the kitchen utensil was in good condition. These failures had the potential for cross contamination and foodborne illnesses to the residents consuming the foods prepared in the facility's kitchen. Findings: Review of the facility's Diet Type Report dated 2/18/25, showed 80 of 86 residents consumed the foods prepared in the kitchen. 1. Review of the facility's P&P titled Dishwashing dated 2023 showed all the dishes will be properly sanitized through the dishwasher. The dishwasher will be kept clean and in good working order. Gross food particles shall be removed by careful scraping and pre-rinsing in running water. According to the USDA Food Code 2022, 4-601.11 Equipment, Food - Contact Surfaces, Nonfood Contact Surface, and Utensils, the equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations; and the nonfood- contact surface of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. According to the USDA Food Code 2017, 4-602.13, Non- Contact Surfaces, nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. On 2/18/25 at 0833 hours, during the initial kitchen tour, a concurrent observation and interview was conducted with the RD. The following was observed and verified by the RD: - Three cutting knives with black handles were dirty, with fuzzy stains on the blades and had dry food residue. - One serving fork with black handle was dirty with dry, crusted residue, had watermark and fuzzy stains. - One stainless steel slotted serving scoop with cream handle was dirty and had fuzzy stains. - One white dough cutter was dirty with dry, crusted residue and had fuzzy stains. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The RD acknowledged the above findings and stated the kitchen utensils should have been stored clean for infection control purposes. 2. According to the USDA Food Code 2022 Section 4-502.11 Good Repair and Calibration, (A) Utensils shall be maintained in a state of repair and condition that complies with the requirements specified under Parts 4-1 and 4-2 or shall be discarded. According to the USDA Food Code 2022, Section 4-101.11, Multiuse, Characteristics, materials that are used in the construction of utensils and food contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be durable, corrosion-resistant, nonabsorbent, finished to have a smooth, easily cleanable surface, and resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition. During the initial kitchen tour on 2/18/25 at 0833 hours, a concurrent observation and interview was conducted with the RD. One white basting brush was observed worn out and bristles was frayed. The RD verified the findings and stated they had a new one and it should have been changed.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49258 Based on interview, medical record review, facility document review, and the facility P&P review, the facility failed to ensure the medical records were complete and accurately maintained for six of 22 final sampled residents (Residents 2, 5, 10, 40, 336, and 586) and three nonsampled residents (Resident 20, 51, and 68). * Resident 2's Advance Directive Acknowledgement showed a wrong information regarding the advance directive, and the POLST failed to show the resident had no advance directive. * Resident 5's bowel continence documentation was not completed. * Resident 10's MAR failed to show the monitoring was completed for anticoagulant (medication use to prevent blood clot) use, Covid symptoms, and pain scale on 2/15/25. * Resident 20's MAR was incomplete for medication administration on 2/14/25; and the monitoring for adverse reactions related to the use of anticoagulant, quetiapine, and risperidone (antipsychotic medications) medications, episodes of depression related to the use of zoloft (medication use to treat depression) medication, episodes of schizophrenia (false beliefs or seeing or hearing things that are not there, and disorganized speech and thinking) related to the use of quetiapine medication, and the monitoring for the tardive dyskinesia (involuntary movements of the face, arms, legs, neck, and other body parts) on 2/6/25, for the evening shift. * Resident 40's MAR failed to show the Advair Diskus (inhaler use for shortness of breath) and Hydralazine (medication use to lower blood pressure) administration on 2/2/25 at 0600 hours. In addition the POLST failed to show the resident had no advance directive. * Resident 51's Narcotic and Controlled Substance Sheet on Tramadol HCl was inaccurately recorded. * Resident 68's TAR failed to show the treatment for the perineal area was completed on 2/16/25, for the morning shift. * The facility failed to ensure Resident 336's POLST had the correct name and birthdate. In addition, the facility failed to ensure Resident 336's Informed Consents for immunizations, and the Consent to Treat had the correct name. * Resident 586's IV Administration Record failed to show the IV (intravenous, a plastic catheter that is placed through the skin into a vein used to give fluids and medications) site monitoring was completed on 2/16 and 2/17/25. These failures had the potential for the residents' care needs not being met as their medical information was inaccurate and incomplete. Findings: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's P&P titled Charting and Documentation (undated) showed the documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. Documentation of procedures and treatments will include care-specific details, including: - The date and time the procedure/treatment was provided; - The name and title of the individual(s) who provided the care; - The assessment data and/or any unusual findings obtained during the procedure/treatment; - How the resident tolerated the procedure/treatment; - Whether the resident refuse the procedure/treatment; - Notification of family, physician or other staff, if indicated; and - The signature and title of the individual documenting. Review of the facility's P&P titled Advanced Directives (undated) showed the POLST is a form designed to improve patient care by creating a portable medical order form that records patient's treatment wishes so that emergency personnel know what treatments the patient wants in the event of a medical emergency, taking the patient's current medical condition into consideration. Upon admission the interdisciplinary team assess the resident's decision-making capacity and identifies the primary decision-maker if the resident is determined not to have decision-making capacity. Nursing staff will document in the medical record the offer to assist and the resident's decision to accept or decline assistance. Information about whether or not the resident has executed an advance directive is displayed prominently in the medical record in a section of the record that is retrievable by any staff. Review of the facility's P&P titled Administering Medications (undated) showed if the drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose. The induvial administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones. Topical medications used in the treatments are recorded on the resident's TAR. As required or indicated for a medication, the individual administering the medication records in the resident's medical record: - The date and time the medication was administered; - The dosage; - The route of administration; - The injection site; - Any complaints or symptoms for which the drug was administered; - Any results achieved and when those results were observed; and (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The signature and title of the person administering the drug. 1. Medical record review for Resident 2 was initiated on 2/18/25. Resident 2 was readmitted to the facility on [DATE]. Review of Resident 2's MDS assessment dated [DATE], showed Resident 2 was cognitively intact. Review of Resident 2's Advance Directive Acknowledgement dated 2/11/25, showed Resident 2 had executed an advance directive for healthcare and the copy was requested. However, review of Resident 2's medical record failed to show the copy of the advance directive. Review of Resident 2's POLST dated 2/11/25, showed Section D: Information and Signatures were left blank for advance directive dated, available and reviewed, advance directives not available, no advance directive, and healthcare agent information if named in advance directive. Review of Resident 2's Baseline Care Plan Person-centered Care Planning - V3.1 dated 2/14/25, showed the SSD discussed with Resident 2 stating Resident 2 did not have an advance directive. The completion was offered to Resident 2 and the resident was educated on the importance. Resident 2 stated she still had the blank copy provided by the SSD on her first admission but had not been able to complete it. The SSD advised Resident 2 if the resident had any questions to let the SSD know and to notify any of the staff or SSD once the resident had completed the form. On 2/19/25 at 1450 hours, an interview and concurrent medical record review was conducted with the SSD. The SSD stated if the resident was to be transferred out of the facility in an emergency, the POLST would be sent with the resident to show the selected treatment, if there was an Advanced Directive and health care agent. The SSD stated the POLST should be filled up by either the licensed nurse or social services staff and would be reviewed and signed by the physician. The SSD stated after she spoke with Resident 2 on 2/14/25, Resident 2 verified she did not have an advance directive. The SSD verified the Advance Directive Acknowledgement form should have been updated. The SSD further verified the POLST should be filled up with the appropriate and correct information regarding Resident 2. On 2/24/25 at 1445 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings for Resident 2. 2. Medical record review for Resident 40 was initiated on 2/18/25. Resident 40 was readmitted to the facility on [DATE]. Review of Resident 40's MDS assessment dated [DATE], showed Resident 40 had short and long-term memory problems. a. Review of Resident 40's Order Summary Report showed the following physician's orders: - dated 1/26/25, to administer advair diskus aerosol powder breath activated (fluticasone-salmeterol) 500-50 mcg/dose one inhalation to inhale orally every 12 hours; and - dated 1/24/25, to administer hydralazine hydrochloride 50 mg one tablet enterally every eight hours for HTN and to hold for SBP less than 110 mmHg. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 40's MAR for February 2025 showed on 2/2/25 at 0600 hours, did not show documented evidence Resident 40 received the advair diskus and hydralazine hydrochloride medications, and there was no blood pressure reading recorded. On 2/20/25 at 1400 hours, a medical record review was conducted with the ADON. The ADON verified the above findings. On 2/21/25 at 1450 hours, a telephone interview was conducted with LVN 13. LVN 13 verified he administered the Advair diskus and hydralazine to Resident 40 on 2/2/25 at 0600 hours. LVN 13 further stated the save button on the PCC must have been lagged so it did not save his documentation. On 2/24/25 at 1513 hours, an interview was conducted with the DON. The DON stated after administering the medication or treatment to the resident, the charge nurse should document it. The DON stated the documentation was important so everybody was on the same page with the residents, and the facility staff could provide appropriate care for all the residents if there was an accurate documentation. The DON was informed and acknowledged the above findings. b. Review of Resident 40's Advance Directive Acknowledgement dated 1/24/25, showed Resident 40 had not executed an advance directive for healthcare and declined to initiate an advance directive at this time. The form was signed by Responsible Party 2. Review of Resident 40's POLST dated 1/24/25, showed Section D: Information and Signatures were left blank for the advance directive dated, available and reviewed, advance directives not available, no advance directive, and healthcare agent information if named in advance directive. On 2/19/25 at 1450 hours, an interview and concurrent medical record review was conducted with the SSD. The SSD stated if the resident was to be transferred out of the facility in an emergency, the POLST would be sent with the resident to show the selected treatment if there was an Advance Directive and health care agent. The SSD stated the POLST should be filled up by either the licensed nurse or social services staff and would be reviewed and signed by the physician. The SSD further verified the POLST should be filled up with the appropriate and correct information regarding Resident 40. On 2/24/25 at 1445 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings for Resident 40. 50967 3. Medical record review for Resident 10 was initiated on 2/21/25. Resident 10 was admitted to the facility on [DATE]. Review of Resident 10's MDS assessment dated [DATE], showed Resident 10 had moderate cognitive impairment. Review of Resident 10's Order Summary Report showed the following: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- a physician's order dated 1/13/25, to monitor for symptoms of Covid-19/RSV/Influenza such as cough, shortness of breath or difficulty breathing, chills, muscle pain, sore throat, new loss of taste or smell, congestion or runny nose, nausea, vomiting, diarrhea, headache, and to monitor for emergency warning signs such as trouble breathing, persistent pain or pressure in the chest, new confusion or inability to arouse, and bluish lips or face. - a physician's order dated 1/13/25, to monitor for pain using a 0-10 pain scale: 0 = no pain; 1-3 = mild pain; 4-6 = moderate pain; and 7-10 = severe pain every shift. - a physician's order dated 1/19/25, to monitor for discolored urine, black tarry stools, sudden severe headache, nausea and vomiting, diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status and/or vital signs, SOB, and nose bleeds related to anticoagulant/antiplatelet medication every shift. Review of Resident 10's MAR for February 2025 showed no documented evidence Resident 10 was monitored for adverse reactions related to anticoagulant use, symptoms of Covid-19/RSV/Influenza, and pain for the morning shift (0700 hours to 1500 hours) on 2/15/25. On 2/21/25 at 1450 hours, an interview was conducted with LVN 12. LVN 12 stated Resident 10 was monitored for the adverse reactions related to use of anticoagulant, symptoms of Covid-19/RSV/Influenza, and pain for the morning shift of 2/15/25. LVN 12 verified she missed documenting the monitoring for Resident 10. 4. Medical record review for Resident 20 was initiated on 2/21/25. Resident 20 was admitted to the facility on [DATE]. Review of Resident 20's MDS assessment dated [DATE], showed Resident 20 had moderate cognitive impairment. Review of Resident 20's Order Summary Report showed the following: - a physician's order dated 12/25/24, to apply estradiol vaginal cream one gram in the vagina at bedtime every Monday, Wednesday, and Friday for vaginal discomfort. - a physician's order dated 12/26/24, to monitor for discolored urine, black tarry stools, sudden severe headache, nausea and vomiting, diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status and/or vital signs, SOB, and nose bleeds related to anticoagulant medication every shift. - a physician's order dated 12/26/24, to monitor for episodes of depression as evidenced by verbalization of sadness related to use of zoloft every shift. - a physician's order dated 1/27/25, to monitor for episodes of schizophrenia as evidenced by auditory hallucination related to use of quetiapine every shift. - a physician's order dated 1/27/25, to monitor for side effects of tardive dyskinesia such as facial or tongue movement, inability to sit still, and drooling related to use of quetiapine and risperidone every shift. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- a physician's order dated 1/27/25, to monitor for adverse reactions related to use of quetiapine and risperidone such as dry mouth, blurred vision, and confusion every shift. Review of Resident 20's MAR for February 2025 showed no documented evidence Resident 20 was monitored for on 2/6/25, the evening shift (1500 hours to 2300 hours) for the following: - adverse reactions related to use of anticoagulant, quetiapine and risperidone; - episodes of depression related to the use of zoloft; - episodes of schizophrenia related to the use of quetiapine; and - side effects of tardive dyskinesia. Further review of Resident 20's MAR for February 2025 showed no documented evidence the vaginal cream was applied to Resident 20 on 2/14/25, for the evening shift. On 2/21/25 at 1424 hours, a telephone interview was conducted with LVN 3. LVN 3 verified he monitored Resident 20 for the above findings but forgot to document in the MAR. 5. Medical record review for Resident 68 was initiated on 2/21/25. Resident 68 was admitted to the facility on [DATE]. Review of Resident 68's MDS assessment dated [DATE], showed Resident 68 was cognitively intact. Review of Resident 68's Order Summary Report showed a physician's order dated 11/16/24, to cleanse the perineal area with normal saline, pat dry, apply house supply barrier cream, and leave open to air daily and as needed if soiled every shift for skin maintenance. Review of Resident 68's TAR for February 2025 showed no documented evidence the perineal care was provided to Resident 68 on 2/16/25. On 2/21/25 at 1025 hours, an interview and concurrent record review was conducted with LVN 9. LVN 9 stated the treatment nurse was responsible in providing treatment like wound care and GT care for the morning shift. LVN 9 stated when the CNA would provide peri care to the resident, she would go with the CNA to apply the ordered treatment to the resident. LVN 9 stated she would also check if the resident had any concerns or discomfort and would document after the treatment was completed. LVN 9 stated if the treatment was not documented, it meant it was not done. LVN 9 verified she worked on 2/16/25, and was assigned to the perineal treatment to Resident 68. LVN 9 stated she was busy that day and could not remember if she provided the perineal treatment to Resident 68. 6. Medical record review for Resident 586 was initiated on 2/20/25. Resident 586 was admitted to the facility on [DATE]. Review of Resident 586's MDS assessment dated [DATE], showed Resident 586 had moderate cognitive impairment and no acute change in mental status. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 586's Order Summary Report showed a physician's order dated 2/16/25, to monitor IV site every shift for signs and symptoms of infection such as redness, swelling, warmth, and pain. Review of Resident 586's IV Administration Record for February 2025 showed no documented evidence the IV site monitoring for signs and symptoms of infection was completed on 2/16 and 2/17/25, for the evening shift. On 2/20/25 at 1418 hours, an interview and concurrent medical record and facility document review was conducted with the ADON. The ADON verified two IV certified LVNs had worked on 2/16 and 2/17/25 for the evening shift. The ADON verified the missing documentation for IV site monitoring on 2/16 and 2/17/25, for Resident 586. The ADON stated it was very important to check and document if the IV line was intact and had no signs and symptoms of infection. On 2/24/25 at 1513 hours, an interview was conducted with the DON. The DON stated after administering medication or treatment to the resident, the charge nurse should document it. The DON was informed and acknowledged the above findings for Residents 10, 20, 68, and 586. 39453 7. Medical record review for Resident 336 was initiated on 2/18/25. Resident 336 was admitted to the facility on [DATE]. Review of Resident 336's POLST dated 2/14/25, showed a different resident name and the wrong birthdate. Review of Resident 336's Informed Consent - Immunization (Updated) - V2 dated 2/14/25, for influenza vaccine, showed a different resident name. Review of Resident 336's Informed Consent - Immunization (Updated) - V2 dated 2/14/25, for pneumonia vaccine, showed a different resident name. Review of Resident 336's Informed Consent - Immunization (Updated) - V2 dated 2/14/25, for Covid-19 vaccine, showed a different resident name. Review of Resident 336's Consent to Treat dated 2/14/25 showed a different resident name. On 2/21/25 at 1338 hours, an interview and concurrent medical record review for Resident 336 was conducted with RN 4. RN 4 verified the above findings. 50787 8. Review of the facility's P&P titled Medication Ordering and Receiving from Pharmacy dated May 2022 showed medications included in the Drug Enforcement Administration (DEA) classification as controlled substances, and medications classified as controlled substances by state law, are subject to special ordering, receipt and recordkeeping requirements in the facility, in accordance with federal and state laws and regulations. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/19/25 at 1218 hours, medication storage inspection for Medication Cart #1 was conducted with LVN 12. The controlled drug inspection was done and showed Resident 51's Tramadol (controlled substance used to treat moderate to moderately severe chronic pain in adults) bubble pack with three slots of empty bubbles with red asterisk written next to it and actual remaining tablets as 12. This observation was acknowledged and verified by LVN 14. Review of the Narcotic and Controlled Substance Sheet showed the Tramadol HCL 50 mg medication with the prescription number 2317044, to take one tablet by mouth every six hours PRN for moderate to severe pain. Review of the Narcotic and Controlled Substance Sheet was conducted and showed the following entries: - dated 8/25/24, with 22 remaining tablets - three blank spaces thereafter, then an entry dated 11/13/24, with 18 remaining tablets. - on the bottom part of the sheet, three entries dated 10/17/24, with no time, quantity administered as wasted and quantity remaining of 3, 2, and 1 tablets. Review of Resident 51's medical record was initiated on 2/19/25. Resident 51's admitted was on 6/22/24. Review of Resident 51's Order Summary Report showed the physician's order dated 8/12/24, for tramadol HCl oral tablet *Controlled Drug* 50 mg by mouth every six hours as needed for moderate pain (pain level of 4-6) to hold if RR below 12 breaths per minute. An interview with the DON was conducted on 02/20/25 at 0905 hours. The DON stated he was not aware of Resident 51's wasted tramadol medications. The DON further stated he would investigate the wasted tramadol. A written statement from RN 1 who co-signed Resident 51's Narcotic and Controlled Substance Sheet was submitted to the DON dated 2/21/25. RN 1 stated the tramadol bubble pack back portion, two tablets were secured with tape and one tablet was ripped halfway, thus wasted the three tablets with LVN 13. Interview with LVN 13 was conducted on 2/24/25 at 0900 hours. LVN 13 stated she was doing the narcotic count with another nurse, observed the back of the bubble pack opened. LVN 13 stated she applied a tape, informed her supervisor (RN 1) of the condition of the bubble pack. LVN 13 and RN 1 wasted the medications and signed the signature part of Resident 51's Narcotic and Controlled Substance Sheet. LVN 13 was unable to account why the 10/17/24 entries in the Narcotic and Controlled Substance Sheet was written at the bottom part of the sheet and the information was inaccurate. 43119 10. Medical record review for Resident 26 was initiated on 2/19/25. Resident 26 was admitted to the facility on [DATE], and readmitted on [DATE]. Resident 26 had a diagnosis of end stage renal disease which required to have an access site for the hemodialysis. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 26's H&P evaluation dated 3/25/24, showed Resident 26 had the capacity to understand and make medical decisions. Review of Resident 26's Plan of Care initiated on 4/22/22, showed a care plan problem addressing Resident 26's risk for complications of the shunt/catheter site on the left upper chest permacath. Review of Resident 26's Dialysis Communication Observation/Assessment Sheets for January 2025 showed, yes for the bruit and thrill assessments for the pre and/or post hemodialysis treatments on 1/22, 1/24, 1/29, and 1/31/25. Further review of the Dialysis Communication Observation/Assessment Sheets for January 2025 showed the assessment of the permacath located on the right side of the chest on 1/22/24. On 2/20/25 at 1454 hours, an interview and concurrent medical record review was conducted with LVN 5. LVN 5 stated the licensed nurses were responsible for the documentation on the Dialysis Communication Observation/Assessment Sheet. LVN 5 verified the above findings. LVN 5 verified Resident 26's permacath was on the left upper chest and not properly assessed and documented in Resident 26's medical record. LVN 5 acknowledged Resident 26's permacath hemodialysis access should not be assessed for the presence of the bruit and thrill. On 2/20/25 at 1514 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 52238 9. Medical record review for Resident 5 was initiated on 2/18/25. Resident 5 was admitted to the facility on [DATE]. Review of Resident 5's Documentation Survey Report for February 2025 showed the missing documentation for the bowel continence documentation on the following dates and shifts: - 2/16/25, for the day shift; - 2/15, 2/19, and 2/21/25, for the evening shift; and - 2/1, 2/10, and 2/16/25, for the NOC shift. On 2/24/25 at 1308 hours, an interview was conducted with the ADON. The ADON acknowledged the missing documentation in Resident 5's bowel and bladder elimination record. The ADON also acknowledged the CNAs caring for Resident 5 did not document and should have documented the information.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to maintain the infection control program designed to help prevent the development and transmission of diseases and infections. * The facility failed to implement their infection control surveillance program for November 2024, December 2024, and January 2025. The facility failed to correctly identify the HAIs and CAIs. The facility failed to conduct an accurate infection surveillance as per the McGeer criteria. The facility failed to ensure the residents infections were mapped and tracked. In addtion, the facility failed to ensure the infection control data presented to the infection control meeting was accurate and complete. * The facility failed to ensure the clean personal clothing and linen cart were covered during transportation. * The facility failed to ensure LVN 10 had performed hand hygiene while providing a wound care treatment to Resident 336. * The facility failed to ensure Resident 686's nasal canula tubing was not touching the trash can or floor. These failures posed the risk for not identifying infections and controlling the transmission of communicable disease to other residents throughout the facility. Findings: 1. Review of the facility's P&P titled Infection Prevention and Control Program (IPCP) dated 2001 showed an IPCP is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The Elements of the IPCP section showed the surveillance data and reporting information is used to inform the committee of potential issues and trends. The Surveillance and Reporting section showed the process surveillance (adherence to infection prevention and control practices) and outcome surveillance (incidence and prevalence of HAIs) are used as measures of the IPCP effectiveness, and the information obtained from the infection control surveillance activities is compared with acknowledged standards (for examples, acceptable rates of new infections), and used to assess the effectiveness of established infection prevention and control practices. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/20/25 at 0836 hours, an interview and concurrent medical record review, facility document review, and facility P&P review was conducted with the IP and DSD. The IP stated she identified the CAI and HAI based on the date of admission and onset of signs and symptoms of infection. The IP stated she started working two weeks ago, and the DSD was the previous IP. The DSD acknowledged she was the previous IP. The DSD stated she was responsible for conducting the surveillance of the residents' infections within the facility from November 2024 to January 2025. The DSD was asked to review and explain the facility's infection control surveillance program. The DSD stated the facility utilized the McGeer Criteria to define infection surveillance activities. The DSD was asked to review and explain the facility's infection control surveillance program. The DSD stated she reviewed the infection screening report in the residents' EHR, change in condition reports, and nurses' progress notes. The DSD stated she marked the infection as HAI if the onset of the signs and symptoms of infection 72 hours after admission, and when the infection met the McGeer Criteria. The DSD also stated she separated the monthly infection control surveillance report and logs from the flu response or those flu and flu-like infections, and other infections other than the flu-like symptoms. a. Review of the Monthly Infection Control Surveillance from November 2024 to January 2025 failed to show infections were classified as CAI or HAIs accurately. In addition, review of the Infection Prevention and Control Surveillance Log from November 2024 to January 2025 failed to show HAIs were accurately identified as meeting the McGeer criteria or not. For example: - The Monthly Infection Control Surveillance for November 2024 showed 19 CAIs. However, the log showed Resident 87 was admitted on [DATE], and the onset of the signs and symptoms was 11/6/24. - The Monthly Infection Control Surveillance for December 2024 showed five HAIs. However, review of the Infection Prevention and Control Surveillance Log for December 2024 showed Resident 86 did not meet the McGeer Criteria for pneumonia but was marked as HAI. - The Monthly Infection Control Surveillance for flu-response for December 2024 showed 33 HAIs. However, review of the Infection Prevention and Control Surveillance Log for flu-response for December 2024 showed the 33 HAIs did not meet McGeer Criteria. - The Monthly Infection Control Surveillance for January 2025 showed seven HAIs. However, review of the Infection Prevention and Control Surveillance Log for January 2025 showed the following: * Resident 338 did not meet the McGeer Criteria for fungal skin infection but was marked as HAI; * Resident 36 did not meet the McGeer Criteria for bronchitis but was marked as HAI; and * Resident 15 did not meet the McGeer Criteria for respiratory tract infection but was marked as HAI. - The Monthly Infection Control Surveillance for flu-response for January 2025 showed three HAIs. However, review of the Infection Prevention and Control Surveillance Log for flu-response for January 2025 showed the following: * Resident 56 had duplicate entries for signs and symptoms of infection, with the onset dates of 1/23 and 1/24/25; and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* Resident 13 did not meet the McGeer Criteria for influenza-like illness but was marked as HAI. b. Review of the facility's mapping of infections showed incomplete mapping and trending of all infections in the facility. The mapping only included the influenza and RSV infections. c. Review of the facility's documented titled Fourth Quarter Microbiology Report for October to December 2024 showed incomplete reporting of the total infections in the facility. The report showed zero on the respiratory infections, and did not include those not meeting McGeer Criteria. The IP and DSD verified the above findings. The DSD acknowledged she made a mistake when identifying the CAIs and HAIs as meeting McGeer Criteria or not. The DSD stated the Microbiology Report was from General Acute Care Hospital 1, and she did not include the reports from General Acute Care Hospital 2, and the facility's report. 2. Review of the facility's P&P titled Laundry and Bedding, Soiled dated 2001 showed clean linen is protected from dust and soiling during transport and storage to ensure cleanliness. On 2/20/25 at 1055 hours, the Laundry Aide was observed transporting an uncovered linen cart with the residents' clothing was hanging on the handlebars of the linen cart, and blankets were on the linen cart. On 2/20/25 at 1058 hours, an observation and concurrent interview was conducted with the Laundry Aide. Residents' clothing was observed hanging on the handlebars, and blankets were on the linen cart which was not covered. The Laundry Aide verified the above findings. The Laundry Aide stated she used a blanket to cover the clothing and blankets, but only when she transported the clean linen outside the facility. 3. Review of the facility's P&P titled Handwashing/ Hand Hygiene dated 2001 showed hand hygiene is indicated before moving from work on a soiled body site to a clean body site on the same resident, and immediately after glove removal. On 2/21/25 at 0937 hours, a wound care observation for Resident 336 and concurrent interview was conducted with LVN 9. LVN 9 stated Resident 336's staples at the surgical site were removed at her appointment, and she came back at 1600 hours, yesterday (2/20/25). LVN 9 stated, there was an opening, so I need to apply the Steri-Strips. The following was observed: - LVN 9 was observed washing her hands then donning clean gloves and cleaning Resident 336's mid back surgery site with a gauze soaked with normal saline. - Without performing hand hygiene, LVN 9 was observed removing gloves then donning clean gloves and patting Resident 336's mid back surgery site with a dry gauze. - Without performing hand hygiene, LVN 9 was observed removing gloves then donning clean gloves and applying Steri-Strips to Resident 336's mid back surgery site. - LVN 9 was observed removing gloves, donning clean gloves and applying Steri-Strips to Resident 336's mid back surgery site four more times without performing hand hygiene until the entire surgical site was applied with Steri-Strips. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055929	A. Building B. Wing	02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crystal Cove Care Center	1445 Superior Avenue Newport Beach, CA 92663

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Without performing hand hygiene, LVN 9 was observed removing gloves then donning clean gloves and applying an adhesive dressing to Resident 336's mid back surgery site. - Then, LVN 9 was observed removing gloves and washing her hands after the wound care treatment. On 2/21/25 at 1451 hours, a follow-up interview was conducted with LVN 9. When asked about performing a hand hygiene during wound care treatment, LVN 9 stated she washed her hands when she was done with the wound care treatment. LVN 9 stated, it was not a wound I was doing, I was just putting the Steri-Strips. I thought that by removing the gloves, it would be okay. LVN 9 acknowledged she should have performed hand hygiene when performing a wound care from dirty to clean, and immediately after removing gloves. 52238 4. On 2/18/25 at 0907 hours, during the initial tour of the facility, Resident 686 was observed in bed using an oxygen via nasal caula at a rate of 4 liters per minute and the green color nasal cannula tubing was observed touching the inside of the trash can next to the oxygen concentrator. Medical record review for Resident 686 was initiated on 2/18/25. Resident 686 was admitted to the facility on [DATE]. On 2/18/25 at 1211, 1238, and 1509 hours, a follow-up observation was conducted in Resident 686's room. Resident 686 was observed using her oxygen via nasal canula at a rate of 4 liters per minute and the green color nasal canula tubing was observed touching the floor. On 2/18/25 at 1513 hours, an observation and concurrent interview was conducted with LVN 6. When asked if the nasal canula tubing should be touching the floor when the resident was using the oxygen, LVN 6 stated the nasal canula tubing should not be touching the floor as it posed the risk for infection. LVN 6 verified the green color nasal canula tubing was touching the floor while Resident 686 was using her oxygen via nasal canula.

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F 0908 Level of Harm - Potential for minimal harm Residents Affected - Some	Keep all essential equipment working safely. 50787 Based on observation, interview, and facility document review, the facility failed to ensure the resident's specimen refrigerator was in safe operating condition. * The facility failed to ensure the specimen refrigerator was maintained at the temperature range of 36-46 degrees F and the freezer compartment of the specimen refrigerator was free of ice buildup. These failures had the potential to affect the resident's health due to the refrigerator not being maintaned. Findings: On 2/19/25 at 1115 hours, an inspection of the specimen refrigerator in the nurses' station and concurrent interview was conducted with RN 3. The specimen refrigerator's temperature was 28 degrees F. Additionally, there was ice build-up in the freezer compartment of the refrigerator. Review of the facility's document titled Specimen Refrigerator Temperature Log for February 2025 showed the temperature should be between 36F- 46F and the refrigerator's latest temperature on 2/19/25 was 36 degrees F. RN 3 acknowledged and confirmed the above findings. On 2/24/25 at 1630 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.