STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055932	A. Building B. Wing	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Four Seasons Healthcare & Wellness Center, LP	5335 Laurel Canyon Blvd. North Hollywood, CA 91607

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 43988 Based on observation, interview, and record review, the facility failed to provide care in a manner that maintained a resident's dignity for one (1) of 1 sampled resident (Resident 16) reviewed for dignity by failing to ensure Certified Nursing Assistant (CNA) 7 was sitting at eye level when assisting the resident while eating. This deficient practice had the potential to negatively affect the residents' psychosocial wellbeing. Findings: During a review of Resident 16's Admission Record, the Admission Record indicated the facility originally admitted the resident on 6/5/2012 and readmitted the resident on 8/22/2023, with diagnoses including adult failure to thrive (a gradual decline in a person's physical and emotional well-being), dementia (a progressive state of decline in mental abilities), and generalized muscle weakness. During a review of Resident 16's History and Physical (H&P), dated 8/29/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 16's Minimum Data Set (MDS - a resident assessment tool), dated 11/29/2024, the MDS indicated Resident 159 had severely impaired cognition (mental action or process of acquiring knowledge and understanding). The MDS further indicated Resident 16 had impairment on both upper extremities and required total assistance from staff with all activities of daily living (ADLs - activities such as bathing, dressing and toileting a person performs daily). During a concurrent observation and interview, on 4/24/2025, at 7:47 a.m., inside Resident 16's room, Resident 16 laid in bed with the head of the bed elevated to seat Resident 16 upright. CNA 7 stood over Resident 16 and fed Resident 16 breakfast. CNA 7 stated staff should be sitting at eye level while assisting residents with eating to respect the dignity of the residents. CNA 7 stated that she forgot to get a chair and that she should be sitting at eye level while assisting the resident with eating to respect Resident 16's dignity. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 4/24/2025, at 9:30 a.m., with the Director of Nursing (DON), the DON stated the staff should be assisting the residents with eating at eye level either by increasing the height of the bed if there was no chair available or grab a chair and sit. The DON stated multiple reminders have been provided to the staff regarding assistance with eating and dignity. The DON stated CNA 7 should have assisted Resident 16 while eating at eye level to respect the resident's dignity. During a review of the facility's policy and procedure (P&P) titled, Resident Right - Accommodation of Needs, last reviewed on 1/29/2025, the P&P indicated the resident's environment is designed to assist the resident in achieving independent functioning and maintaining the resident's dignity and well-being. The P&P further indicated: - The facility staff will assist residents in achieving these goals. - Facility staff interacts with the residents in a way that accommodates the physical or sensory limitations of the residents, promotes communication, and maintains each resident's dignity.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 44244 Based on interview and record review, the facility failed to ensure residents were free from the use of unnecessary psychotropic (any medication capable of affecting the mind, emotions, and behavior) medications in accordance with the facility policy and procedure for one of two sampled residents (Resident 130) reviewed during the Sufficient and Competent Nurse Staffing task, by failing to obtain informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) for lorazepam (a psychotropic medication use to treat feelings of anxiousness). This deficient practice had the potential to result in the use of unnecessary psychotropic drugs resulting in adverse effects (an undesired and harmful result of a treatment or intervention, such as a medication or surgery) of the medication and a violation of the resident's right to make medical decisions regarding the use of psychotropic medications. Cross reference F758 Findings: During a review of Resident 130's Admission Record, the Admission Record indicated the facility admitted the resident on 7/15/2024 with diagnoses that included end stage renal disease (ESRD - irreversible kidney failure), dependence on hemodialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), monoplegia (paralysis affecting a single limb due to brain or spinal damage) of upper limb following unspecified cerebrovascular disease (condition that affects blood flow to the brain). During a review of Resident 130's Minimum Data Set (MDS - resident assessment tool), dated 1/27/2025, the MDS indicated the resident was able to understand others and was able to make himself understood. The MDS further indicated the resident required set up assistance from staff for eating and was dependent on staff for toileting, bathing, and dressing. During a review of Resident 130's History and Physical (H&P), dated 7/15/2024, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 130's Physician Psychiatric Consultation Note, dated 1/8/2025, the Physician Psychiatric Consultation Note indicated the resident had a diagnosis of anxiety (a mental health condition that may result in restlessness, irritability, feelings of nervousness, panic, and fear) with an overall stable mood but anxious feeling at times. During a review of Resident 130's Order Summary Report, the report indicated orders for the following: - On 3/23/2025, and clarified on 3/25/2025, Lorazepam oral tablet 0.5 milligrams (mg - a unit of measure) give one tablet by mouth every 24 hours as needed for anxiety verbalized by aggression towards staff. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 3/23/2025, Trileptal (medication that may be used to treat mood disorders) 150 mg by mouth twice a day for mood disorder manifested by inability to control paranoia thoughts. During a review of Resident 130's Care Plan (CP) regarding the resident is on lorazepam 0.5 mg as needed, initiated 3/25/2025, the CP indicated to educate the resident on the risks and benefits and the side effects and / or toxic symptoms of lorazepam. The CP indicated the resident is taking anti-anxiety medication which is associated with increased risk of confusion, amnesia, loss of balance, and cognitive impairment and increased risk of falls with broken hips and legs. During a review of Resident 130's CP regarding the resident's diagnosis of mood disturbance manifested by inability to control paranoia thoughts, initiated 9/10/2025, the CP indicated a goal that the resident would remain free of psychotropic drug related complications. During a concurrent interview and record review, on 4/23/2025, at 4:06 p.m., with the Minimum Data Set Coordinator (MDSC), Resident 130's physician orders, medication administration record (MAR) and informed consent forms were reviewed. The MDSC stated psychotropic medications are any medication that affects resident mentation and brain functioning. The MDSC stated psychotropic medications have a high risk for side effects potentially resulting in resident falls and injury. The MDSC stated because psychotropic medications have a high risk for side effects, the facility wants to limit the use of the medications in facility residents for safety reasons. The MDSC stated when psychotropic medications are prescribed, the physician explains the risks and benefits of the medication with the resident or resident representative and obtains informed consent prior to administration. The MDSC stated the nurse speaks with the resident to ensure informed consent was obtained by the physician, and the informed consent form is completed with the resident's signature. The MDSC stated the informed consent form is kept in the resident's chart. The MDSC reviewed Resident 130's informed consent forms and stated there was no documented evidence that the facility staff or physician obtained informed consent for Resident 130's lorazepam prior to administration. The MDSC stated resident 130 was self-responsible and able to consent for his own medical treatments. During an interview, on 4/23/2025, at 4:37 p.m., with Resident 130, the resident stated the facility never explained the risk and benefits of the medication lorazepam and does not remember ever signing an informed consent form. During an interview, on 4/23/2025, at 5:12 p.m., with Licensed Vocational Nurse (LVN) 3, LVN 3 stated LVN 3 received Resident 130's order for lorazepam and Trileptal at the same time on 3/23/2025. LVN 3 stated LVN 3 checked to ensure that informed consent was received for Trileptal, but LVN 3 missed ensuring informed consent was received for lorazepam. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 4/23/2025, at 5:23 p.m., with the Assistant Director of Nursing (ADON), the ADON stated informed consent for psychotropic medication must be obtained prior to the administration of any medication that can affect a resident's mood or cause sedation. The ADON stated if a resident is self-responsible, then the physician will obtain informed consent from the resident and the informed consent form will be completed with the resident and physician's signature. The ADON stated informed consent must be obtained to ensure the resident consents to taking a medication that can affect the brain with side effects and to ensure the medication is not administered to a resident who does not want the medication. The ADON stated when a self-responsible resident is administered lorazepam without their consent, it may be considered unnecessary medications resulting in a chemical restraint (any drug that is used for discipline or staff convenience and not required to treat medical symptoms). The ADON stated when informed consent was not obtained prior to administration there was a potential that the resident may have adverse effects of unnecessary medication resulting in a fall and injury. During an interview, on 4/25/2025, at 9:08 a.m., with the Director of Nursing (DON), the DON stated lorazepam is a class of medication called anti-anxiety and is a psychotropic medication. The DON stated psychotropic medications generally have a higher risk of side effects especially in the elderly, so it is important to obtain informed consent to ensure the resident or resident representative is aware of the risk and benefits of the medication prior to administration. The DON stated lorazepam could potentially sedate a resident and limit their cognitive or physical abilities. The DON stated when the facility did not obtain informed consent from Resident 130 prior to the administration of PRN lorazepam, there was a potential that lorazepam could be administered without the resident's consent potentially affecting the resident's psychosocial wellbeing. The DON stated when informed consent was not obtained for Resident 130, the facility policy and procedure (P&P) was not followed. During a review of the facility P&P titled, Behavior / Psychoactive Medication Management, last reviewed 1/29/2025, the P&P indicated psychotropic medications are also referred to as psychoactive medications. There are several classes of psychoactive medications including anti-anxiety medications, medications that are used to treat anxiety. If the resident exhibits mood or behavior problems upon admission, assessments will be conducted to address the resident's mood or behavior status. Facility must obtain a resident's written informed consent for treatment using psychotherapeutic drugs and consent renewal every 6 (six) months. During a review of the facility P&P titled Informed Consent, last reviewed 1/29/2025, the P&P indicated the resident's physician will determine the resident's capacity to make decisions. If the Resident is determined to have capacity, the Resident may provide informed consent. It is the Healthcare Practitioner's responsibility to obtain informed consent. The licensed nurse will confirm that the Healthcare Practitioner obtained informed consent and will document the verification in the resident's medical record before administering the first dose or first increased dose of psychoactive medications. The licensed nurse will contact the healthcare practitioner to request the practitioner obtain the informed consent, if the licensed nurse is unable to verify that the Healthcare Practitioner obtained informed consent from the resident or decision-maker. The informed consent will be placed in the resident's medical record.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44376 Based on observation, interview, and record review, the facility failed to keep the call light (an alerting device for nurses or other nursing personnel to assist a patient when in need) within reach of the resident for four of four sampled residents (Residents 489, 390, 139, and 133) reviewed under the environment care area. This deficient practice had the potential for residents not being able to summon health care workers for help as needed. Findings: During a review of Resident 489 ' s Admission Record, the Admission Record indicated the facility admitted the resident on 4/17/2025, with diagnoses including epileptic seizures (abnormal electrical brain activity, also known as seizures, kind of like an electrical storm inside the head), muscle weakness, and difficulty in walking. During a review of Resident 489 ' s History and Physical (H&P), dated 4/19/2025, the H&P indicated the resident was unable to make decisions. During a review of Resident 489 ' s Fall Risk Evaluation, dated 4/17/2025, the Fall Risk Evaluation indicated the resident was at risk for falls. During a concurrent observation and interview, on 4/22/2025, at 10:22 a.m., with Certified Nursing Assistant (CNA) 5, inside Resident 489 ' s room, Resident 489 ' s call light was on the right side of the bed on the floor. CNA 5 stated it is the responsibility of all staff working in the facility to ensure the call light was within reach of the resident to ensure the residents can call for help when needed. CNA 5 also stated the residents can fall while reaching for the call light on the floor sustaining injury. During an interview, on 4/25/2025, at 12:37 p.m., with the Director of Nursing (DON), the DON stated the call light should be within the reach of Resident 489 at all times so she can call for help when needed. The DON stated they are doing environmental safety checks every Monday to Friday to ensure the residents ' environment is safe. During a review of the facility's recent policy and procedure (P&P) titled, Resident Rights - Accommodation of Needs, last reviewed on 1/29/2025, the P&P indicated to ensure that the facility provides an environment and services that meet residents' individual needs. Facility staff arrange toiletries and personal items so that they are within easy reach of the resident. During a review of the facility's recent P&P titled, Resident Safety, last reviewed on 1/29/2025, the P&P indicated residents will be evaluated on admission, quarterly and whenever there is a change in condition to identify circumstances that pose a risk for the safety and wellbeing of the resident. Any facility staff member who identifies an unsafe situation, practice or environmental risk factors should immediately notify their supervisor or charge nurse. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's recent P&P titled, Communication - Call System, last reviewed on 1/29/2025, the P&P indicated the facility will maintain a communication system to allow residents to call for staff assistance from their rooms and toileting/bathing facilities. 43988 2. During a review of Resident 390 ' s Admission Record, the Admission Record indicated the facility originally admitted the resident on 1/7/2025 and readmitted the resident on 2/24/2025 with diagnoses including schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), type two (2) diabetes mellitus (DM 2 - a disorder characterized by difficulty in blood sugar control and poor wound healing), and anxiety disorder (a mental health condition where excessive fear and worry interfere with daily life, causing significant distress). During a review of Resident 390 ' s H&P, dated 3/8/2025, the H&P indicated the resident was alert and aware of her identity, location, and the time. During a review of Resident 390 ' s MDS, dated [DATE], the MDS indicated Resident 390 had an intact cognition (mental action or process of acquiring knowledge and understanding) and was able to understand others and make herself understood. The MDS further indicated Resident 390 had impairment on one side of the upper extremity and required total assistance from staff with all activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 390 ' s Fall Risk Evaluation, dated 1/25/2025 and 2/24/2025, the fall risk evaluations indicated Resident 390 was a high risk for falls. During a review of Resident 390 ' s care plan (CP) on risk for falls, initiated on 2/27/2025, the CP indicated to ensure the resident ' s call light is within reach and encourage the resident to use it for assistance as needed as one of the interventions for the resident to be free from falls. During a concurrent observation and interview, on 4/22/2025, at 11:20 a.m., inside Resident 390 ' s room, with LVN 5, Resident 390 laid in bed asleep with a pad call light (a type of call light with a sensitive touch surface that is ideal for residents with limited movement of the upper extremity) placed on top of the resident ' s lap. LVN 5 stated Resident 390 ' s call light was placed on top of the resident ' s lap and not within Resident 390 ' s reach. LVN 5 stated all residents ' call lights should be placed appropriately and within reach so the residents would be able to call for assistance when needed. LVN 5 stated Resident 390 had weakness on the upper extremities and would not be able to call for assistance if the pad call light was placed on the lap. LVN 5 stated Resident 390 ' s pad call light should have been placed next to either side of the resident ' s face so Resident 390 would be able to call for assistance when needed and prevent delay in the care the resident needed. During an interview, on 4/25/2025, at 12:49 p.m., with the DON, the DON stated the staff should ensure all residents ' call lights should be placed appropriately, especially the pad call light, and within the resident ' s reach prior to leaving the room so the residents can call for assistance and the staff can attend to their needs. The DON stated Resident 390 ' s pad call light should have been placed appropriately on the resident ' s side of the face for easy access to the pad call light so the staff can attend and meet Resident 390 ' s needs. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's recent P&P titled, Communication - Call System, last reviewed on 1/29/2025, the P&P indicated the facility will maintain a communication system to allow residents to call for staff assistance from their rooms and toileting/bathing facilities. 50521 3. During a review of Resident 139's Admission Record, the Admission Record indicated the facility admitted the resident on 12/3/2024 with diagnoses including seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), DM 2, and muscle weakness. During a review of Resident 139's MDS, dated [DATE], the MDS indicated Resident 139 had the mental capacity to understand others and sometimes had the ability to make himself understood. The MDS indicated the resident had impairment of left upper extremity that interfered with daily functions or placed the resident at risk of injury. The MDS further indicated the resident required substantial/maximal assistance from staff with eating, oral hygiene, and personal hygiene and was dependent with all other ADLs. During a review of Resident 139 ' s Fall Risk Evaluation, dated 3/11/2025, the Fall Risk Evaluation indicated the resident was a high risk for potential fall. During a review of Resident 139 ' s care plan on risk for falls, initiated on 12/3/2024, the care plan interventions indicated an intervention to keep call light within easy reach and encourage the resident to use it for assistance as needed, the resident needs prompt response to all requests for assistance. During an observation, on 4/22/2025, at 10:19 a.m., inside Resident 139 ' s room, Resident 139 laid in bed with a left-hand splint in place and the call light not within reach to the left side of the bed. During an observation, on 4/23/2025, at 8:15 a.m., inside Resident 139 ' s room, Resident 139 laid in bed with a left-hand splint in place and the call light dangling from the left side of the bed not within reach. During a concurrent observation and interview, on 4/24/2025, at 8:50 a.m., inside Resident 139 ' s room, with Resident 139, Resident 139 ' s call light was tangled around the left side of his bedrail. Resident 139 stated he was not able to reach for his call light with his left hand. During a concurrent observation and interview, on 4/24/2025, at 8:56 a.m., with CNA 4, inside Resident 139 ' s room, CNA 4 confirmed and stated Resident 139 ' s call light was tangled on the left side rail. CNA 4 stated leaving the call light tangled around the left side rail will make it difficult for the resident to ask for assistance due to his impairment of left upper extremity. CNA 4 stated the call light should be within reach for the resident to call for help when needed. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview, on 4/24/2025, at 10:27 a.m., with LVN 3, inside Resident 139 ' s room, LVN 3 confirmed and stated the call light was on the floor to the right side of Resident 139 ' s bed. LVN 3 stated the call light should be within reach for the resident to call for assistance when needed. During an interview, on 4/25/2025, at 12:46 p.m., with the DON, the DON stated the call light should be placed to the resident ' s dominant side without physical limitations to get the staff services when needed. The DON stated the failure of the staff to ensure the call light was within reach could result in the resident not being able to call for help and could eventually fall from trying to reach for the call light. During a review of the facility's recent P&P titled, Call Lights, last revised on 4/17/2024, the P&P indicated to ensure that the call light is within the resident's reach when in his/her room or when on the toilet, to assure resident receives prompt assistance. 44244 4. During a review of Resident 133 ' s Admission Record, the Admission Record indicated the facility admitted the resident on 12/21/2023 with diagnoses including epilepsy (chronic disorder that causes recurrent seizures [abnormal electrical activity in the brain]), lack of coordination, Parkinson ' s disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), and hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (partial paralysis or weakness on one side of the body) following cerebral infarction (CVA - stroke, loss of blood flow to a part of the brain) affecting the left dominant side. During a review of Resident 133 ' s MDS, dated [DATE], the MDS indicated the resident usually was able to understand others and usually was able to make himself understood. The MDS further indicated the resident had impairment on one side of the upper and lower extremities, was dependent on staff for toileting, bathing, personal and oral hygiene, dressing, and mobility. During a review of Resident 133 ' s H&P, dated 12/22/2023, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 133 ' s Order Summary Report, dated 3/17/2025, the Order Summary Report indicated orders for a floor mat (a cushioned floor pad designed to help prevent injury should a person fall) and low bed to decrease the potential for injury. During a review of Resident 133 ' s CP on the resident ' s risk for falls, initiated 7/12/2024, the CP indicated to be sure the resident ' s call light is within reach and encourage the resident to use it for assistance as needed. The CP indicated Resident 133 needs prompt response to all requests for assistance. During a concurrent observation and interview, on 4/23/2025, at 8 a.m., Resident 133 laid awake in bed. Resident 133 ' s call light dangled off the right side of the bed toward the floor. CAN 1 entered the resident ' s room carrying a pitcher of water and a cup. CNA 1 placed the water pitcher and cup on the resident ' s nightstand. CNA 1 exited the resident ' s room. The call light remained dangling from the resident ' s bed and not within reach of the resident. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview, on 4/23/2025, at 8:07 a.m., Resident 133 stated he wanted a drink of water but could not reach the pitcher. Resident 133 stated he did not know where the call light was located. Resident 133 ' s call light dangled from the right side of the resident ' s bed and not within reach of the resident. During a concurrent observation and interview, on 4/23/2025, at 8:10 a.m., CNA 2 entered Resident 133 ' s room and stated CNA 2 was caring for Resident 133. CNA 2 confirmed and stated the call light was not within reach of the resident, but it should be. CNA 2 stated, at approximately 7:30 a.m., CNA 2 repositioned Resident 133 and the call light must have fallen off the bed, and CNA 2 must not have noticed the fallen call light. During an interview, on 4/23/2025, at 8:15 a.m., with CNA 1, CNA 1 stated CNA 1 delivered water to all the unit residents and should check every resident ' s environment for safety and ensure the call light is within reach of residents. CNA 1 stated when CNA 1 delivered water to Resident 133, CNA 1 did not notice the call light was not within reach of the resident because CNA 1 was nervous. CNA 1 stated CNA 1 should have noticed the call light was not within reach of the resident. CNA 1 stated it was important to ensure the call light was always within reach of residents in case there is an emergency and the resident needs to call for assistance. During an interview, on 4/25/2025, at 9:08 a.m., with the DON, the DON stated the call light is used by residents of the facility to communicate with staff when the resident needs assistance. The DON stated it was a resident ' s right to have the call light and the call light should always be within reach of the resident. The DON stated when any staff member enters a resident ' s room, the staff member should do a safety scan of the room to ensure the call light is within reach, the bed is in a low position if not attended, and there are no tripping hazards. The DON stated residents need the call light because they may be unable to do something by themselves and need help such as when a resident is sliding off the bed, is not positioned properly, or drops something that they cannot reach. The DON stated all facility residents are at risk for fall, including Resident 133, and when the call light is not within reach it may result in an injury from sliding to the floor when the resident was not able to call for assistance. The DON stated the facility P&P was not followed when the call light was not within reach of Resident 133. During a review of the facility P&P titled, Resident Rights - Accommodation of Needs, last reviewed 1/29/2025, the P&P indicated the purpose of the P&P is to ensure that the facility provides an environment and services that meet the residents ' individual needs. The facility environment is designed to assist the resident in achieving independent functioning and maintaining the resident ' s dignity and well-being. Facility staff will assist residents in achieving these goals. During a review of the facility P&P titled, Communication - Call system, last reviewed 1/29/2025, the P&P indicated the facility will maintain a communication system to allow residents to call for staff assistance from their rooms. The purpose of the P&P was to ensure the residents have a means of contacting facility staff for assistance. During a review of the facility P&P titled, Resident Safety, last reviewed 1/29/2025, the P&P indicated the purpose of the P&P was to provide a safe and hazard free environment.

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Four Seasons Healthcare & Wellness Center, LP	5335 Laurel Canyon Blvd. North Hollywood, CA 91607

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. 47441 Based on observation, interview, and record review, the facility failed to ensure the confidential personal information of 15 of 15 sampled residents were protected by failing to: 1. Ensure the diet type report for Resident 144, Resident 83, Resident 162, Resident 70, Resident 3, Resident 29, Resident 107, Resident 147, Resident 106, Resident 85, Resident 63, Resident 182, Resident 157 was not in the handwashing trash in the kitchen. 2. Ensure documents containing protected health information ([PHI]- any health information that can be used to identify a specific individual which must remain confidential to prevent harmful consequences) was shredded prior to disposing in the waste container for Resident 38 and Resident 129. These failures had the potential to violate Resident 144, Resident 83, Resident 162, Resident 70, Resident 3, Resident 29, Resident 107, Resident 147, Resident 106, Resident 85, Resident 63, Resident 182, Resident 157, Resident 38 and Resident 129's rights for privacy and confidentiality of personal and medical records. Findings: 1. During an observation, on 4/22/2025, at 12:40 p.m., of the handwashing trash can in the kitchen, the diet type report page 9 was inside the handwashing trash along with soiled paper towels. The diet type report indicated 13 residents' name, room number, allergies, diet order and allergies. During an interview, on 4/23/2025, at 2:13 p.m., with the Assistant Dietary Supervisor (ADS), the ADS stated he was the one who printed the diet type report yesterday and gave it to the staff delivering the meal cart. The ADS stated the delivery person gives the diet type report to nursing staff and the report contained the name of residents, diets, allergies, food likes and dislikes and private information. The ADS stated the nursing staff gives the diet type report back to the dietary staff after checking it and dietary staff must place it in the little basket on top of the printer in the office. The ADS stated the basket gets emptied into the locked container to ensure Health Insurance Portability and Accountability Act (HIPPA - federal standards protecting sensitive health information from disclosure without resident's consent) was followed and protected. The ADS stated the diet type report should not be in the trash can as the residents' information could be taken away and it could be dangerous to the residents violating HIPPA. The DS stated he did not know who threw the diet type report in the trash. During an interview, on 4/23/2025, at 2:36 p.m., with Director of Staff Development (DSD) 1 and DSD 2, DSD 2 stated they provided HIPPA in-service to the staff by disposing printed paper with residents' private information in the shredder or HIPPA locked bin. DSD 1 stated it was important to in-service staff about HIPPA to protect the residents' rights. DSD 1 stated the diet list had pertinent information and should not be in the trash as it would expose residents' information as a potential outcome. 43455 (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During an observation, on 4/23/2025, at 1:13 p.m., in Nursing Station 3, a black plastic trash bin contained a handwritten document that listed the names of Resident 38 and 129 and the name of two (2) medications and their doses for each of the residents. During an interview, with Licensed Vocational Nurse (LVN) 10, LVN 10 stated the document contained confidential resident information and should not be discarded in the black plastic trash bin which was a regular trash bin. LVN 10 stated the document needed to be disposed (discarded) of in the shredder (a disposal container for confidential documents) to prevent HIPPA violation and to prevent resident information from being exposed. During an interview, on 4/23/2025, at 1:17 p.m., in Nursing Station 3, with LVN 9, LVN 9 stated the document found in the black plastic trash bin contained her handwriting and that it should not be disposed of in the regular trash bin and should be shredded instead. LVN 9 stated this was considered a HIPPA and confidentiality violation as Resident 38's and 129's health information was visibly exposed. During an interview, on 4/23/2025, at 2:32 p.m., with the Director of Nursing (DON), the DON stated documents containing resident medical information should not be disposed in the regular trash bin and instead shredded to ensure compliance with HIPPA and maintain resident confidentiality. The DON stated the facility failed to protect Resident 38's and 129's privacy by failing to dispose of documents containing resident medical information in the black plastic trash bin in Nursing Station 3, visibly exposing resident private health information. During a review of the facility's policies and procedures titled, Education Requirements, reviewed 1/29/2025, the P&P indicated, Purpose: To ensure that the facility's workforce received necessary and appropriate training with regard the privacy and security of PHI to carry out their functions at the facility. I. The facility shall provide training to members of its workforce on federal and state confidentiality requirements with regard to PHI upon hire, annually, and as necessary thereafter to effectively carry out functions in accordance with the privacy regulations.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44244 Based on interview and record review, the facility failed to follow its Grievance and Complaint Policy and Procedure (P&P) by failing to: 1. Follow the Grievance and Complaint Policy and Procedure (P&P) when Resident 13 complained to Licensed Vocational Nurse (LVN) 4 that Certified Nursing Assistant (CNA) 3 refused to warm up Resident 130's meal for one of two sampled residents (Resident 130) reviewed during the Sufficient and Competent Staffing task. 2. Follow the Grievance and Complaint P&P when the Grievance Official failed to follow-up and inform Resident 157 of the findings of the investigation for one of seven sampled residents (Resident 157) reviewed during the Dining Observation task. This deficient practice had the potential to affect the residents' quality of life and provision of care of effective therapeutic diet (a meal plan that controls the intake of certain food and nutrients). 3. Take reasonable steps to protect the resident's personal property when LVN 2 failed to notify SSA 1 when Resident 188 reported missing home medications for one of three sampled residents (Resident 188) reviewed under Discharge care area. This deficient practice resulted in Resident 130's grievance with CNA 3 and Resident 188's grievance with missing home medications went unresolved resulting in distress to the resident with a potential to cause a decline in the resident's psychosocial wellbeing. Findings: 1. During a review of Resident 130's Admission Record, the Admission Record indicated the facility admitted the resident on 7/15/2024 with diagnoses that included end stage renal disease (ESRD -irreversible kidney failure), dependence on hemodialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), monoplegia (paralysis affecting a single limb due to brain or spinal damage) of upper limb following unspecified cerebrovascular disease (condition that affects blood flow to the brain). During a review of Resident 130's Minimum Data Set (MDS - resident assessment tool) dated 1/27/2025, the MDS indicated the resident was able to understand others and was able to make himself understood. The MDS further indicated the resident required set up assistance from staff for eating and was dependent on staff for toileting, bathing, and dressing. During a review of Resident 130's History and Physical (H&P), dated 7/15/2024, the H&P indicated the resident had the capacity to understand and make decisions. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 4/22/2025 at 10:25 a.m., Resident 130 was awake and lying in bed. Resident 130 stated Resident 130 had a problem with CNA 3. Resident 130 stated on 4/21/2025 the resident returned from hemodialysis and requested CNA 3 to warm up the breakfast tray. Resident 130 stated CNA 3 refused to warm up the meal and Resident 130 ate a cold breakfast. During a concurrent observation and interview on 4/23/2025 at 7:55 a.m., Resident 130 was observed speaking to the Activities Director (AD), Resident 130 stated CNA 3 was assigned to care for Resident 130 and Resident 130 did not like CNA 3. The AD exited the room and then returned with LVN 4. LVN 4 stated the assignment would be changed and CNA 3 would no longer be assigned to Resident 130. During an interview on 4/24/2025 at 7:30 a.m., with LVN 4, LVN 4 stated on 4/21/2025 or 4/22/2025, LVN 4 walked into Resident 130's room after the breakfast trays were delivered. LVN 4 stated Resident 130 complained that the CNA refused to warm the resident's breakfast tray. LVN 4 stated Resident 130 complained to LVN 4 that the resident did not like CNA 3 because CNA 3 refused to heat up the resident's food. LVN 4 stated on 4/23/2025, Resident 130 was upset because Resident 130 thought CNA 3 was assigned to care for the resident. During an interview on 4/24/2025 at 7:57 a.m. with Social Services Assistant (SSA) 2, SSA 2 stated when something has happened and a resident complains about a CNA for a specific reason, then the resident is offered to file a grievance to fix the problem. SSA 2 stated SSA 2 was the assigned SSA for Resident 130. SSA 2 was not aware Resident 130 complained that CNA 3 refused to warm the resident's food. SSA 2 stated there was no grievance for Resident 130's complaint. SSA 2 stated when Resident 130 complained to LVN 4 about CNA 3 refusing to warm the resident's food, a grievance should have been started but it wasn't. SSA 2 stated it was important to begin a grievance because they need to ensure the residents trays are warm, their needs are met, and that the problem does not continue. During a follow up interview on 4/24/2025 at 8:19 a.m., with LVN 4, LVN 4 stated Resident 130 complained that CNA 3 refused to warm up the resident's tray. LVN 4 stated LVN 4 did not report to anyone that Resident 130 complained that CNA 3 refused to warm the meal. LVN 4 stated when a resident complains about a CNA refusing to provide care by not providing a warm meal, then a grievance should be offered and the grievance process should be started, but it wasn't. During a follow up interview on 4/24/2025 at 8:34 a.m., SSA 2 stated LVN 4 should have reported to SSA 2 that Resident 130 complained about the care provided by CNA 3, but LVN 4 did not. The SSA stated when Resident 130 was not provided the opportunity to file a grievance in a timely manner regarding CNA 3's refusal to warm the resident's food, there was a delay in Resident 130's issue being investigated and resolved. SSA 2 stated the grievance should have been started the day the resident made the complaint, but it was not. SSA 2 stated because the grievance was not offered and started, it resulted in Resident 130 being assigned CNA 3 on 4/23/2024 potentially causing distress in the resident. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 4/25/2025 at 9:08 a.m., with the Director of Nursing (DON), the DON reviewed the facility policy and procedures regarding grievances. The DON stated a grievance is a concern or complaint that requires follow up action to prevent whatever caused the concern from happening again. The DON stated the grievance process includes making a report to address a concern and taking steps to mitigate any further concerns by the resident. The DON stated Resident 130's complaint regarding CNA 3's refusal to provide warm food was a grievance, but the facility policy was not followed when LVN 4 did not act and report Resident 130's grievance. The DON stated when the P&P was not followed it could potentially affect the resident's right to file a grievance and have the grievance followed up on. During a review of the facility P&P titled Grievance and Complaints, and last reviewed 1/29/2025, the P&P indicated the purpose of the P&P was to ensure that residents, family members, and representatives know about the procedure for filing grievances and complaints to the facility or other agency or entity that hears grievances. The Facility advises residents and their representatives (including family, legal representatives and/or advocates) of their right to file grievances without discrimination or reprisal, and of the process for filing grievances or complaints. The disposition of all resident grievances and/or complaints is recorded in the Facility's Resident Grievance/Complaint Log. Duties and Obligations of Staff: - When a facility staff member overhears or receives a grievance/ complaint from a resident, a resident's representative, or another interested family member of a resident concerning the resident's medical care, treatment, food, clothing, or behavior of other residents, etc., the facility staff member is encouraged to advise the resident that the resident may file a complaint or grievance without fear of reprisal or discrimination, and will assist the resident, or person acting on the resident's behalf, in filing a written complaint with the Facility. - Facility staff will inform the resident or the person acting on the resident's behalf that he or she may file a grievance/complaint with the facility without fear of threat or any other form of reprisal. - As necessary, the facility staff will take immediate action to prevent further potential violation of resident right while the alleged violation is being investigated. 47441 2. During a review of Resident 157's Admission Record, the Admission Record indicated the facility initially admitted Resident 157 on 10/23/2024 and readmitted the resident on 1/8/2025 with diagnoses that included type two (2) diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing) with foot ulcer (a small open sore or wound), end stage renal disease (ESRD, irreversible kidney failure), and hypertensive chronic kidney disease (kidney problems that occur because of high blood pressure that is present over a long time). During a review of Resident 157's Physician Orders dated 1/8/2025, the Physician Orders indicated to provide renal diabetic diet (CCHO, renal diet) regular texture (texture with no restriction). During a review of Resident 157's MDS, dated [DATE], the MDS indicated Resident 157 understood others and made self-understood. The MDS indicated the resident required set-up or clean up assistance when eating. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/22/2025 at 10:28 a.m. with Resident 157, Resident 157 stated the food here was too salty and he was already on a special diet but the food the facility served was still too salty. Resident 157 stated he had already informed the facility regarding the salty food. During an interview on 4/22/2025 at 12:03 p.m. with [NAME] 1, [NAME] 1 stated the regular and therapeutic diets got the same roast turkey meat and the only difference was the sauce as she prepared a cranberry-ginger citrus sauce for regular diet and gravy for residents on renal and diabetic diets. During a concurrent observation and interview on 4/22/2025 at 12:54 p.m. of the test tray (a process of tasting, temping, and evaluating the quality of food) of a renal CCHO diet with the Dietary Supervisor (DS) and Assistant Supervisor (ADS), tasted the roasted turkey with gravy and it was salty. The ADS stated the renal diet should not be salty and the cook followed recipes and maybe the amount of base the cooks used made it salty. The ADS stated [NAME] 1 prepared everything for lunch. The ADS stated it was important to follow the recipe because if the food was salty the residents would not eat and enjoy their food. The DS stated renal diet should not be salty as it would be contraindicated in the diet, making them sick and retain water as a potential outcome. During an interview on 4/23/2025 at 8:46 p.m. with [NAME] 1, [NAME] 1 stated she did not follow the recipe for the gravy for the renal CCHO diet because they do not have too many residents on it. [NAME] 1 stated she just guessed the ingredients and added the juice of the turkey, flour and some seasonings. [NAME] 1 stated she did not follow the recipe of the gravy because it was not available in the recipe binder however it was important that they follow the exact recipe to ensure the food of the residents would taste good. [NAME] 1 stated the residents would not eat if the food did not taste good. During an interview on 4/23/2025 at 9:46 a.m. with the DS, the DS stated they could not find the recipe for gravies, but all the food has standardized recipes, and it was important to follow the recipes to ensure residents would get the right amount of nutrition. The DS stated [NAME] 1 did not follow the recipe for gravy and residents on renal diet could get sick by not getting proper nutrition causing malnutrition if the recipes were not accurately followed. The DS stated [NAME] 1 should not have prepared gravy as all the diets get the same sauce and the spreadsheet was confusing as it was indicating gravy. During a review of the facility's P&P titled Standardized Recipes, dated 1/29/2025, the P&P indicated To provide the dietary department with guidelines for the use of standardized recipes. Food products prepared and served by the dietary department will utilize standardized recipes. I. Standardized recipes are provided with the menu cycle. III. Standardized recipes will have adjustments or separate recipes for therapeutic and consistency modifications. IV. Recipes will have diet modifications noted. During a review of the facility's standardized recipe titled Gravies dated 2024, the recipe indicated, ingredients included salt 1 Tablespoon for 120 servings and Worcestershire sauce 3 tablespoon plus 2 1/4 tsp for 120 servings. The recipe further indicated turkey juice was not part of the ingredient. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's undated, product specification titled Turkey Breast boneless Raw Bag 15% the product specification indicated the turkey used for all the diets including renal and CCHO diets contained the following ingredients: contains up to 15% solution of turkey broth, salt, sugar, sodium phosphate. During a concurrent interview and record review on 4/24/2025 at 1:47 p.m. with the DS, the facility's resident council minutes titled Resident Council Department Response Form dated 3/28/2025 was reviewed. The minutes indicated Resident 157 was not compliant with the renal diet and would like to eat hot dogs, and salty foods. The DS stated he attended the resident council meeting and Resident 157 complained about having salty food and wanted less salty food on his tray. The DS stated he educated Resident 157 of the risk and benefits of not following the diet especially when he orders two servings of food. The DS stated he served hotdog and quesadilla to Resident 157 and notified the Registered Dietitian. The DS stated the RD came and talked to Resident 157 however, he remained non-complaint with his diet. The DS stated he did not review the menus or recipes of what was given to Resident 157. During an interview on 4/24/2025 at 4:05 p.m. with the Administrator (ADM), the ADM stated every resident has the right to express their grievances and they start the paperwork by notifying the department head responsible to talk to the resident to resolve the resident's grievance. The ADM stated Resident 157 complained about salty food sometimes but was not specific about his complaint. The ADM stated they offered alternative menus, and their resolution was Resident 157 would pick and choose from the alternative menu. ADM stated she did a lunch test tray consisting of chicken with sauce on top, and broccoli and tasted it and it was not salty. The ADM stated she did not document the test tray somewhere and did not communicate with the resident the results of the test tray. The ADM stated she should have told Resident 157 the results of the test tray and got more details about the complaints. The ADM stated Resident 157's laboratory results pertaining to dialysis would not be good would be the potential outcome for not investigating the grievance in detail. During a review of the facility's policies and procedures titled Grievance and Complaints, dated 1/29/2025, the P&P indicated, Policy: The facility advices residents and their representatives (including family, legal representatives and/or advocates) of their right to file grievances without discrimination or reprisal, and of the process for filing grievance and complaints The facility ensures that there is not retaliation for filing a grievance or complaint and ensures that there is a prompt review, investigation and response to and resolution of grievance and complaints. The disposition of all resident grievances and/or complaints is recorded in the Facility's Resident Grievance/Complaint log. II. The facility administrator is the Grievance Official responsible for overseeing the grievance process, receiving and tracking grievance through their conclusions, maintaining confidentiality of information associated with grievance as necessary and assuring written grievance decisions are provided to the residents upon requests. In the event the Administrator is not in the facility or is unavailable, he/she delegates the Grievance Official's responsibilities to the Assistant Administrator or Director of Nursing Services. 38552 (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During a review of Resident 188's Admission Record, the Admission Record indicated the facility admitted the resident on 2/27/2025 with diagnoses including congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), atrial fibrillation (an irregular heartbeat), presence of a heart assist device (mechanical pump that supports heart function and blood flow in individuals with weakened hearts), and unspecified glaucoma (an eye disease that gradually deteriorates your vision). During a review of Resident 188's History and Physical, dated 3/1/2025, the H & P indicated the resident had the capacity to make decisions. During a review of Resident 188's MDS, dated [DATE], the MDS indicated the resident had intact cognitive mental status (mental action or process of acquiring knowledge and understanding). The MDS indicated the resident required set up or clean-up assistance with activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily) included shower/bathing self, lower body dressing, putting on/taking off footwear, and personal hygiene. During a concurrent interview and record review on 4/25/2025 at 10:22 a.m. with LVN 2, Resident 188's Resident Inventory was reviewed. LVN 2 stated she should have signed the Resident Inventory Form when Resident 188 was discharged to ensure the resident's belongings were all released to the resident. LVN 2 stated when Resident 188 was discharged on [DATE], resident had complained to her about the medications he brought from home being kept in the medication room. LVN 2 stated she searched all the medication rooms and could not locate his home medications stored at the facility. LVN 2 stated she notified her Director of Nursing (DON) when it happened, and they were able to get a hold of their pharmacy to ensure he had enough medications until his next primary doctor visit. LVN 2 stated she explained to him that it was discarded, and Resident 188 was upset. LVN 2 stated the resident's medications he brought from home should have been documented in the belongings inventory, so everyone is on the same page. During a concurrent interview and record review on 4/25/2025 at 1:50 p.m. with Social Services Assistant (SSA) 1, Resident 188's Discharge Assessment, dated 4/2/2025 was reviewed. SSA 1 stated he was at the facility when Resident 188 was discharged home. SSA 1 stated the licensed nurses or charge nurses are in charge of the discharge paperwork and release of resident belongings. SSA 1 stated he was not made aware of Resident 188's complaint about his missing medications that he brought from home. SSA 1 stated if he received the complaint, he would immediately notify the DON and the Administrator to start a search and he would log it on the grievance log for tracking. SSA 1 stated for medication concerns the nursing department would be in charge. SSA 1 stated it is important to keep track because it is the resident's right and their property. During an interview on 4/25/2025 at 3:28 p.m. with the DON, the DON stated it is important that the resident's medications that he brought from home be returned to him. The DON stated she was informed of Resident 188's medications and they ordered extra supply until he visits his primary doctor. The DON stated they should have documented the plan and how to correct it and ensure the follow up steps and resolution were documented. The DON stated not documenting the resident's grievance could result in improper follow-up on the items that the resident is missing. (continued on next page)

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	055932	A. Building B. Wing	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Four Seasons Healthcare & Wellness Center, LP	5335 Laurel Canyon Blvd. North Hollywood, CA 91607

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 4/25/2025 at 4:25 p.m. with Registered Nurse (RN) 2, Resident 188's discharge notes, discharge medication list, from 3/26/2025 to 4/25/2025, was reviewed. RN 2 stated she would print out the Order Summary Report and document on it the last dose and the amount supplied to the resident. RN 2 stated Resident 188's Home Discharge Instructions should have the last dose and amount supplied. RN 2 stated the reason for indicating the last dose is to prevent the resident from double dosing, it could affect their blood pressure if they take more medications. RN 2 stated the reason for documenting the amount supplied is to ensure the resident has sufficient amount of medications to see their primary care to refill his medications. RN 2 stated especially for the coumadin medication, a blood thinner, if the resident does not get enough supply there is a potential for the resident to be hospitalized because either the resident ran out of medication or double dose. RN 2 stated it is imperative that he has enough because he takes two different doses for coumadin. RN 2 stated it is important that resident receive complete discharge instructions for safe discharge. RN 2 stated there should also be documentation on what time the resident left, who picked up the resident, and what was the resident's condition when they left. RN 2 stated this shows that the resident was picked up by the correct person/transportation, the resident's overall health status, and that the resident was stable at the time of discharge. During a review of the facility P&P titled Grievance and Complaints, and last reviewed 1/29/2025, the P&P indicated the purpose of the P&P was to ensure that residents, family members, and representatives know about the procedure for filing grievances and complaints to the facility or other agency or entity that hears grievances. The Facility advises residents and their representatives (including family, legal representatives and/or advocates) of their right to file grievances without discrimination or reprisal, and of the process of filing grievances or complaints. The disposition of all resident grievances and/or complaints is recorded in the Facility's Resident Grievance/Complaint Log. Duties and Obligations of Staff: - When a facility staff member overhears or receives a grievance/ complaint from a resident, a resident's representative, or another interested family member of a resident concerning the resident's medical care, treatment, food, clothing, or behavior of other residents, etc., the facility staff member is encouraged to advise the resident that the resident may file a complaint or grievance without fear of reprisal or discrimination, and will assist the resident, or person acting on the resident's behalf, in filing a written complaint with the Facility. - Facility staff will inform the resident or the person acting on the resident's behalf that he or she may file a grievance/complaint with the facility without fear of threat or any other form of reprisal. - As necessary, the facility staff will take immediate action to prevent further potential violation of resident right while the alleged violation is being investigated. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility P&P titled Personal Property, and last reviewed 1/29/2025, the P&P indicated the purpose of this policy is to ensure the facility takes reasonable steps to protect the resident's personal property. The P&P indicated the facility will make every effort to maintain the security of the residents' property while helping to create a home-like environment. The P&P indicated the facility will promptly investigate any complaints of misappropriation or mistreatment of resident property. The P&P indicated Upon discharge home, the resident/resident representative will review the Resident Inventory to ensure all personal items are taken. The resident/resident representative will sign the inventory indicating that all personal property is released to them. If an item(s) is missing, the staff will initiate a search and notify Social Services/designee in accordance with the Theft and Loss policy for resolution.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43988 Based on observation, interview, and record review, the facility failed to ensure residents were treated with respect and dignity including the right to be free from physical restraints (any manual method, physical or mechanical device, material or equipment that is attached or adjacent to the resident's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body) for six (6) of 6 sampled residents (Residents 16, 159, 73, 489, 97, and 72) reviewed for physical restraints care area by failing to: 1. Complete Resident 16's restraint assessment quarterly. 2. Ensure Resident 159 had a physician's order and care plan for the placement of bed against the wall. 3. Accurately complete Resident 73's restraint assessments for the use of restraint bed against the wall. 4. Ensure Resident 489's bed alarm (a pad with sensors that will alarm when a resident stands up unassisted to help prevent falls by alerting staff) had a restraint assessment. 5. Ensure Residents 97 and 52's had a restraint assessment for a bed placed against the wall. These deficient practices had the potential to result in the restriction of residents' freedom of movement, a decline in physical functioning, psychosocial harm, physical harm from entrapment (a state in which a person is trapped by the bed rail in a position that they cannot move from), and death of residents. Findings: a. During a review of Resident 16's Admission Record, the Admission Record indicated the facility originally admitted the resident on 6/5/2012 and readmitted the resident into the facility on [DATE], with diagnoses that included adult failure to thrive (a gradual decline in a person's physical and emotional well-being), dementia (a progressive state of decline in mental abilities), and generalized muscle weakness. During a review of Resident 16's Order Summary Report, the Order Summary Report indicated a physician's order dated 8/28/2024 to place a bed against the wall on the right side for safety precautions every shift. During a review of Resident 16's History and Physical (H&P), dated 8/29/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 16's Minimum Data Set (MDS, a resident assessment tool), dated 11/29/2024, the MDS indicated Resident 16 had severely impaired cognition (mental action or process of acquiring knowledge and understanding). The MDS further indicated Resident 16 had impairment on both upper extremities and required total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a review of Resident 16's fall risk evaluations, the fall risk evaluations indicated the following: - 8/27/2024: Resident 16 was not a risk for falls - 11/8/2024: Resident 16 was a risk for falls - 11/12/2024: Resident 16 was a risk for falls During a review of Resident 16's restraint assessments, the restraint assessments indicated the following: - 8/27/2024: The initial restraint assessment did not indicate the use of bed against the wall. - 2/7/2025: The annual restraint assessment indicated the use of bed against the wall on the right side as one of the recommendations for safety precaution. During a concurrent observation and interview on 4/23/2025 at 7:47 a.m. while inside Resident 16's room with Certified Nursing Assistant (CNA) 7, CNA 7 stated Resident 16's bed had always been placed against the wall for the resident's safety. CNA 7 stated Resident 16 does not move at all. During a concurrent interview and record review on 4/25/2025 at 9:30 a.m., Resident 16's physician's orders, fall risk evaluations and restraint assessments with the MDS Coordinator (MDSC) were reviewed. The MDSC stated that Resident 16 had a physician's order to place the bed against the wall. The MDSC stated Resident 16's initial restraint assessment did not indicate a recommendation to place the bed against the wall and that the quarterly assessment for 11/2024 was not completed per facility policy. The MDSC stated restraint assessments are done quarterly. The MDSC stated Resident 16's restraint assessment for the continued use of the bed against the wall should have been done quarterly per the facility policy to evaluate the appropriateness of the continued use of having the bed placed against the wall. During an interview on 4/25/2025 at 2 p.m. with the Director of Nursing (DON), the DON stated restraint assessments are completed prior to initiation of the restraint, quarterly, annually, and as needed to ensure the use of any restraint on a resident was appropriate and the least restrictive interventions have been attempted. The DON stated Resident 16's quarterly assessment for the restraint assessment should have been completed for 11/2024 to ensure the continued use of the bed against the wall for the resident was appropriate for the resident or if the restraint should have been discontinued as it had the potential for unnecessary use of the restraint and restricts Resident 16's freedom of movement. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's recent policy and procedure (P&P) titled Restraints, last reviewed on 1/29/2025, the P&P indicated the facility honors the resident's right to be free from any restraints that are imposed for reasons other than that of treatment of the resident's medical symptoms. The P&P further indicated: - Restraints require a physician order and are used as a last resort to be used only when deemed necessary by the Interdisciplinary Team (IDT - a group of health professionals from different disciplines who collaborate to provide patient-centered care), and in accordance with the resident's assessment and plan of care. - If restraints are used, the facility complies with all applicable laws and regulations. The least restrictive alternative is used for the least amount of time, and only under carefully monitored circumstances. Every attempt will be made to avoid a decline in the resident's physical functioning. - Once decision has been reached to use a restraint, a Licensed Nurse will complete the Physical Restraint-Assessment form and will be included in the resident's medical record. - Continued need for physical restraints will be reassessed at least quarterly by the IDT to consider elimination of restraints, less frequent use of restraints, or a less restrictive device whenever possible. b. During a review of Resident 159's Admission Record, the Admission Record indicated the facility originally admitted the resident on 10/18/2024 and readmitted the resident into the facility on [DATE] with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness of the arm, leg, and trunk on the same side of the body) following cerebral infarction (also known as stroke, loss of blood flow to a part of the brain) affecting left non-dominant side, type two (2) diabetes mellitus (DM 2-a disorder characterized by difficulty in blood sugar control and poor wound healing), and anxiety disorder (a mental health condition where excessive fear and worry interfere with daily life, causing significant distress). During a review of Resident 159's History and Physical (H&P) dated 3/11/2025, the H&P indicated Resident 159 did not have the capacity to understand and make decisions. During a review of Resident 159's Minimum Data Set (MDS, a resident assessment tool), dated 1/24/2025, the MDS indicated Resident 159 had severely impaired cognition (mental action or process of acquiring knowledge and understanding). The MDS further indicated Resident 159 had impairment on one side of the upper and lower extremity and required total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 159 received insulin. During a review of Resident 159's Order Summary Report dated 4/25/2025, the Order Summary Report did not indicate a physician's order for the use of a bed placed against the wall. During a review of Resident 159's care plan (CP) for risk for falls, dated 2/8/2025, the CP did not indicate the use of a bed placed against the wall for Resident 159. During a review of Resident 159's fall risk evaluations dated 1/23/2025, 2/7/2025, and 3/10/2025, the fall risk evaluations indicated Resident 159 was a risk for falls. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 159's initial restraint assessment dated [DATE], the initial restraint assessment did not indicate a recommendation for placement of the bed against the wall. During a concurrent observation and interview on 4/23/2025 at 7:47 a.m. while inside Resident 159's room with Certified Nursing Assistant (CNA) 7, CNA 7 stated Resident` 159's bed had always been placed against the wall for the resident's safety. CNA 7 further stated Resident 159 does not move at all. During a concurrent interview and record review on 4/25/2025 at 9:30 a.m., Resident 159's physician's orders, fall risk evaluations, restraint assessments, and CP was reviewed with the MDS Coordinator (MDSC). The MDSC stated that Resident 159 did not have a physician's order, or a CP initiated for the bed to be placed against the wall. The MDSC stated Resident 159's initial restraint assessment dated [DATE] did not indicate a recommendation to place the bed against the wall. The MDSC stated if a restraint needed to be used on a resident, an initial assessment should be completed to indicate the least restrictive measures attempted and indicate in the recommendation the type of restraint to be utilized for the resident's safety, obtain a physician's order and informed consent, and initiate a CP. The MDSC stated the licensed nurses should have obtained a physician's order so the physician would be aware of the current plan of care and a CP should have been initiated for the use of bed against the wall for Resident 159. The MDSC stated the purpose of a CP is to ensure the proper interventions are being implemented for the resident's safety. During an interview on 4/25/2025 at 2 p.m. with the Director of Nursing (DON), the DON stated physician's order, informed consent, CP, and restraint assessments are completed prior to initiation of the restraint to ensure the use of any restraint on a resident was appropriate, the least restrictive interventions have been attempted, and the proper interventions are being implemented for the residents. The DON stated the purpose of physician's order was so the physician would be aware of the resident's current plan of care so the informed consent can be obtained from the resident representative. The DON stated not obtaining a physician's order and initiating a CP placed Resident 159 at risk for unnecessary use of the restraint and restricting the resident's freedom of movement. During a review of the facility's recent policy and procedure (P&P) titled Restraints, last reviewed on 1/29/2025, the P&P indicated the facility honors the resident's right to be free from any restraints that are imposed for reasons other than that of treatment of the resident's medical symptoms. The P&P further indicated: - Restraints require a physician order and are used as a last resort to be used only when deemed necessary by the Interdisciplinary Team (IDT - a group of health professionals from different disciplines who collaborate to provide patient-centered care), and in accordance with the resident's assessment and plan of care. - If restraints are used, the facility complies with all applicable laws and regulations. The least restrictive alternative is used for the least amount of time, and only under carefully monitored circumstances. Every attempt will be made to avoid a decline in the resident's physical functioning. - Once decision has been reached to use a restraint, a Licensed Nurse will complete the Physical Restraint-Assessment form and will be included in the resident's medical record. - Restraint order from the Attending Physician: (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 4/25/2025 at 9:30 a.m., Resident 73's physician's orders, fall risk evaluations, and restraint assessments were reviewed with the MDS Coordinator (MDSC). The MDSC stated that Resident 73's restraint assessments for 8/6/2024, 11/4/2024, and 2/3/2025 were not completed accurately to reflect that the resident had a restraint for bed placed against the wall on the left. The MDSC stated Resident 73 had hemiplegia on the right side of the body and placing the bed against the wall on the left side was restricting resident's freedom of movement from the side that is not affected. The MDSC stated restraint assessments should be completed accurately to reflect the current interventions or recommendations for resident's safety and to make sure the recommendations/interventions remained appropriate for the resident. The MDSC stated Resident 73's restraint assessments should have been completed accurately to make sure the recommendations/interventions remained appropriate for the resident as it placed Resident 73 at risk for restricting his freedom of movement. During an interview on 4/25/2025 at 2 p.m. with the Director of Nursing (DON), the DON stated restraint assessments should be completed accurately to reflect the current interventions or recommendations for resident's safety and to make sure the recommendations/interventions remained appropriate for the resident. The DON stated Resident 73's restraint assessments should have been completed accurately for the IDT to evaluate and make sure the recommendations/interventions remained appropriate for the resident. The DON stated not completing the assessments accurately placed the resident at risk for restrictions of his freedom of movement. During a review of the facility's recent policy and procedure (P&P) titled Restraints, last reviewed on 1/29/2025, the P&P indicated the facility honors the resident's right to be free from any restraints that are imposed for reasons other than that of treatment of the resident's medical symptoms. The P&P further indicated: - Restraints require a physician order and are used as a last resort to be used only when deemed necessary by the Interdisciplinary Team (IDT - a group of health professionals from different disciplines who collaborate to provide patient-centered care), and in accordance with the resident's assessment and plan of care. - If restraints are used, the facility complies with all applicable laws and regulations. The least restrictive alternative is used for the least amount of time, and only under carefully monitored circumstances. Every attempt will be made to avoid a decline in the resident's physical functioning. - Once decision has been reached to use a restraint, a Licensed Nurse will complete the Physical Restraint-Assessment form and will be included in the resident's medical record. - Continued need for physical restraints will be reassessed at least quarterly by the IDT to consider elimination of restraints, less frequent use of restraints, or a less restrictive device whenever possible. 44376 d. During a review of Resident 489's Admission Record, the Admission Record indicated the facility admitted the resident on 4/17/2025, with diagnoses including dementia (a progressive state of decline in mental abilities), muscle weakness, and difficulty walking. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 489's Fall Risk Evaluation, dated 4/17/2025, the Fall Risk Assessment indicated the resident was at risk for falls. During a review of Resident 489's Restraint- Physical (Initial Evaluation), dated 4/17/2025, the Restraint-Physical indicated the resident had bilateral padded upper half side rails (bars attached to the sides of a bed) up when in bed for activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily) changes only. The Restraint- Physical did not include bed alarm in the assessment. During a review of Resident 489's Order Summary Report, dated 4/18/2025, the Order Summary Report indicated an order of may have bed alarm to reduce risk of injury every shift. During a review of Resident 489's History and Physical (H&P), dated 4/19/2025, the H&P indicated the resident was unable to make decisions. During a concurrent observation and interview on 4/24/2025, at 7:48 a.m., with Director of Staff Development (DSD) 1, while inside Resident 489's room, Resident 489 was observed with a bed alarm on. DSD 1 stated the bed alarm was placed to prevent falls on the resident. DSD 1 stated the bed alarm will let the staff know if the resident is getting out of bed without assistance. During a concurrent interview and record review on 4/24/2025, at 7:57 a.m., with Registered Nurse (RN) 3, reviewed Resident 489's Order Summary Report, Consents, Restraint Assessment, and Care Plan. RN 3 stated there was no assessment of restraint bed alarm on the resident. RN 3 stated the restraint assessment is done on admission, quarterly and annually to ensure the restraint is still needed and safe to use. During an interview on 4/25/2025, at 12:37 p.m., with the Director of Nursing (DON), the DON stated there should be a restraint assessment for the use of Resident 489's bed alarm. The DON stated the restraint assessment is done on admission, quarterly, and annually and it serves as the evaluation points to which they determine if the restraint is still needed or another least restrictive restraint that can be appropriate for the resident. The DON stated their ultimate goal for residents will be to not have any form of restraints. During a review of the facility's recent policy and procedure (P&P) titled Restraints, last reviewed on 1/29/2025, the P&P indicated the facility honors the resident's right to be free from any restraints that are imposed for reasons other than that of treatment of the resident's medical symptoms. Restraints require a physician order and are used as a last resort to be used only when deemed necessary by the Interdisciplinary Team (IDT, a group of health care professionals with various areas of expertise who work together toward the goals of their clients), and in accordance with the resident's assessment and Plan of Care. Continued need for physical restraints will be reassessed at least quarterly by the IDT. During a review of the facility's recent P&P titled Resident Rooms and Environment, last reviewed 1/29/2025, the P&P indicated to provide residents with a safe, clean, comfortable and homelike environment. (continued on next page)

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	055932	A. Building B. Wing	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Four Seasons Healthcare & Wellness Center, LP	5335 Laurel Canyon Blvd. North Hollywood, CA 91607

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	e. During a review of Resident 97's Admission Record, the Admission Record indicated the facility admitted the resident on 5/25/2022, and readmitted the resident on 10/8/2023, with diagnoses including disorders of brain, alcohol abuse, and cocaine abuse. During a review of Resident 97's H&P, dated 10/3/2023, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 97's Minimum Data Set (MDS, a resident assessment tool), dated 1/16/2025, the MDS indicated the resident had the ability to make self-understood and understand others and had impaired vision. The MDS indicated the resident had intact cognition (a participant who has sufficient judgment, planning, organization, self-control, and the persistence needed to manage the normal demands of the participant's environment) and uses a walker (a type of mobility device that can help residents get around) to ambulate. During a review of Resident 97's Fall Risk Evaluation, dated 3/5/2025, the resident was not at risk for falls. During a review of Resident 97's Change in Condition Evaluation, dated 3/5/2025, the Change in Condition Evaluation indicated at 7:30 p.m., the resident had a fall without injury, resident seen walking in the hallway with walker and suddenly fell to his back. During a review of Resident 97's Order Summary Report, dated 3/7/2025, the Order Summary Report indicated an order to place the bed against the wall on the left side per the resident's preference. During a review of Resident 97's Care Plan (CP) Report regarding the resident needing to wear a helmet at all times for safety secondary to absence of frontal skull due to trauma, with history of fall, last revised on 2/2/2025, the CP indicated an intervention to maintain a safe environment and report any incident of falls/injury. During a concurrent observation and interview on 4/24/2025, at 7:50 a.m., with Director of Staff Development (DSD) 1, while inside Resident 97's room, Resident 97's bed was placed against the wall on the left side of the bed. DSD 1 stated placing the bed against the wall is a restraint since they are limiting the way the resident exits the bed; the resident can exit only on one side of the bed. DSD 1 stated it was the resident's preference, but they still need to get a physician's order, an informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered), a restraint assessment, and develop and implement a care plan on its use. During a concurrent interview and record review on 4/24/2025, at 8:09 a.m., with RN 3, reviewed Resident 97's Order Summary Report, Consents, Restraint Assessment, and Care Plan. RN 3 stated there was no quarterly assessment for the use of restraint as a bed to be placed against the wall on the resident's electronic chart. RN 3 stated it was important to assess the restraint bed placed against the wall quarterly to evaluate the effectiveness of the restraints and if a least restraining effort can be applied to the resident. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/25/2025, at 12:37 p.m., with the DON, the DON stated there should be a restraint assessment for the use of Resident 97's bed being placed against the wall. The DON stated the restraint assessment is done on admission, quarterly, and annually and it serves as the evaluation points to which they determine if the restraint is still needed or another least restrictive restraint that can be appropriate for the resident. The DON stated their ultimate goal for residents will be to not have any form of restraints. During a review of the facility's recent P&P titled Restraints, last reviewed on 1/29/2025, the P&P indicated the facility honors the resident's right to be free from any restraints that are imposed for reasons other than that of treatment of the resident's medical symptoms. Restraints require a physician order and are used as a last resort to be used only when deemed necessary by the Interdisciplinary Team (IDT), and in accordance with the resident's assessment and Plan of Care. Continued need for physical restraints will be reassessed at least quarterly by the IDT. During a review of the facility's recent P&P titled Resident Rooms and Environment, last reviewed 1/29/2025, the P&P indicated to provide residents with a safe, clean, comfortable and homelike environment. f. During a review of Resident 52's Admission Record, the Admission Record indicated the facility admitted the resident on 4/6/2018, and readmitted the resident on 2/2/2023, with diagnoses including muscle weakness, convulsions (a medical condition where the body muscles contract and relax rapidly and repeatedly, resulting in uncontrolled shaking), and glaucoma (condition where eye pressure builds up, damaging the optic nerve, which connects the eye to the brain). During a review of Resident 52's Order Summary Report, dated 12/4/2023, the Order Summary Report indicated an order of bed against the wall on the right side for safety. Every shift. During a review of Resident 52's Fall Risk Evaluation, dated 8/9/2024, the Fall Risk Evaluation indicated the resident was at risk for falls. During a review of Resident 52's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had moderate cognitive impairment (more pronounced deficits emerge, interfering with daily activities). The MDS indicated the resident needed substantial assistance to set up, mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 52's H&P, dated 3/29/2025, the H&P indicated the resident was unable to make decisions. During a review of Resident 52's Care Plan (CP) Report titled Risk for Falls, initiated on 3/28/2025, the CP included an intervention that if resident is a fall risk, initiate fall risk precautions. During a concurrent observation and interview on 4/24/2025, at 8:15 a.m., with DSD 1, while inside Resident 52's room, Resident 97's bed was placed against the wall on the right side of the bed. DSD 1 stated placing the bed against the wall is a restraint since they are limiting the way the resident exits the bed; the resident can exit only on one side of the bed. DSD 1 stated it was the resident's preference, but they still need to get a physician's order, an informed consent, a restraint assessment, and develop and implement a care plan on its use. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 4/24/2025, at 8:19 a.m., with RN 3, Resident 52's Physicians Summary Report Order, Consents, Restraint Assessment, and Care Plan were reviewed. RN 3 stated there was no assessment for the use of a restraint bed being placed against the wall on the resident's electronic chart. RN 3 stated it was important to assess the restraint bed placed against the wall quarterly to evaluate the effectiveness of the restraints and determine if if a least restraining effort can be applied to the resident. During an interview on 4/25/2025, at 12:37 p.m., with the DON, the DON stated there should be a restraint assessment for the use of Resident 52's bed being placed against the wall. The DON stated the restraint assessment is done on admission, quarterly, and annually and it serves as the evaluation points to which they determine if the restraint is still needed or another least restrictive restraint can be appropriate for the resident. The DON stated their ultimate goal for residents will be to not have any form of restraints. During a review of the facility's recent P&P titled Restraints, last reviewed on 1/29/2025, the P&P indicated the facility honors the resident's right to be free from any restraints that are imposed for reasons other than that of treatment of the resident's medical symptoms. Restraints require a physician order and are used as a last resort to be used only when deemed necessary by the Interdisciplinary Team (IDT), and in accordance with the resident's assessment and Plan of Care. Continued need for physical restraints will be reassessed at least quarterly by the IDT. During a review of the facility's recent P&P titled Resident Rooms and Environment, last reviewed 1/29/2025, the P&P indicated to provide residents with a safe, clean, comfortable and homelike environment.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 44376 Based on interview and record review, the facility failed to develop and implement a baseline care plan for each resident for one of six sampled residents (Resident 489) reviewed for physical restraints (any manual method, physical or mechanical device, material or equipment that is attached or adjacent to the resident's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body) on the use of side rails (bars attached to the sides of a bed) and bed alarms (a pad with sensors that will alarm when a resident stands up unassisted to help prevent falls by alerting staff). The deficient practice had the potential for delay in the provision of essential healthcare services affecting the resident's well-being. Findings: During a review of Resident 489's Admission Record, the Admission Record indicated the facility admitted the resident on 4/17/2025, with diagnoses that included epileptic seizures (abnormal electrical brain activity, kind of like an electrical storm inside the head), dementia (a progressive state of decline in mental abilities), and muscle weakness. During a review of Resident 489's History and Physical (H&P), dated 4/19/2025, the H&P indicated the resident was unable to make decisions. During a review of Resident 489's Order Summary Report, the Order Summary Report indicated the following physician's orders dated: 4/17/2025 - Bilateral padded upper half side rails up when in bed for activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily) changes, mobility and positioning secondary to generalized muscle weakness with diagnosis (dx) of hypertension (HTN, elevated blood pressure) every shift. 4/18/2025 May have bed alarm to reduce risk of injury. Every shift. During a review of Resident 489's Fall Risk Evaluation, dated 4/17/2025, the Fall Risk Evaluation indicated the resident was high risk for falls. During a review of Resident 489's Restraint-Physical (Initial Evaluation), dated 4/17/2025, the Restraint-Physical (Initial Evaluation) indicated the device bilateral padded upper half side rails up when in bed for ADL changes, mobility and positioning secondary to generalized muscle weakness with dx of HTN. During a review of Resident 489's Care Plan (CP) Report regarding Resident 489's risk for decreased functional mobility without physical therapy (PT) intervention, falls, and increased deconditioning, initiated on 4/18/2025, the CP goal indicated the resident will perform safe transfers and ambulation activities using appropriate devices. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 4/24/2025, at 7:48 a.m., with Director of Staff Development (DSD) 1, inside Resident 489's room, observed Resident 489 had a bed/pad alarm on the bed. DSD 1 stated the bed/pad alarm is for fall prevention so they (facility staff) would know if the resident was getting out of bed unassisted. During a concurrent interview and record review on 4/24/2025, at 7:57 a.m., with DSD 1, reviewed Resident 489's Order Summary Report, Consents, Restraint Assessment, and Care Plans. DSD 1 stated there was no baseline care plan on the use of restraints side rails and bed/pad alarm on the resident. DSD 1 stated the care plan is important to communicate all interventions to the interdisciplinary team to standardize the care and improve outcomes. During an interview on 4/25/2025, at 12:37 p.m., with the Director of Nursing (DON), the DON stated Resident 489 should have a baseline care plan on the use of side rails and bed/pad alarm to ensure safe use of the restraints. The DON stated the baseline care plan should have been developed and implemented within 48 hours on admission on the use of side rails and bed/pad alarms. During a review of the facility's recent policy and procedure (P&P) titled Side Rails, last reviewed on 1/29/2025, the P&P indicated to ensure the safe use of side rails as an assistive device, to aid mobility, or to treat medical symptoms. The Licensed Nurse will maintain the Side Rail Evaluation in the resident's medical record and develop a Care Plan reflecting that assessment. During a review of the facility's recent P&P titled Restraints, last reviewed on 1/29/2025, the P&P indicated the facility honors the resident's right to be free from any restraints that are imposed for reasons other than that of treatment of the resident's medical symptoms. Restraints require a physician order and are used as a last resort to be used only when deemed necessary by the Interdisciplinary Team (IDT), and in accordance with the resident's assessment and Plan of Care. During a review of the facility's recent P&P titled Comprehensive Person-Centered Care Planning, last reviewed on 1/29/2025, the P&P indicated the baseline care plan summary will be developed and implemented, using the necessary combination of problem specific care plans, within 48 hours of the resident's admission. It will include, at minimum, the following information necessary on each care plan to properly care for a resident: i. Initial goals based on the admission orders ii. Physician orders iii. Dietary orders iv. Physician services v. Social services vi. PASRR recommendations, if applicable

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44376 Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan (is a tool that ensures residents receive personalized, comprehensive, and goal-oriented care in a nursing home setting) for: 1. Two of four sampled residents (Residents 489 and 42) reviewed for mood/behavior by failing to develop and implement a care plan on the use of antidepressants (Trazadone and Alprazolam, prescription medicines to treat depression). 2. One of two sampled residents (Resident 10) reviewed for antibiotic use by failing to develop and implement a care plan on the use of Cefepime HCl. 3. One of one sampled resident (Resident 152) reviewed under the Respiratory Care area by failing to develop and implement resident specific Care Plans (CP - a document outlining a detailed approach to care customized to an individual resident's need) for the use of continuous positive airway pressure (CPAP - a breathing machine designed to increase air pressure, keeping the airway open when the person breathes in) These deficient practices had the potential to result in delays in the delivery of necessary care and services and miscommunication among healthcare providers. Findings: 1. During a review of Resident 489's Admission Record, the Admission Record indicated the facility admitted the resident on 4/17/2025, with diagnoses including dementia (a progressive state of decline in mental abilities), unspecified symbolic dysfunctions (a range of disorders affecting the ability to recognize, process, and use symbols, including language, visual images, and objects), and schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). During a review of Resident 489's History and Physical (H&P), dated 4/19/2025, the H&P indicated the resident was unable to make decisions. During a review of Resident 489's Order Summary Report, dated 4/17/2025, the Order Summary Report indicated an order of trazadone HCl oral tablet 50 milligrams (mg, a unit of weight) (Trazadone HCl). Give 1 tablet by mouth at bedtime for depression monitor for behavior (m/b) poor sleep pattern. During a concurrent interview and record review on 4/24/2025, at 8:29 a.m., with Registered Nurse (RN) 3, Resident 489's Order Summary Report, Medication Administration Record (MAR), and Care Plans were reviewed. RN 3 stated there was no care plan developed and implemented for the use of trazadone on Resident 489. RN 3 stated it was important to develop and implement a care plan on the use of trazadone to ensure the safe use of the medication. RN 3 stated care plans serve as a communication tool to ensure standardized care is provided to the resident and to measure the effectiveness of interventions set for the resident. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/25/2025, at 12:37 p.m., with the Director of Nursing (DON), the DON stated the staff should have developed and implemented a care plan for the use of trazadone on Resident 489 to ensure the safe use of the medication. The DON stated the care plan should be communicated to the interdisciplinary team, the resident, and the resident representative to ensure everybody is on the same page and the care provided to the resident is appropriate and necessary for the resident's health and well-being. During a review of the facility's recent policy and procedure (P&P) titled Comprehensive Person-Centered Care Planning, last reviewed on 1/29/2025, the P&P indicated within 7 days from the completion of the comprehensive MDS assessment, the comprehensive care plan will be developed. All goals, objectives, interventions, etc. from the current baseline care plan will be included in the resident's comprehensive care plan. During a review of the facility's recent P&P titled Behavior/Psychoactive Drug Management, last reviewed on 1/29/2025, the P&P indicated the facility will provide person-centered, comprehensive, and interdisciplinary care that reflects best practice standards for meeting health, safety, psychosocial, behavioral, and environmental needs of residents. Any Psychoactive Medication ordered on an if needed (prn) basis, must be ordered not to exceed 14 days. If the physician feels the medication needs to be continued, he/she must document the reasons for the continued usage and write the order for the medication; not to exceed a 90-day time frame. 2. During a review of Resident 42's Admission Record, the Admission Record indicated the facility admitted the resident on 3/18/2025, with diagnoses including encephalopathy (refers to a general term for brain disease, damage, or malfunction), unspecified symbolic dysfunctions, and dementia. During a review of Resident 42's H&P, dated 3/19/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 42's Minimum Data Set (MDS, a resident assessment tool), dated 3/25/2025, the MDS indicated the resident sometimes had the ability to make self-understood and understand others and had severe cognitive impairment (a person has a significant problem with their ability to think, learn, remember, and make decisions). During a review of Resident 42's Order Summary Report, dated 4/10/2025, the Order Summary Report indicated an order to administer alprazolam oral tablet 0.25 mg (Alprazolam) one tablet by mouth every eight hours as needed for anxiety m/b inability to relax. During a concurrent interview and record review on 4/24/2025, at 9:22 a.m., with RN 3, Resident 42's Order Summary Report, MAR, and Care Plans were reviewed. RN 3 stated there was no care plan developed and implemented for the use of alprazolam on resident 42. RN 3 stated a care plan should have been developed and implemented for the use of alprazolam to ensure its safe use. RN 3 stated the care plan can standardize the care provided to the resident by outlining specific interventions to implement care on the resident such as monitoring for adverse effect (an undesired effect of a drug or other type of treatment, such as surgery) of the drug and drug regimen review (a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences associated with medication). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/25/2025, at 12:37 p.m., with the DON, the DON stated the staff should have developed and implemented a care plan for the use of alprazolam on Resident 42 to ensure the safe use of the medication. The DON stated the care plan should be communicated to the interdisciplinary team, the resident, and the resident representative to ensure everybody is on the same page and the care provided to the resident is appropriate and necessary for the resident's health and well-being. During a review of the facility's recent P&P titled Comprehensive Person-Centered Care Planning, last reviewed on 1/29/2025, the P&P indicated within 7 days from the completion of the comprehensive MDS assessment, the comprehensive care plan will be developed. All goals, objectives, interventions, etc. from the current baseline care plan will be included in the resident's comprehensive care plan. During a review of the facility's recent P&P titled Behavior/Psychoactive Drug Management, last reviewed on 1/29/2025, the P&P indicated the facility will provide person-centered, comprehensive, and interdisciplinary care that reflects best practice standards for meeting health, safety, psychosocial, behavioral, and environmental needs of residents. Any Psychoactive Medication ordered on a prn basis, must be ordered not to exceed 14 days. If the physician feels the medication needs to be continued, he/she must document the reasons for the continued usage and write the order for the medication; not to exceed a 90-day time frame. 44244 3. During a review of Resident 10's Admission Record, the Admission Record indicated the facility admitted the resident on 12/30/2024, with diagnoses including local infection of the skin and subcutaneous tissue (the layer of tissue that underlies the skin) and type 2 diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing with other skin ulcer (open sores caused by poor blood circulation). During a review of Resident 10's H&P, dated 12/30/2024, the H&P indicated the resident is alert, oriented to person, place, and time, and communicated clearly without evidence of cognitive impairment or language barrier. During a review of Resident 10's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (a participant who has sufficient judgment, planning, organization, self-control, and the persistence needed to manage the normal demands of the participant's environment). During a review of Resident 10's Order Summary Report, dated 4/16/2025, the Order Summary Report indicated an order of Cefepime HCl intravenous solution reconstituted 2 grams (gm, a unit of weight) (Cefepime HCl). Use one dose intravenously (within a vein) one time a day for osteomyelitis (an infection in a bone) for 14 days. During a concurrent interview and record review on 4/24/2025, at 8:38 a.m., with RN 3, Resident 10's Order Summary Report and Care Plans were reviewed. RN 3 stated there was a care plan for the use of intravenous (IV) antibiotic Cefepime, but it was just created today 4/24/2025. RN 3 was aware that on 4/22/2025 during an initial chart review the care plan was not there, and it was placed after the fact when it was brought up to their attention. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/25/2025, at 12:37 p.m., with the DON, the DON stated the staff should have developed and implemented a care plan for the use of Cefepime for Resident 10 to ensure the safe use of the medication. The DON stated the care plan should be communicated to the interdisciplinary team, the resident, and the resident representative to ensure everybody is on the same page and the care provided to the resident is appropriate and necessary for the resident's health and well-being. During a review of the facility's recent P&P titled Comprehensive Person-Centered Care Planning, last reviewed on 1/29/2025, the P&P indicated within 7 days from the completion of the comprehensive MDS assessment, the comprehensive care plan will be developed. All goals, objectives, interventions, etc. from the current baseline care plan will be included in the resident's comprehensive care plan. 4. During a review of Resident 152's Admission Record, the Admission Record indicated the facility admitted the resident on 7/23/2024, with diagnoses including paraplegia (loss of movement and/or sensation, to some degree, of the legs), morbid obesity (a serious health condition that results from an abnormally high body mass), obstructive sleep apnea (a sleep-related breathing disorder), and chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing). During a review of Resident 152's Minimum Data Set (MDS, a resident assessment tool), dated 1/27/2025, the MDS indicated the resident had the ability to make self-understood and the ability to understand others. The MDS further indicated the resident was dependent on staff for toileting, bathing, dressing, and transfers from the bed to chair. The MDS indicated that the resident required substantial/maximal assistance with personal hygiene and partial assistance with eating and oral hygiene. During a review of Resident 152's Order Summary Report, dated 4/24/2025, the Order Summary Report indicated orders for the following: - CPAP: pressure 10 centimeters of water (cm H2O, a measurement of pressure). change filter every two weeks and as needed if soiled, every night shift for sleep apnea, dated 3/10/2025. During an observation on 4/24/2025 at 9:36 a.m., observed Resident 152 sleeping in bed. A CPAP was observed at bedside. During a concurrent interview and record review on 4/24/2025 at 9:38 a.m., Licensed Vocational Nurse (LVN) 2 reviewed Resident 152's physician orders and CPs. LVN 2 stated CPs are developed at admission and as needed to coordinate and communicate to the interdisciplinary staff the residents plan of care. LVN 2 stated Resident 152 has a history of sleep apnea and has used a CPAP since admission to the facility, but the resident is not always compliant with CPAP administration. LVN 2 stated Resident 152 should have a CP regarding sleep apnea and the CPAP administration. LVN 2 stated Resident 152's CP should include interventions regarding CPAP refusal like encouraging the use of the CPAP, education regarding refusal, and notification of the physician when the resident refused. LVN 2 reviewed Resident 152's CPs and stated there was no documented evidence that Resident 152 had a CP developed for the CPAP. LVN 2 stated when Resident 152 did not have a CP for CPAP use and noncompliance there was the potential that the resident's refusal would result in respiratory issues while sleeping and potentially heart issues because there was no plan of care developed for staff to follow for the use and refusal of the CPAP. (continued on next page)

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Four Seasons Healthcare & Wellness Center, LP	5335 Laurel Canyon Blvd. North Hollywood, CA 91607

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 4/25/2025 at 9:08 a.m., with the Director of Nursing (DON), the DON reviewed the facility policy and procedure regarding CPs. The DON stated CPs are used to address the specific needs of each resident. The DON stated the CP focuses on a resident problem with a goal and interventions to reach the goal in a specific timeframe. The DON stated Resident 152 was admitted with a CPAP and a CP regarding the CPAP and sleep apnea should have been developed and implemented at admission but was not. The DON stated the facility policy was not followed when Resident 152 did not have a CP for CPAP administration. During a review of the facility P&P titled, Comprehensive Person - Centered Care Planning, last reviewed 1/29/2035, the P&P indicated the Baseline Care Plan Summary will be developed and implemented using the necessary combination of problem specific care plans, within 48 hours of the resident's admission. The baseline care plan must reflect the resident's stated goals and objectives and include interventions that address his or her needs. All goals, objectives, interventions, etc. from the baseline care plan will be included in the resident's comprehensive care plan. Additional changes or updates to the resident's comprehensive care plan will be made based on the assessed needs of the resident. The comprehensive care plan will be periodically reviewed and revised by the interdisciplinary team. In addition, the comprehensive care plan will also be reviewed and revised at the following times: i. Onset of new problems; ii. Change of condition; iii. In preparation for discharge; iv. To address changes in behavior and care; and v. Other times as appropriate or necessary.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44376 Based on interview and record review, the facility failed to provide care in accordance with professional standards to three of three sampled residents (Residents 52, 390, and 159) reviewed for insulin (a hormone that lowers the level of glucose [a type of sugar] in the blood) by failing to rotate (a method to ensure repeated injections are not administered in the same area) subcutaneous (beneath the skin) insulin administration sites. The deficient practice had the potential for adverse effect (unwanted, unintended result) of same site subcutaneous administration of insulin such as excessive bruising, lipodystrophy (abnormal distribution of fat) and cutaneous amyloidosis (is a condition in which clumps of abnormal proteins called amyloids build up in the skin). Cross reference F760 Findings: 1. During a review of Resident 52's Admission Record, the Admission Record indicated the facility admitted the resident on 4/6/2018, and readmitted the resident on 2/2/2023, with diagnoses including type 2 diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), long term use of insulin, and metabolic encephalopathy (a change in how your brain works due to an underlying condition). During a review of Resident 52's History and Physical (H&P), dated 3/29/2025, the H&P indicated the resident was unable to make decisions. During a review of Resident 52's Minimum Data Set (MDS, a resident assessment tool), dated 2/7/2025, the MDS indicated the resident had the ability to make self-understood and understand others and had moderate cognitive impairment (more pronounced deficits emerge, interfering with daily activities). The MDS indicated the resident was on a high-risk drug class hypoglycemic (agents that lower glucose levels in the blood) medication. During a review of Resident 52's Order Summary Report, the Order Summary Report indicatedthe following physician orders dated: 4/5/2025 - Insulin glargine solution 100 unit per milliliter (unit/ml, a milliliter is a unit of fluid volume equal to one-thousandth of a liter). Inject 5 units subcutaneously at bedtime for DM, rotate sites. Hold (do not administer) if blood sugar (BS) less than (<)100 milligrams per deciliter (mg/dL, a milligram is one-thousandth of a gram). (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3/28/2025 - Humulin R (a short acting insulin) injection solution 100 unit/ml (Insulin Regular [Human]). Inject as per sliding scale (increasing administration of the pre?meal insulin dose based on the blood sugar level before the meal): if 70-130=0; 131-180=4; 181-240=8; 241-300=10; 301-350=12; 351-400=14. Notify the resident's physician (MD) if BS <70 or greater than (>) 400, subcutaneously one time a day every Monday, Wednesday, Friday for diabetes mellitus. Finger stick blood sugar (a method of drawing drops of blood for at-home medical tests) using test strips (small, plastic strips used with a meter to measure the amount of sugar [glucose] in the blood) and lancets (finger-stick blood samplers) with diagnosis of diabetes mellitus. During a review of Resident 52's Location of Administration Report of insulin for 2/2025 to 4/2025, the Location of Administration of insulin indicated that: Insulin Glargine Solution 100 unit/ml was administered on: 2/21/2025 at 10:15 p.m. at the Arm-left 2/22/2025 at 11:45 p.m. at the Arm-left 3/29/2025 at 10:51 p.m. at the Abdomen-Right Lower Quadrant (RLQ) 3/30/2025 at 9:12 a.m. at the Abdomen-RLQ Humulin R injection R injection solution 100 unit/ml was administered on: 4/5/2025 at 6:09 a.m. at the Arm-left 4/5/2025 at 9:59 a.m. at the Arm-left 4/17/2025 at 11:59 a.m. at the Arm-left 4/18/2025 at 5:34 p.m. at the Arm-left During a concurrent interview and record review on 4/24/2025, at 9:36 a.m., with Registered Nurse (RN) 3, reviewed Resident 52's Order Summary Report, Location of Administration Report, and Care Plan. RN 3 stated there were multiple instances that the licensed staff did not rotate the insulin administration sites on Resident 52 from 2/2025 to 4/2025 on the Location of Administration Report for insulin. RN 3 stated the sites of administration should be rotated to prevent lipodystrophy on residents. RN 3 stated injecting insulin on sites with lipodystrophy will affect its absorption (the passage of a drug from its site of administration into the systemic circulation) causing hypoglycemia (low blood sugar levels in the blood)/hyperglycemia (high blood sugar levels in the blood). During an interview on 4/25/2025, at 12:37 p.m., with the Director of Nursing (DON), the DON stated licensed staff should have rotated the sites of insulin administration of Resident 52 to prevent lipodystrophy. The DON stated injecting medications on the same site where lipodystrophy occurred decreases the absorption of the medication. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's recent policy and procedures (P&P) titled Subcutaneous Injection, last reviewed on 1/29/2025, the P&P indicated medications are administered via subcutaneous injection appropriately and safely as ordered by an Attending Physician when a rapid and systemic effect is desired and also to administer medications that cannot be given orally. During a review of the facility-provided Highlights of Prescribing Information titled Insulin Glargine-YGFN injection, for subcutaneous use, with initial U.S. Approval in 2021, the Highlights of Prescribing Information indicated rotate injection sites to reduce risk of lipodystrophy and localized cutaneous amyloidosis. During a review of the facility-provided Highlights of Prescribing Information titled Humulin R (insulin human) injection, for subcutaneous or intravenous use, with initial U.S. approval in 1982, the Highlight of Prescribing Information indicated inject subcutaneously 30 minutes before a meal into the thigh, upper arm, abdomen, or buttocks. Rotate injection sites to reduced risk of lipodystrophy and localized cutaneous amyloidosis. 43988 2. During a review of Resident 390's Admission Record, the Admission Record indicated the facility originally admitted the resident on 1/7/2025 and readmitted the resident on 2/24/2025 with diagnoses including schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), type 2 DM, and anxiety disorder (a mental health condition where excessive fear and worry interfere with daily life, causing significant distress). During a review of Resident 390's H&P dated 3/8/2025, the H&P indicated the resident was alert and aware of her identity, location, and the time. During a review of Resident 390's MDS, dated [DATE], the MDS indicated Resident 390 had an intact cognition (mental action or process of acquiring knowledge and understanding) and was able to understand others and make herself understood. The MDS further indicated Resident 390 had impairment on one side of the upper extremity and required total assistance from staff with all ADLS. The MDS indicated Resident 390 received insulin. During a review of Resident 390's care plan (CP) on risk for hypoglycemia/hyperglycemia, initiated on 2/27/2025, the CP indicated to administer Humulin R insulin for sliding scale as one of the interventions to keep Resident 390 free from hypoglycemia/hyperglycemia. During a review of Resident 390's Order Summary Report, the Order Summary Report indicated the following physician's order dated 2/24/2025 and last revised on 4/2/2025: - Humulin R injection solution 100 unit per milliliter (unit/ml) inject as per sliding scale: if 71 - 150 = 0 units; blood sugar (BS) below 70 = call physician (MD); 151 - 200 = 2; 201 - 250 = 4; 251 - 300 = 6; 301 - 350 = 8; 351 - 400 = 10; 401 plus give 12 units then call MD, subcutaneously before meals and at bedtime for DM 2. Finger stick blood sugar (FSBS) check four (40 times daily. Give Humulin R insulin for sliding scale as coverage. Rotate sites. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 4/25/2025 at 9 a.m., reviewed Resident 390's physician's order, CP, and subcutaneous administration sites for Humulin R from 2/24/2025 to 4/25/2025 with the MDS Coordinator (MDSC). The MDSC stated Resident 390 received insulin, had a physician's order for Humulin R, and were administered as follows: - 4/12/2025 12:21p.m. - left lower quadrant (LLQ) - 4/13/2025 4:46 p.m. - LLQ - 4/20/2025 6:06 p.m. - LLQ - 4/21/2025 7:10 p.m. LLQ - 4/22/2025 9:17 pm LLQ - 4/23/2025 4:30 p.m. LLQ The MDSC stated the administration sites for insulin should be rotated per standards of practice, manufacturer's guideline, and per physician's order to prevent hardening or lumps in the skin. The MDSC stated Resident 390 had a physician's order to rotate administration sites. The MDSC stated the location of administration sites for Resident 390's insulin was not rotated. The MDSC stated Resident 390's administration sites should have been rotated to prevent pain, redness, irritation, and lumps on the resident's skin which can affect the absorption of the insulin. During an interview on 4/25/2025 at 12:40 p.m. with the DON, the DON stated the nurses are supposed to rotate insulin administration sites according to physician's order, standards of practice, and as indicated in the manufacturer's guideline. The DON stated the location of administration sites for Resident 390 was not rotated. The DON stated Resident 390's administration sites for the Humulin R should have been rotated to prevent adverse effects such as bruising, skin irritation, skin pits, lipodystrophy and amyloidosis which can affect absorption of insulin. During a review of the facility's P&P titled, Subcutaneous Injection, last reviewed on 1/29/2025, the P&P indicated medications are administered via subcutaneous injection appropriately and safely as ordered by a physician. During a review of the facility-provided Highlights of Prescribing Information titled Humulin R (insulin human) injection, for subcutaneous or intravenous use, with initial U.S. approval in 1982, the Highlight of Prescribing Information indicated inject subcutaneously 30 minutes before a meal into the thigh, upper arm, abdomen, or buttocks. Rotate injection sites to reduce risk of lipodystrophy and localized cutaneous amyloidosis. 3. During a review of Resident 159's Admission Record, the Admission Record indicated the facility originally admitted the resident on 10/18/2024 and readmitted the resident on 3/10/2025 with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness of the arm, leg, and trunk on the same side of the body) following cerebral infarction (also known as stroke, loss of blood flow to a part of the brain) affecting left non-dominant side, type 2 DM, and anxiety disorder. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 159's H&P dated 3/11/2025, the H&P indicated Resident 159 did not have the capacity to understand and make decisions. During a review of Resident 159's MDS, dated [DATE], the MDS indicated Resident 159 had severely impaired cognition. The MDS further indicated Resident 159 had impairment on one side of the upper and lower extremity and required total assistance from staff with all ADLs. The MDS indicated Resident 159 received insulin. During a review of Resident 159's care plan (CP) on risk for hypoglycemia and hyperglycemia initiated on 2/8/2025, the CP indicated to administer insulin lispro (a short acting insulin) for sliding scale as one of the interventions to keep Resident 159 free from hypoglycemia/hyperglycemia. During a review of Resident 159's Order Summary Report, the Order Summary Report indicated the following physician's order dated 3/10/2025: - Insulin lispro (1 unit dial) subcutaneous solution pen-injector 100 unit/ml. inject as per sliding scale: if 0-149 = 0 units; 150 - 199 = 3; 200 - 249 = 4; 250 - 299 = 7; 300 - 349 = 10; 350 - 399 = 12. Call MD if BS <70 or >400, SQ 3 times a day for DM 2. Rotate sites. During a concurrent interview and record review on 4/25/2025 at 9:46 a.m., reviewed Resident 159's physician's order, CP, and subcutaneous administration sites for insulin lispro from 3/10/2025 to 4/25/2025 with the MDSC. The MDSC stated Resident 159 received insulin, had a physician's order for insulin lispro, and were administered as follows: - 3/29/2025 12:00 p.m. - right arm - 3/30/2025 5:34 a.m. - right arm - 4/8/2025 7:12 a.m. - left lower quadrant (LLQ) - 4/9/2025 6:34 a.m. LLQ - 4/12/2025 9:46 p.m. - left arm - 4/13/2025 8:02 a.m. - left arm - 4/22/2025 6:20 a.m. - LLQ - 4/22/2025 8:31 p.m. - LLQ The MDSC stated the administration sites for insulin should be rotated per standards of practice, manufacturer's guideline, and per physician's order to prevent hardening or lumps in the skin. The MDSC stated Resident 159 had a physician's order to rotate administration sites. The MDSC stated the location of administration sites for Resident 159's insulin was not rotated. The MDSC stated Resident 159's administration sites should have been rotated to prevent pain, redness, irritation, and lumps on the resident's skin which can affect the absorption of the insulin. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/25/2025 at 12:40 p.m. with the DON, the DON stated the nurses are supposed to rotate insulin administration sites according to physician's order, standards of practice, and as indicated in the manufacturer's guideline. The DON stated the location of administration sites for Resident 159 was not rotated. The DON stated Resident 159 administration sites for the Humulin R should have been rotated to prevent adverse effects such as bruising, skin irritation, skin pits, lipodystrophy and amyloidosis which can affect absorption of the insulin. During a review of the facility's P&P titled, Subcutaneous Injection, last reviewed on 1/29/2025, the P&P indicated medications are administered via subcutaneous injection appropriately and safely as ordered by a physician. During a review of the facility-provided Highlights of Prescribing Information titled insulin lispro injection solution, for subcutaneous or intravenous use, with initial U.S. approval in 1996, the Highlight of Prescribing Information indicated to administer insulin lispro by subcutaneous injection into the abdominal wall, thigh, upper arm, or buttocks within 15 minutes before a meal or immediately after a meal. Rotate injection sites to reduce risk of lipodystrophy and localized cutaneous amyloidosis.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41379 Based on observation, interview, and record review, the facility failed to provide services to two of 10 sampled residents (Residents 116 and 173) with limited range of motion (ROM - full movement potential of a joint [where two bones meet]) by failing to: 1. Ensure Resident 116 did not have a delay in start of Restorative Nursing Aide (RNA - nursing aide program that help residents to maintain their function and joint mobility) services for passive range of motion (PROM - movement at a given joint with full assistance from another person) for both upper extremities (BUE - shoulder, elbow, wrist, hand) and both lower extremities (BLE - hip, knee, ankle, foot) five times a week. 2. Ensure Resident 173 did not have a delay in the start of RNA services for PROM for the left lower extremity and right residual limb five times a week. These deficient practices had the potential to cause a decline in ROM and function for Residents 116 and 173. Findings: 1. During a review of Resident 116's Admission Record (AR), the AR indicated Resident 116 was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (any damage or disease that affects the brain) and polyneuropathy (disease or dysfunction of one or more nerves, typically causing numbness or weakness in the hands and feet). During a review of Resident 116's Minimum Data Set (MDS - resident assessment tool), dated 2/4/2025, the MDS indicated Resident 116 had severe cognitive (sufficient judgement, planning, organization to manage average demands in one's environment) impairment. The MDS indicated Resident 116 had functional limitation impairments in ROM on both sides of the UE and did not have any ROM limitations in the lower extremity. During a review of Resident 116's care plan (CP), dated 2/19/2025, the CP indicated Resident 116 was at risk for developing contracture (loss of motion of a joint) or decrease in ROM and has orders of Restorative Nursing. The CP goal indicated Resident 116 will maintain current joint range of motion. The CP interventions included RNA as ordered and monitor progress. During a review of Resident 116's Occupational Therapy (OT - rehabilitative profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) Discharge Summary (DC), dated 6/23/2024, the OT DC indicated a discharge recommendation for RNA for PROM exercises to BUEs five times a week or as tolerated. During a review of Resident 116's Physical Therapy (PT - a rehabilitation profession that restores, maintains, and promotes optimal physical function) DC, dated 6/23/2024, the PT DC indicated a discharge recommendation for RNA to provide PROM to BLEs five times a week or as tolerated. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 116's orders, dated 6/23/2024, the orders indicated an order for RNA to provide PROM to BUE and BLE five times a week or as tolerated. During a review of Resident 116's RNA Flowsheet, for June 2024, the RNA Flowsheet indicated Resident 116 did not receive RNA services during the week of 6/23/2024. During a concurrent observation and interview, on 4/24/2025, at 8:50 a.m., Resident 116 laid in bed. Resident 116 was able to move the LUE and LLE without limitations and was not able to move the RUE. Resident 116 stated his right arm was not very good. Resident 116's right elbow and wrist was straight, and the right hand was in a fisted position. During a concurrent interview and record review, on 4/24/25, at 11:16 a.m., with Director of Staff Development (DSD) 2, Resident 116's physician's orders, dated 6/23/2024, were reviewed and DSD 2 stated Resident 116 had an order for RNA for PROM to BUE and BLE five times a week. DSD 2 reviewed Resident 116's June 2024 RNA flowsheet and stated the RNA flowsheet was blank during the week of 6/23/2024 and that meant Resident 116 did not receive any RNA services that week. DSD 2 reviewed Resident 116's July 2024 RNA flowsheet and stated RNA treatment for Resident 116 did not start until 7/1/2024. DSD 2 stated RNA treatment for Resident 116 should have started 6/24/2024, the day after the RNA order was written. During an interview, on 4/24/2025, at 9:33 a.m., with Occupational Therapist (OT) 1, OT 1 stated the RNA program was to help prevent contractures and minimize worsening of contractures. OT 1 stated contractures could cause pain, skin breakdown, and could inhibit activities of daily living performance which was why the facility tried to prevent declines in ROM. OT 1 stated once therapy was completed, an order for RNA was written and RNA should be started the day after. OT 1 stated if there was a delay in starting RNA, then a resident could have a change in condition. During an interview, on 4/24/2025, at 12:14 p.m., the Director of Nursing (DON) stated the RNA program was recommended by therapy staff once a resident was discharged from therapy or in conjunction with a therapy program. The DON stated an RNA program helped residents maintain their level of function for the residents to have their best quality of life. The DON stated once an order for RNA was written, RNA treatments should start right away. The DON stated if there was a delay in starting RNA, it could cause a resident to decline in their level of function. During a review of the facility's policy and procedures (P&P) titled, Restorative Nursing Program Guidelines, last revised 9/19/2019, the P&P indicated Restorative Nursing Programs are initiated when a resident is discharged from formalized physical, occupational, or speech rehabilitation therapy. 2. During a review of Resident 173's AR, the AR indicated Resident 173 was admitted to the facility on [DATE] with diagnoses including acquired absence of right leg above knee and acquired absence of left foot. During a review of Resident 173's H&P, dated 2/27/2025, the H&P indicated Resident 173 had the capacity to understand and make medical decisions. (continued on next page)

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	055932	A. Building B. Wing	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 173's MDS, dated [DATE], the MDS indicated Resident 173 had moderate cognitive (mental processes involved in gaining knowledge and comprehension, includes thinking, knowing, remembering, judging, problem-solving) impairment. The MDS indicated Resident 173 had no functional ROM limitations in the upper extremities and had functional ROM limitation impairments in both sides of the lower extremities. During a review of Resident 173's CP, dated 4/23/2025, the CP indicated Resident 173 was at risk for developing contracture or decrease in ROM. The CP goal indicated Resident 173 will maintain current joint ROM. The CP interventions included RNA as ordered and monitor progress. During a review of Resident 173's PT DC, dated 4/16/2025, the PT DC indicated discharge recommendations for RNA to provide PROM to LLE and right residual limb five times a week or as tolerated. During a review of Resident 173's orders, dated 4/16/2025, the orders indicated an order for RNA to provide PROM to right residual limb five times a week or as tolerated and an order for RNA to provide PROM to left lower extremity five times a week or as tolerated. During a review of Resident 173's RNA Task Flowsheet, for April 2025, the RNA Flowsheet indicated X on 4/16/2025 to 4/22/2025. The RNA Flowsheet indicated Resident 173 received RNA treatment on 4/23/2025. During a concurrent observation and interview, on 4/22/2025, at 2:50 p.m., with Resident 173, inside Resident 173's room, Resident 173 laid bed. Resident 173 was able to move both arms and stated he had not received any exercises. During a concurrent interview and record review, on 4/23/2025, at 1:41 p.m., with Licensed Vocational Nurse (LVN) 1, Resident 173's orders, dated 4/16/2025, and RNA Task Flowsheet, for April 2025, were reviewed. LVN 1 stated once therapy discharged a resident on therapy and wrote an order for RNA, nursing would confirm the order, and nursing would create an RNA task for the RNA to start providing RNA treatment to the resident. LVN 1 reviewed Resident 173's orders and stated there was an order, with a start date of 4/17/2025, for RNA to provide PROM on the right residual limb and RNA to provide PROM on the LLE. LVN 1 reviewed the RNA Task Flowsheet and stated RNA was not started until today, 4/23/2025. LVN 1 stated RNA should have started on 4/17/2025 and there was a delay in starting RNA treatment for Resident 173. LVN 1 stated if there was a delay in starting RNA for Resident 173, Resident 173's joints could get stiff and contracted. During an interview, on 4/24/2025, at 9:33 a.m., OT 1 stated the RNA program was to help prevent contractures and minimize worsening of contractures. OT 1 stated contractures can cause pain, skin breakdown, and can inhibit ADL performance which was why the facility tried to prevent declines in ROM. OT 1 stated once therapy is completed, an order for RNA is written and RNA should be started the day after. OT 1 stated if there was a delay in starting RNA, then a resident could have a change in condition. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview, on 4/24/2025, at 12:14 p.m., the DON stated the RNA program is recommended by therapy staff once a resident was discharged from therapy or in conjunction with a therapy program. The DON stated an RNA program helped residents maintain their level of function for the residents to have their best quality of life. The DON stated once an order for RNA was written, RNA treatments should start right away. The DON stated if there was a delay in starting RNA, it could cause a resident to decline in their level of function. During a review of the facility's P&P titled, Restorative Nursing Program Guidelines, last revised 9/19/2019, the P&P indicated Restorative Nursing Programs are initiated when a resident is discharged from formalized physical, occupational, or speech rehabilitation therapy.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43988 Based on observation, interview, and record review, the facility failed to ensure the resident environment was free of accident hazards for seven (7) of nine (9) sampled residents (Residents 390, 99, 8, 489, 97, 54, and 488) reviewed for accidents by: 1. Failing to ensure Resident 390's bed was not placed in a high position. 2. Failing to ensure Resident 8's bed pad alarm (a pressure-sensitive pad placed under the mattress or seat cushion that trigger an alarm or warning light when they detect a change in pressure) was functioning properly. These deficient practices placed the residents at risk for increased chances of incurring injury such as falls with fracture (a break or crack in a bone) and even death. 3. Failing to ensure Residents 489, 97, 99, and 54's bed remote control's (a device typically found near a resident's bed or within reach to adjust bed configuration) cord was free from exposed/frayed wires. This deficient practice had the potential to place Resident 489, 97, 99, and 54 at risk for injury caused by electrocution. 4. Failing to ensure Resident 488's bilateral fall mat (a cushioned mat that reduces the risk of injury from a fall) did not have furniture or medical equipment on top of them. This deficient practice increased the risk of accidents such as falls with injuries. Findings: a. During a review of Resident 390's Admission Record, the Admission Record indicated the facility originally admitted the resident on 1/7/2025 and readmitted in the facility on 2/24/2025 with diagnoses including schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), type two (2) diabetes mellitus (DM 2 - a disorder characterized by difficulty in blood sugar control and poor wound healing), and anxiety disorder (a mental health condition where excessive fear and worry interfere with daily life, causing significant distress). During a review of Resident 390's History and Physical (H&P), dated 3/8/2025, the H&P indicated the resident was alert and aware of her identity, location, and the time. During a review of Resident 390's Minimum Data Set (MDS - a resident assessment tool), dated 1/14/2025, the MDS indicated Resident 390 had intact cognition (mental action or process of acquiring knowledge and understanding) and was able to understand others and make herself understood. The MDS further indicated Resident 390 had impairment on one side of the upper extremity and required total assistance from staff with all activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 390's fall risk evaluations, dated 2/24/2025 and 1/25/2025, the fall risk evaluations indicated Resident 390 was a risk for falls. During a review of Resident 390's care plan (CP) on risk for falls, initiated on 2/24/2025, the CP indicated the resident needs a safe environment with the bed in low position to keep Resident 390 free from falls. During an observation, on 4/22/2025, at 11:20 a.m., inside Resident 390's room, Resident 390 laid in bed asleep with the height of bed in a high position. During a concurrent observation and interview, on 4/22/2025, at 11:30 a.m., inside Resident 390's room, with Licensed Vocational Nurse (LVN) 5, LVN 5 stated Resident 390's bed was a little high and was measured by Maintenance Supervisor (MS) at 31 inches (a unit of measurement) from the top of the mattress to the floor. LVN 5 lowered down the height of bed and stated the bed had room to be at a lower height. LVN 5 stated staff should make sure that the bed for all residents should be placed at a low position prior to leaving the room especially for residents who were a high risk for falls to prevent injury in case of a fall incident. LVN 5 stated Resident 390's bed was a little high and staff should have placed it at the low position prior to leaving the room as Resident 390 was a high risk for falls and to prevent the resident from incurring an injury due to a fall which may lead to hospitalization from the injuries. During a concurrent interview and record review, on 4/25/2025, at 8:51 a.m., with the MDS Coordinator (MDSC), Resident 390's CP and fall risk evaluations were reviewed. The MDSC stated Resident 390's CP on risk for falls indicated to keep the bed in low position as one of the interventions and the resident was a high risk for falls. The MDSC stated the acceptable height of bed in a healthcare setting is between 18 to 23 inches. The MDSC stated all staff are responsible to keep the beds at a low position prior to leaving the room for safety. The MDSC stated Resident 390's bed should have been at an acceptable height of 18 to 23 inches from the floor to the top of the mattress to promote safety for the resident and prevent injury in care of a fall incident. During an interview, on 4/25/2025, at 2:45 p.m., with the Director of Nursing (DON), the DON stated everyone in the facility is responsible to ensure that the residents' beds are all placed in a low position for the safety of the residents. The DON stated Resident 390's bed should have been placed at a low position between 18 to 23 inches as the resident was a high risk for falls and can get injured during a fall incident. During a review of the facility's policy and procedure (P&P) titled, Fall Management, last reviewed on 1/29/2025, the P&P indicated a purpose to provide a safe environment that minimizes complications associated with falls. During a review of the facility's P&P titled, Resident Safety, last reviewed on 1/29/2025, the P&P indicated: - Residents will be provided a safe and hazard free environment. - Residents will be evaluated on admission, quarterly, and whenever there is a change in condition to identify circumstances that pose a risk for the safety and well-being of the resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- After a risk evaluation is completed, a resident-centered care plan will be developed to mitigate safety risk factors. - A resident check will be made at least every two (2) hours by nursing service personnel for the safety and well-being of the residents. b. During a review of Resident 99's Admission Record, the Admission Record indicated the facility admitted the resident on 9/17/2024 with diagnoses including urinary tract infection (UTI - an infection in the bladder/urinary tract), neuromuscular dysfunction of bladder (a condition when a person lacks bladder control due to brain, spinal cord or nerve problems), and dementia (a progressive state of decline in mental abilities). During a review of Resident 99's H&P, dated 4/15/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 99's MDS, dated [DATE], the MDS indicated Resident 8 had severely impaired cognition and required total assistance from staff with all ADLs. During a concurrent observation and interview, on 4/23/2025, at 7:32 a.m., inside Resident 99's room, with LVN 1, Resident 99 laid in bed awake and non-verbal. LVN 1 confirmed and stated the base of Resident 99's bed controller had a black tape wrapped around the cord and further down the cord had exposed black, red, blue, white, pink, and green wires. LVN 1 stated staff are supposed to notify maintenance department if the bed controllers or call lights have exposed wires to replace immediately. LVN 1 stated the maintenance department should have been notified by the staff upon observing the exposed wires to replace Resident 99's bed controller as it placed the resident at risk for electrocution. During an interview, on 4/25/2025, at 12:39 p.m., with the DON, the DON stated all staff are responsible in checking the resident room and environment and report to the maintenance department immediately to ensure the residents are safe. The DON stated Resident 99's bed controller wires were exposed and should have been reported to the maintenance department to replace right aware as it placed the resident at risk from shock when touching the exposed wires. During a review of the facility's P&P titled, Resident Safety, last reviewed on 1/29/2025, the P&P indicated the facility will provide a safe and hazard free environment. The P&P further indicated any facility staff member who identifies an unsafe situation, practice or environmental risk factors should immediately notify their supervisor or charge nurse. During a review of the facility provided manufacturer's guideline for Hospital Bed (HB) 1, dated 2021, the manufacturer's guideline indicated to never operate the bed if controller cords look damaged. c. During a review of Resident 8's Admission Record, the Admission Record indicated the facility originally admitted the resident on 2/22/2022 and readmitted the resident on 4/16/2025 with diagnoses including UTI, neuromuscular dysfunction of bladder (a condition when a person lacks bladder control due to brain, spinal cord or nerve problems), and dementia. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 8's H&P, dated 4/17/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 8's MDS, dated [DATE], the MDS indicated Resident 8 had severely impaired cognition and required total assistance from staff with all ADLs. During a review of Resident 8's fall risk evaluations, dated 3/14/2025, 3/26/2025, and 4/16/2025, the fall risk evaluations indicated Resident 8 was a risk for falls. During a review of Resident 8's CP on risk for falls, initiated on 1/20/2025 and last revised on 3/3/2025, the CP indicated to monitor the bed alarm functioning to keep Resident 8 free from falls. During a review of Resident 8's Order Summary Report, dated 4/16/2025, the Order Summary Report indicated the following physician's orders: - May have padding alarm while in bed anticipate immediate needs - Monitor bed alarm function every shift - Monitor bed alarm placement every shift During an observation, on 4/26/2025, at 7:38 a.m., inside Resident 8's room, Resident 8 laid in bed, asleep, with the bed alarm box placed on top of the mattress without any blinking light. During a concurrent observation and interview, on 4/26/2025, at 7:42 a.m., inside Resident 8's room, with Certified Nursing Assistant (CNA) 4, CNA 4 stated Resident 8's bed alarm box was turned off because there was no blinking green light. CNA 4 turned on the power button and the bed alarm box made a single beeping sound and had a green blinking light. CNA 4 stated staff are supposed to monitor the bed alarm's functioning and placement every shift at the start of the shift and prior to leaving the resident's room after providing care. CNA 4 stated Resident 8's bed alarm should have been turned on after providing care to alert staff and for the resident to call for assistance to prevent falls and injury. During a concurrent interview and record review, on 4/25/2025, at 9:15 a.m., with the MDSC, Resident 8's physician's order, dated 4/16/2025, was reviewed. The MDSC stated Resident 8 had a physician's order for pad alarm while bed and to monitor for placement and functioning every shift. The MDSC stated the staff are supposed to make sure that the bed alarm was placed and functioning properly by turning on the power button prior to leaving the room and after providing care. The MDSC the staff should have checked or monitored at the start of the shift Resident 8's bed alarm as it placed the resident at risk for falls and incurring injury when the resident tries to get out of bed unassisted. During an interview, on 4/25/2025, at 2:15 p.m., with the DON, the DON stated all staff are responsible to ensure proper placement and function of the bed alarm every shift and as needed. The DON stated monitoring of placement and functioning is usually at the start of the shift and prior to leaving the room. The DON stated Resident 8's bed alarm should have been turned on by the staff prior to leaving the room to reduce the risk of injury during a fall from unassisted getting out of bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Resident Safety, last reviewed on 1/29/2025, the P&P indicated the residents will be provided a safe and hazard free environment. During a review of the facility provided owner's manual for Bed Alarm 1 (BA 1) dated 1/26/2010, the owner's manual indicated: - Turn on the monitor - Move the switch to the on position - The in use light will blink as a visual indication that the alarm is in use - Always test the system before every use - Make sure that the switch is in the on position 44376 d. During a review of Resident 489's Admission Record, the Admission Record indicated the facility admitted the resident on 4/17/2025, with diagnoses including dementia, unspecified symbolic dysfunctions (difficulty with understanding and using symbols, such as words, gestures, and pictures, to communicate or represent ideas), and schizoaffective disorder. During a review of Resident 489's H&P, dated 4/19/2025, the H&P indicated the resident was unable to make decisions. During a review of Resident 489's Fall Risk Evaluation, dated 4/17/2025, the Fall Risk Evaluation indicated the resident was at risk for falls. During a concurrent observation and interview, on 4/22/2025, at 10:09 a.m., with LVN 6, inside Resident 489's room, Resident 489's bed controller had an inch of exposed wires on the bed controller's cord. LVN 6 stated there should be no exposed/frayed wires on the resident's environment to protect them from accidents such as electrocution. During an interview, on 4/25/2025, at 12:37 p.m., with the DON, the DON stated there should be no frayed/exposed wires on Resident 489's bed remote control cord. The DON stated all staff are responsible for environmental safety checks. The DON stated they do Monday to Friday environmental checks with the department managers of the facility and reports all environmental issues identified to her and the Administrator (ADM). The DON stated having frayed/exposed wires on resident's bed remote control can affect its functionality and can predispose the residents to accidents such as electrical shocks. During a review of the facility's recent P&P titled Resident Safety, last reviewed on 1/29/2025, the P&P indicated to provide a safe and hazard free environment. Residents will be evaluated on admission, quarterly and whenever there is a change in condition to identify circumstances that pose a risk for the safety and wellbeing of the Resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's recent P&P titled Resident Rooms and Environment, last reviewed on 1/29/2025, the P&P indicated to provide residents with a safe, clean, comfortable and homelike environment. During a review of the facility-provided Hospital Bed Instructions, copyright date of 2021, the Hospital Bed Instructions indicated on safe use instructions to never operate if controller cords look damaged. e. During a review of Resident 97's Admission Record, the Admission Record indicated the facility admitted the resident on 5/25/2022, and readmitted the resident on 10/8/2023, with diagnoses including disorders of brain, alcohol abuse, and cocaine abuse. During a review of Resident 97's H&P, dated 10/13/2023, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 97's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had impaired vision. The MDS indicated the resident had intact cognition. During a concurrent observation and interview, on 4/22/2025, at 10:06 a.m., with LVN 6, inside Resident 97's room, Resident 97's bed controller had an inch of exposed wires on the bed controller's cord. LVN 6 stated there should be no exposed/frayed wires on the resident's environment to protect them from accidents such as electrocution. During an interview, on 4/25/2025, at 12:37 p.m., with the DON, the DON stated there should be no frayed/exposed wires on Resident 97's bed remote control cord. The DON stated all staff are responsible for environmental safety checks. The DON stated they do Monday to Friday environmental checks with the department managers of the facility and reports all environmental issues identified to her and the ADM. The DON stated having frayed/exposed wires on resident's bed remote control can affect its functionality and can predispose the residents to accidents such as electrical shocks. During a review of the facility's recent P&P titled, Resident Safety, last reviewed on 1/29/2025, the P&P indicated to provide a safe and hazard free environment. Residents will be evaluated on admission, quarterly and whenever there is a change in condition to identify circumstances that pose a risk for the safety and wellbeing of the resident. During a review of the facility's recent P&P titled, Resident Rooms and Environment, last reviewed 1/29/2025, the P&P indicated to provide residents with a safe, clean, comfortable and homelike environment. During a review of the facility-provided Hospital Bed Instructions, copyright date of 2021, the Hospital Bed Instructions indicated on safe use instructions to never operate if controller cords look damaged. f. During a review of Resident 488's Admission Record, the Admission Record indicated the facility admitted the resident on 4/1/2025, with diagnoses including subdural hemorrhage (a collection of blood between the covering of the brain [dura] and the surface of the brain), dementia, and history of falling. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 488's H&P, dated 4/3/2024, the H&P indicated the resident does not have the capacity to understand and make decisions and had confusion. During a review of Resident 488's MDS, dated [DATE], the MDS indicated the resident sometimes had the ability to make self-understood and understand others and had impaired vision. The MDS indicated the resident had severe cognitive impairment (a person has a significant problem with their ability to think, learn, remember, and make decisions) and was dependent to needing supervision on mobility and ADLs. The MDS indicated the resident had history of fall without injury. During a review of Resident 488's Order Summary Report, dated 4/1/2025, the Order Summary Report indicated an order of bilateral fall mats to reduce risk of injury every shift. During a review of Resident 488's CP Report regarding the resident's high risk for falls related to confusion and gait balance problems, last revised on 4/17/2025, the CP indicated an intervention of bilateral floor mats to reduce risk of injury. During a concurrent observation and interview, on 4/22/2025, at 9:32 a.m., with LVN 6, inside Resident 488's room, Resident 488's fall mat at the left side of the bed had two wheels of the side table and visible dents on the fall mat. LVN 6 stated there should be no furniture or medical equipment on top of the fall mat as the resident could fall on them sustaining injury. LVN 6 also stated the presence of the two wheels of the side table on top of the mat compromises the stability of the table and it could fall on the resident. LVN 6 stated placing furniture and medical equipment on top of the fall mat creates permanent dents on the mat that reduces the ability of the mats to lessen the impact of the resident's fall. During an interview, on 4/25/2025, at 12:37 p.m., with the DON, the DON stated there should be no side table on top of Resident 488's fall mat to prevent the resident from sustaining an injury when the resident falls on the mat hitting the furniture on top of them. The DON stated leaving furniture or medical equipment on top of the fall mat will create a permanent dent on the mat decreasing the purpose of the fall mat to reduce the impact of the fall. During a review of the facility-provided Owner's Manual titled Fall Mat (FM) 1, undated, the Owner's Manual indicated do not place objects on the product during storage. During a review of the facility's recent P&P titled, Fall Management Program, last reviewed on 1/29/2025, the P&P indicated the facility will implement a Fall Management Program that supports providing an environment free from fall hazards. During a review of the facility's recent P&P titled Resident Rooms and Environment, last reviewed 1/29/2025, the P&P indicated to provide residents with a safe, clean, comfortable and homelike environment. During a review of the facility's recent P&P titled Resident Safety, last reviewed on 1/29/2025, the P&P indicated to provide a safe and hazard free environment. Residents will be evaluated on admission, quarterly and whenever there is a change in condition to identify circumstances that pose a risk for the safety and wellbeing of the Resident. 50521 (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Four Seasons Healthcare & Wellness Center, LP	5335 Laurel Canyon Blvd. North Hollywood, CA 91607

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	g. During a review of Resident 54's Admission Record, the Admission Record indicated the facility admitted the resident on 08/11/2024 with diagnoses including depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), epilepsy (recurrent sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), and chronic obstructive pulmonary disease (a chronic lung disease causing difficulty in breathing). During a review of Resident 54's MDS, dated [DATE], the MDS indicated Resident 54 had the mental capacity to understand others and had the ability to make herself understood. The MDS indicated the resident required partial/moderate assistance on staff with personal hygiene, putting on/taking off footwear, lower body dressing and toileting hygiene. During a review of Resident 54's Fall Risk Evaluation, dated 3/11/2025, the evaluation indicated the resident was a high risk for potential fall. During a review of Resident 54's care plan, initiated on 3/11/2025, the care plan interventions indicated Resident 54 needs a safe environment with adequate, glare-free light; floors that are even and free from spills; call light and personal items within reach. During a concurrent observation and interview, on 4/22/2025, at 11:01 a.m., inside Resident 54's room, with Laundry Staff (LS), Resident 54's bed remote control cord had frayed wires. LS stated Resident 54's bed remote control cord had exposed wires. LS stated the frayed wires can cause accidents to residents such as electrocution. During an interview, on 4/24/2025, at 9:26 a.m., with CNA 6, CNA 6 stated on 4/22/2025, at 11:01 a.m., Resident 54's bed remote control cord had exposed wires. CNA 6 stated having the frayed wires on the bed remote control cord is not safe and if the resident accidently spills water, she will get electrocuted. During an interview, on 4/24/2025, at 9:44 a.m., with Maintenance Staff (MS) 1, MS 1 stated on 4/22/2025, at 12:00 p.m., Resident 54's bed remote control cord had about 12 inches of exposed/frayed wires. MS 1 stated exposed wires on the bed remote control cord can cause an electric shock to the resident. During an interview, on 4/25/2025, at 12:37 p.m., with the DON, the DON stated all staff are responsible for environmental safety and maintenance staff are expected to replace frayed wires immediately. The DON stated there should be no frayed/exposed wires to prevent accidental electrocution of Resident 54. During a review of the facility's Hospital Bed Instructions, dated 2021, the Hospital Bed Instructions indicated on safe use instructions to never operate if controller cords look damaged. During a review of the facility's recent P&P titled, Resident Rooms and Environment, last reviewed 1/29/2025, the P&P indicated to provide residents with a safe, clean, comfortable and homelike environment.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43988 Based on observation, interview, and record review, the facility failed to ensure residents with a urinary catheter (FC - also known as an indwelling catheter or Foley catheter, a hollow tube inserted into the bladder to drain or collect urine) received appropriate care and services to prevent urinary tract infections (UTI - an infection in the bladder/urinary tract) for three (3) of four (4) sampled resident (Residents 390, 99, and 8) reviewed for urinary catheter or UTI by: 1. Failing to ensure Residents 390's and 99's urinary catheter tubing did not have a kink or loop while hanging on the side of the bed. 2. Failing to ensure Resident 8's urinary catheter was anchored with a leg strap and change the leg bag with a regular urinary drainage bag while in bed. These deficient practices had the potential for the urine to not flow freely, the resident's FC to be pulled out, or move around, which may lead to the development of UTI, pain, trauma, and catheter blockage. Findings: a. During a review of Resident 390's Admission Record, the Admission Record indicated the facility originally admitted the resident on 1/7/2025 and readmitted the resident on 2/24/2025 with diagnoses including schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), type two (2) diabetes mellitus (DM 2 - a disorder characterized by difficulty in blood sugar control and poor wound healing), and neuromuscular dysfunction of bladder (a condition when a person lacks bladder control due to brain, spinal cord or nerve problems). During a review of Resident 390's History and Physical (H&P), dated 3/8/2025, the H&P indicated the resident was alert and aware of her identity, location, and the time. During a review of Resident 390's Minimum Data Set (MDS - a resident assessment tool), dated 1/14/2025, the MDS indicated Resident 390 had intact cognition (mental action or process of acquiring knowledge and understanding) and was able to understand others and make herself understood. The MDS further indicated Resident 390 had impairment on one side of the upper extremity and required total assistance from staff with all activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 390's Order Summary Report, dated 2/28/2025, the Order Summary Report indicated the following physician's orders: - Indwelling FC size French (FR - a unit of measurement) 15 by ten (10) milliliters (ml - a unit of measurement) via gravity drainage for neurogenic bladder (also known as neuromuscular disorder of the bladder, condition in people who lack bladder control due to brain, spinal cord, or nerve problems). (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Change FC per schedule every 24th of the month and as needed. - Change urinary catheter bag per schedule when FC is changed and as needed. During a concurrent observation and interview, on 4/22/2025, at 11:20 a.m., inside Resident 390's room with Licensed Vocational Nurse (LVN) 5, LVN 5 confirmed and stated Resident 390's urinary catheter tubing had a loop preventing the urine from flowing freely into the bag. LVN 5 stated staff must make sure all urinary catheter tubing were free from kinks or loops to allow the urine to flow freely and prevent development of UTI. LVN 5 stated Resident 390's urinary catheter tubing should not have a loop so the urine can flow freely, prevent backing up to the bladder which can cause development of UTI. During an interview, on 4/25/2025, at 2:15 p.m., with the Director of Nursing (DON), the DON stated one of the interventions to prevent development of UTI was for the staff to ensure that the urinary catheter tubing did not have a loop or kinks all the time to allow the urine to flow freely. The DON stated Resident 390's urinary catheter should have been positioned in a way that there is no loop or kink in the tubing as it had the potential for the urine not to flow freely, and back up into the bladder to prevent development of UTI. During a review of the facility's policy and procedure (P&P) titled, Catheter - Care of, last reviewed on 1/29/2025, the P&P indicated a purpose to prevent catheter-associated UTI while ensuring that residents are not given indwelling catheter unless medically necessary. The P&P further indicated the catheter and collecting tube will be kept free from kinking and the collection bag will be kept below the level of the bladder. b. During a review of Resident 99's Admission Record, the Admission Record indicated the facility admitted the resident on 9/17/2024 with diagnoses including UTI, neuromuscular dysfunction of bladder, and dementia (a progressive state of decline in mental abilities). During a review of Resident 99's H&P, dated 4/15/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 99's MDS, dated [DATE], the MDS indicated Resident 99 had severely impaired cognition and required total assistance from staff with all ADLs. The MDS indicated Resident 99 had an indwelling catheter. During a review of Resident 99's Order Summary Report, dated 3/24/2025, the Order Summary Report indicated the following physician's orders: - Foley suprapubic catheter (SP - a thin, flexible tube inserted directly into the bladder through a small incision in the abdomen) to be provided every shift. - Change urinary catheter bag per schedule when foley is changed, and as needed for bag change. - Change urinary catheter bag per schedule when foley is changed and as needed every day shift every 30 days. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview, on 4/23/2025, at 7:32 a.m., inside Resident 99's room, with LVN 1, LVN 1 confirmed and stated Resident 99's urinary catheter tubing had a loop preventing the urine from flowing freely into the bag. LVN 1 stated staff must make sure all urinary catheter tubing were free from kinks or loops to allow the urine to flow freely and prevent development of UTI. LVN 1 stated Resident 99's urinary catheter tubing should not have a loop so the urine can flow freely, prevent backing up to the bladder which can cause urine infection. During an interview on 4/25/2025 at 2:15 p.m. with the Director of Nursing (DON), the DON stated one of the interventions to prevent development of UTI was for the staff to ensure that the urinary catheter tubing did not have a loop or kinks all the time to allow the urine to flow freely. The DON stated Resident 99's urinary catheter should have been positioned in a way that there is no loop or kink in the tubing as it had the potential for the urine not to flow freely, and back up into the bladder to prevent development of UTI. During a review of the facility's P&P titled, Catheter - Care of, last reviewed on 1/29/2025, the P&P indicated a purpose to prevent catheter-associated UTI while ensuring that residents are not given indwelling catheter unless medically necessary. The P&P further indicated the catheter and collecting tube will be kept free from kinking and the collection bag will be kept below the level of the bladder. c. During a review of Resident 8's Admission Record, the Admission Record indicated the facility originally admitted the resident on 2/22/2022 and readmitted in the facility on 4/16/2025 with diagnoses including UTI, neuromuscular dysfunction of bladder, and dementia. During a review of Resident 8's H&P, dated 4/17/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 8's MDS, dated [DATE], the MDS indicated Resident 8 had severely impaired cognition and required total assistance from staff with all ADLs. During a review of Resident 8's Order Summary Report, the Order Summary Report indicated the following physician's orders: - On 4/16/2025: May change urinary catheter bag as needed when dislodged, malfunction. - On 4/23/2025: Suprapubic catheter care to be provided every shift. - On 4/23/2025: Suprapubic catheter size (16 by 10) with balloon via gravity drainage for neurogenic bladder. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview, on 4/22/2025, at 7:45 a.m., inside Resident 8's room, with LVN 3, LVN 3 confirmed and stated Resident 8's urinary catheter was directly connected to a leg bag that was half full without a tubing securement device and placed on top of the resident's left thigh, preventing the urine from flowing freely into the bag. LVN 3 stated the urinary catheter was not anchored to a leg strap. LVN 3 stated Resident 8 returned from suprapubic catheter placement on 4/22/2025, at 5:30 p.m. LVN 3 stated leg bags are used only if there was a physician's order or when residents are out of bed to wheelchair to allow the urine to flow freely and prevent the development of UTI. LVN 3 stated urinary catheters should be anchored with a leg strap to prevent trauma from pulling or traction. LVN 3 stated Resident 8's urinary catheter should have not been left connected to a leg bag all night and should have been replaced with the regular urinary drainage bag so the urine can flow freely and prevent backing up to the bladder which can cause urine infection. LVN 3 stated Resident 8's urinary catheter should have been anchored with a leg strap to prevent trauma from pulling or traction. During an interview, on 4/25/2025, at 2:15 p.m., with the DON, the DON stated one of the interventions to prevent development of UTI was for the staff to ensure that the urinary catheter should have been connected to a regular urinary drainage bag to allow the urine to flow freely and anchored with a leg strap to prevent pulling or traction. The DON stated Resident 8's urinary catheter should have been connected to a regular urinary drainage bag upon arrival from the suprapubic catheter placement so the bag was below the level of the bladder, the urine can flow freely and prevent from backing up to the bladder which can cause urine infection. The DON stated Resident 8's urinary catheter should have been anchored with a leg strap to prevent trauma from pulling or traction. During a review of the facility's P&P titled, Catheter - Care of, last reviewed on 1/29/2025, the P&P indicated a purpose to prevent catheter-associated UTI while ensuring that residents are not given indwelling catheter unless medically necessary. The P&P further indicated: - The catheter and collecting tube will be kept free from kinking and the collection bag will be kept below the level of the bladder. - The collecting bag will be kept below the level of the bladder. - The catheter will be anchored to prevent excessive tension of the catheter.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. 44376 Based on observation, interview, and record review, the facility failed to assure that each resident receives care and services for the provision of parenteral fluids (formulated liquids that are injected into a vein to prevent or treat dehydration [a condition caused by the loss of too much fluid from the body]) consistent with professional standards of practice to one out of two sampled residents (Resident 10) reviewed for antibiotic (medicines that stop bacteria from growing) use by failing to ensure Resident 10's: 1. Midline catheter (a long, thin, flexible tube that is inserted into a large vein in the upper arm) dressing was changed every 48 hours per physician's order. 2. Infusion port (a device used to draw blood and give treatments, including intravenous fluids, blood transfusions, or antibiotics) was swabbed with an antiseptic solution (a chemical agent that slows or stops the growth of microorganisms on external surfaces of the body and helps to prevent infection) before flushing the port with 10 milliliters (ml, a unit of volume) normal saline solution (NS, a mixture of water and salt) and before attaching the antibiotic intravenous (IV, within a vein) line administering Cefepime, an antibiotic. The deficient practice had a potential to cause infection such as phlebitis (inflammation of a vein) and sepsis (a life-threatening condition where the body's response to an infection injures its own tissues and organ). Findings: During a review of Resident 10's Admission Record, the Admission Record indicated the facility admitted the resident on 12/30/2024, with diagnoses including local infection of the skin and subcutaneous tissue (the layer of tissue that underlies the skin) and type 2 diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing) with other skin ulcer (open sores caused by poor blood circulation). During a review of Resident 10's History and Physical (H&P), dated 12/30/2024, the H&P indicated the resident was alert, oriented to person, place, time, and communicated clearly without evidence of cognitive impairment (having difficulty with thinking, learning, remembering, or making decisions) or language barrier. During a review of Resident 10's Minimum Data Set (MDS, a resident assessment tool), dated 4/7/2025, the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (a participant who has sufficient judgment, planning, organization, self-control, and the persistence needed to manage the normal demands of the participant's environment). During a review of Resident 10's Order Summary Report, the Order Summary Report indicated the following physician orders dated: (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/16/2025 - Cefepime HCl intravenous solution reconstituted 2 grams (gm, a unit of weight) (Cefepime HCl). Use 1 dose intravenously one time a day for osteomyelitis (an infection in a bone) for 14 days. 4/17/2025 - Flush with normal saline (NS) 5-10 milliliters (ml, a unit of volume) before and after medication administration and every shift. Every shift for IV maintenance. 4/19/2025 - Change peripheral IV line (a thin, flexible tube) and dressing every 48 hours. During a concurrent observation and interview on 4/22/2025, at 10:43 a.m., with Registered Nurse (RN) 1, inside Resident 10's room, observed RN 1 hung Cefepime IV antibiotic to Resident 10. RN 1 disconnected the old IV tubing line and attached the 10 ml normal saline syringe flush on the midline catheter infusion port and flushed without scrubbing the hub/infusion port with an antiseptic solution and let the midline catheter infusion port rest on the resident's bare skin and attached the new tubing of the antibiotic Cefepime IV infusion to the midline catheter infusion port without scrubbing the hub with an antiseptic solution. RN 1 stated she should have scrubbed the midline catheter infusion port prior to attaching the 10 ml normal saline syringe to flush the port and prior to attaching the new antibiotic IV line to prevent infection to set in on Resident 10. During a concurrent interview and record review on 4/24/2025, at 8:38 a.m., with RN 3, reviewed Resident 10's Order Summary Report, Medication Administration Record (MAR) and Care Plan. RN 3 stated there was an order to flush with NS 5-10 ml before and after medication administration and every shift of the midline catheter for IV maintenance and to change the peripheral IV line and dressing every 48 hours. RN 3 stated RN 1 should have scrubbed the infusion port of the midline catheter before flushing and attaching a new antibiotic IV line on the resident to prevent infection. During a concurrent observation and interview on 4/24/2025, at 9:49 a.m., with RN 4, inside Resident 10's room, observed Resident 10's midline catheter dressing dated 4/20/2025. RN 4 stated the midline catheter dressing should have been changed on 4/22/2025 and that day, 4/24/2025 by the licensed nurses. RN 4 stated the failure of the staff to change the dressing per physician's order predisposed the resident to infection. During an interview on 4/25/2025, at 12:37 p.m., with the Director of Nursing (DON), the DON stated the licensed staff should have wiped the infusion port of the midline catheter of Resident 10 prior to flushing the infusion port with 10 ml of normal saline and prior to attaching the new IV antibiotic line of the resident to prevent infection to set in. The DON also stated the dressing should have been changed by licensed staff every 48 hours per physician's order to prevent infection and to assess for the site of insertion for signs and symptoms of infection and extravasation (the leakage of blood, lymph, or other fluid). During a review of the facility's recent policy and procedure (P&P) titled Universal Precautions, last reviewed on 1/29/2025, the P&P indicated all personnel involved with administering IV therapy will comply with universal precautions guidelines on all patients during any and all IV therapy procedures. Strict aseptic technique shall be used when accessing all injection ports, peripheral or central. All injection ports, peripheral and central, shell be disinfected with a sterile alcohol swab using a vigorous rub for no less than 30 seconds. All peripheral IV sites shall be monitored closely for signs of phlebitis. All peripheral occlusive dressings shall be changed with the peripheral site change. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility-provided P&P titled Infusion Therapy Medication Administration, last reviewed on 1/29/2025, the P&P indicated to provide for safe, accurate, and effective administration of parenteral medications directly into the vascular system. Equipment Required C. Alcohol wipes. Procedures E. Wipe rubber stopper of infusion therapy solution container with alcohol swab.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44244 Based on observation, interview, and record review, the facility failed to ensure respiratory care provided to residents was consistent with professional standards of practice for two of two sampled residents (Resident 152 and 42) reviewed for respiratory care by failing to: 1. Ensure oxygen was administered per physician's order, documented when administered or refused, and the physician was notified when Resident 152 refused the administration of continuous supplemental oxygen and remained on room air (RA). 2. Ensure the oxygen via nasal cannula (NC, a device that gives additional oxygen [supplemental oxygen or oxygen therapy] through the nose) was attached to the Resident 42's nostrils. These deficient practices had a potential for the residents to develop complications such as shortness of breath and desaturation (low levels of oxygen in the blood). Findings: a.During a review of Resident 152's Admission Record, the Admission Record indicated the facility admitted the resident on 7/23/2024, with diagnoses including paraplegia (loss of movement and/or sensation, to some degree, of the legs), morbid obesity (a serious health condition that results from an abnormally high body mass), obstructive sleep apnea (a sleep-related breathing disorder, and chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing). During a review of Resident 152's Minimum Data Set (MDS, a resident assessment tool), dated 1/27/2025, the MDS indicated the resident had the ability to make self-understood and the ability to understand others. The MDS further indicated the resident was dependent on staff for toileting, bathing, dressing, and transfers from the bed to chair. The MDS indicated the resident required substantial/maximal assistance with personal hygiene and partial assistance with eating and oral hygiene. During a review of Resident 152's Order Summary Report, dated 4/24/2025, the Order Summary Report indicated physician's orders for the following: - Oxygen at two to four liters per minute (LPM, the liters of liquid moved in one minute) via nasal cannula (NC) to keep oxygen saturation (O2 sat, a measurement of how much oxygen your blood is carrying as a percentage of the maximum it could carry) at/above 92 percent (%) for diagnosis (dx) of COPD, every shift, dated 3/10/2025. -Resident is incapable of making healthcare decisions, healthcare decision maker assigned to Conservator (a legally appointed decision maker), dated 12/17/2024. During an observation on 4/22/2025 at 4:05 p.m., observed Resident 152 awake and sitting in bed. Observed an oxygen concentrator at bedside with a NC connected. Observed the resident was breathing room air and was not wearing a NC for the administration of supplemental O2. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 4/23/2025 at 1:42 p.m., observed Resident 152 in a wheelchair in the facility lobby. Observed the resident was breathing room air and was not wearing a NC for the administration of supplemental O2. During an observation on 4/24/2025 at 9:36 a.m., observed Resident 152 sleeping in bed. Observed an oxygen concentrator at bedside with a NC connected. Observed the resident was breathing room air and was not wearing a NC for the administration of supplemental O2. During an interview on 4/24/2025 at 9:36 a.m., with Certified Nursing Assistant (CNA) 8, CNA 8 stated CNA 8 was assigned to care for Resident 152 and the resident sometimes uses O2 via NC, but the resident sometimes removes it. CNA 8 stated when Resident 152 refused the NC, the CNA reports the refusal to the assigned nurse. During a concurrent interview and record review on 4/24/2025 at 9:38 a.m., Licensed Vocational Nurse (LVN) 2 reviewed Resident 152's physician orders, Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for 4/2025, Nursing Progress Notes for 4/2025, and Weights and Vital Report for 4/2025. LVN 2 stated supplemental O2 is considered a medication treatment that is administered with a physician's order either continuously or as needed (PRN). LVN 2 stated every shift the nurse documents in the MAR the administration or refusal of O2 treatment. LVN 2 stated when the MAR is blank, there is no documentation regarding the administration of oxygen. LVN 2 stated Resident 152 used O2 via NC PRN, and the resident rarely used the O2. LVN 2 then reviewed Resident 152's order and stated the order indicated to administer O2 via NC continuously and not PRN. LVN 2 stated Resident 152 refused O2 continuously as ordered. LVN 2 stated the physician should be notified if the resident is refusing the O2 treatment because the refusal may have a negative effect on the resident's respiratory status and the physician needs to determine how to proceed with the O2 treatments. LVN 2 reviewed Resident 152's MAR for 4/2025, Nursing Progress Notes for 4/2025, and Weights and Vital Report for 4/2025 and noted there was no documented evidence O2 was administered as ordered or that the physician was notified when Resident 152 was not administered or refused O2 on the following dates and times: - On 4/1/2025 day shift (7 a.m. to 3 p.m.), there was no documented evidence O2 was administered via NC, the MAR was blank. o There was no documented O2 Sat for the day shift. - On 4/2/2025 day shift., there was no documented evidence O2 was administered via NC, the MAR was blank. o At 2:40 p.m., Resident 152's O2 Sat was 97 % on room air (RA). - On 4/2/2025 evening shift (3 p.m. to 11 p.m.), there was no documented evidence O2 was administered via NC, the MAR was blank. o At 10:08 p.m., Resident 152's O2 Sat was 96 % on room air (RA). - On 4/3/2025 day shift., there was no documented evidence O2 was administered via NC, the MAR was blank. (continued on next page)

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	055932	A. Building B. Wing	04/25/2025

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	o At 2:20 p.m., Resident 152's O2 Sat was 98 % on room air (RA). - On 4/4/2025 day shift., there was no documented evidence O2 was administered via NC, the MAR was blank. o At 8:06 a.m., Resident 152's O2 Sat was 97 % on room air (RA). - On 4/4/2025 evening shift., there was no documented evidence O2 was administered via NC, the MAR was blank. o At 5:54 p.m., Resident 152's O2 Sat was 97 % on room air (RA). - On 4/5/2025 day shift., there was no documented evidence O2 was administered via NC, the MAR was blank. o There was no documented O2 Sat for the day shift. - On 4/5/2025 evening shift., there was no documented evidence O2 was administered via NC, the MAR was blank. o At 10:27 p.m., Resident 152's O2 Sat was 98 % on room air (RA). - On 4/6/2025 night shift (11 p.m. to 7 a.m.), there was no documented evidence O2 was administered via NC, the MAR was blank. o There was no documented O2 Sat for the night shift. - On 4/7/2025 day shift., there was no documented evidence O2 was administered via NC, the MAR was blank. o At 1:49 p.m., Resident 152's O2 Sat was 98 % on room air (RA). - On 4/8/2025 day shift., there was no documented evidence O2 was administered via NC, the MAR was blank. o At 8:19 a.m., Resident 152's O2 Sat was 98 % on room air (RA). - On 4/9/2025 day shift., there was no documented evidence O2 was administered via NC, the MAR was blank. o At 12:18 p.m., Resident 152's O2 Sat was 97 % on room air (RA). - On 4/10/2025 day shift., there was no documented evidence O2 was administered via NC, the MAR was blank. o There was no documented O2 Sat for the day shift. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 4/11/2025 day shift., there was no documented evidence O2 was administered via NC, the MAR was blank. o At 3:01 p.m., Resident 152's O2 Sat was 98 % on room air (RA). - On 4/11/2025 evening shift., there was no documented evidence O2 was administered via NC, the MAR was blank. o At 10:21 p.m., Resident 152's O2 Sat was 97 % on room air (RA). - On 4/12/2025 evening shift., there was no documented evidence O2 was administered via NC, the MAR was blank. o At 10:01 p.m., Resident 152's O2 Sat was 98 % on room air (RA). - On 4/13/2025 night shift., there was no documented evidence O2 was administered via NC, the MAR was blank. o There was no documented O2 Sat for the night shift. - On 4/14/2025 day shift., there was no documented evidence O2 was administered via NC, the MAR was blank. o At 12:43 p.m., Resident 152's O2 Sat was 96 % on room air (RA). - On 4/15/2025 day shift., there was no documented evidence O2 was administered via NC, the MAR was blank. o At 2:10 p.m., Resident 152's O2 Sat was 98 % on room air (RA). - On 4/16/2025 day shift., there was no documented evidence O2 was administered via NC, the MAR was blank. o At 7:55.m., Resident 152's O2 Sat was 98 % on room air (RA). - On 4/17/2025 day shift., there was no documented evidence O2 was administered via NC, the MAR was blank. o At 12:45 p.m., Resident 152's O2 Sat was 97 % on room air (RA). - On 4/18/2025 day shift., there was no documented evidence O2 was administered via NC, the MAR was blank. o At 11:59 p.m., Resident 152's O2 Sat was 98 % on room air (RA). - On 4/18/2025 evening shift., there was no documented evidence O2 was administered via NC, the MAR was blank. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	o At 11:59 p.m., Resident 152's O2 Sat was 98 % on room air (RA). - On 4/19/2025 evening shift., there was no documented evidence O2 was administered via NC, the MAR was blank. o At 6:21 p.m., Resident 152's O2 Sat was 98 % on room air (RA). - On 4/19/2025 night shift., there was no documented evidence O2 was administered via NC, the MAR was blank. o There was no documented O2 Sat for the night shift. - On 4/20/2025 day shift., there was no documented evidence O2 was administered via NC, the MAR was blank. o At 2 p.m., Resident 152's O2 Sat was 96 % on room air (RA). - On 4/20/2025 evening shift., there was no documented evidence O2 was administered via NC, the MAR was blank. o At 8:23 p.m., Resident 152's O2 Sat was 98 % on room air (RA). - On 4/21/2025 day shift., there was no documented evidence O2 was administered via NC, the MAR was blank. o At 3:45 p.m., Resident 152's O2 Sat was 95 % on room air (RA). - On 4/22/2025 day shift., there was no documented evidence O2 was administered via NC, the MAR was blank. o At 3:19 p.m., Resident 152's O2 Sat was 98 % on room air (RA) - On 4/23/2025 day shift., there was no documented evidence O2 was administered via NC, the MAR was blank. o At 2:52 p.m., Resident 152's O2 Sat was 98 % on room air (RA) LVN 2 stated when Resident 152's O2 Sat was recorded on RA and the MAR was blank, the resident was refusing O2 per the physician's order. LVN 2 stated if it was not documented, then it was not done. LVN 2 stated Resident 152's oxygen saturation was maintained within normal parameters on RA, but the physician should have been notified that the resident was not administered the O2 per the order, refused the O2, or no longer required the O2. LVN 2 stated the physician should have been notified to clarify the order and change it to PRN, or to discontinue the order if O2 was not needed. LVN 2 stated Resident 152's physician was not notified to determine the appropriate O2 treatment when the resident refused, but should have been. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 4/25/2025 at 9:08 a.m., with the Director of Nursing (DON), the DON reviewed the facility policy and procedure regarding oxygen administration and refusal of treatments. The DON stated the DON was made aware of the blank spots on Resident 152's MAR for continuous O2 administration. The DON stated Resident 152 was non-compliant with the physician's order for continuous O2 administration. The DON stated when a resident is non-compliant with physician's orders, the refusal should be documented in the MAR and the physician should be made aware. The DON stated Resident 152's non-compliance would trigger a change of condition notification to the physician for a recommendation for treatment for the resident's non-compliance. The DON stated Resident 152 was non-complaint with the physician's order for continuous O2 administration and the facility policy was not followed because the physician was not notified, and the MAR was not completed. The DON stated when Resident 152's physician was not made aware of the resident's non-compliance, there was a potential that the physician would not timely assess the resident with potential for a decline in the resident's respiratory status. During a review of the facility's recent policy and procedure (P&P) titled Oxygen Therapy, last reviewed on 1/29/2025, the P&P indicated to ensure the safe administration of oxygen therapy in the facility. Oxygen is administered under safe and sanitary conditions to meet resident needs. Licensed Nursing staff will administer oxygen as prescribed. Administer oxygen per physician orders. During a review of the facility's recent P&P titled Refusal of Treatment, last reviewed on 1/29/2025, the P&P indicated the purpose was to ensure the residents are able to exercise their right to refuse treatment. The resident is not forced to accept any medical treatment and may refuse specific treatment even though it is prescribed by their Attending Physician. When a resident refuses treatment, the Charge Nurse or Director of Nursing Services (DNS) interviews the resident to determine what and why the resident is refusing. The Charge Nurse or DNS will attempt to address the resident's concerns and explain the consequences of the refusal. The Charge Nurse or DNS will document information relating to the refusal in the resident's medical record. Documentation will include at least the following: A. The date and time Nursing Staff tried to give a medication or treatment was attempted; B. The medication or treatment refused; C. The resident's response and reason(s) for refusal; D. The name of the person attempting to administer the treatment; E. That the resident was informed (to the extent of their ability to understand) of the purpose of the treatment and the consequences of not receiving the medication/or treatment; F. The resident's condition and any adverse effects due to such refusal; G. The date and time the Attending Physician was notified and his or her response; H. Other pertinent observations; and I. The signature and title of the Charge Nurse or DNS documenting the refusal. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Attending Physician will be notified of refusal of treatment in a time frame determined by the resident's condition and potential serious consequences of the refusal. The Interdisciplinary Team (IDT) will assess the resident's needs and offer the resident alternative treatments while continuing to provide other services in the Care Plan. 44376 b. During a review of Resident 42's Admission Record, the Admission Record indicated the facility admitted the resident on 3/18/2025, with diagnoses including encephalopathy (refers to a general term for brain disease, damage, or malfunction) and acute respiratory failure (the lungs are not working well enough to get enough oxygen into the blood and remove carbon dioxide, leading to a life-threatening situation) with hypoxia (a deficiency of oxygen reaching the body's tissues). During a review of Resident 42's History and Physical (H&P), dated 3/19/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 42's MDS, dated [DATE], the MDS indicated the resident sometimes had the ability to make self-understood and understand others and had impaired cognition (problems with a person's ability to think, learn, remember, use judgement, and make decisions). During a review of Resident 42's Order Summary Report, dated 4/10/2025, the Order Summary Report indicated a physician's order of oxygen at 2 LPM via NC to keep O2 sat at/above 92 % for dx of acute resp. failure every shift [specify dx or indication for use]) and to check O2 sats every shift. During a concurrent observation and interview on 4/22/2025, at 9:53 a.m., with Restorative Nursing Assistant (RNA) 2, inside Resident 42's room, observed Resident 42's oxygen tubing via NC was off the resident and was on the right side of the bed. RNA 2 stated she does not know how long the resident was off the oxygen. RNA 2 stated it was the responsibility of all staff to ensure residents' medical devices are attached to the residents. RNA 2 stated the failure of the staff to ensure the oxygen was on Resident 42 can result to the resident having difficulty of breathing. During an interview on 4/25/2025, at 12:37 p.m., with the DON, the DON stated the staff should be rounding every hour to check on the resident's environment including if the medical equipment is on the resident. The DON stated the oxygen via nasal cannula should be on Resident 42 at all times to prevent shortness of breath and desaturation. During a review of the facility's recent P&P titled Oxygen Therapy, last reviewed on 1/29/2025, the P&P indicated to ensure the safe storage and administration of oxygen therapy in the facility. Oxygen is administered under safe and sanitary conditions to meet resident needs. Licensed Nursing staff will administer oxygen as prescribed. Administer oxygen per physician orders.

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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. 44376 Based on observation, interview, and record review, the facility failed to ensure licensed nurses had the specific competencies (measurable pattern of training, skills, experience, and knowledge in order to perform occupational tasks successfully) and skill sets necessary to care for residents' needs for one of five sampled staff reviewed for sufficient and competent nurse staffing by failing to ensure Registered Nurse (RN) 1 had a skills competency on administering intravenous (IV, within a vein) antibiotics (medicines that fight bacterial infections) through a midline/peripheral catheter (thin, soft tube that is placed into a vein, usually in the arm). The deficient practice had the potential to induce bloodstream infections such as sepsis (a serious condition in which the body responds improperly to an infection) to residents. Findings: During a concurrent observation and interview on 4/22/2025, at 10:43 a.m., with RN 1, inside Resident 10's room, observed RN 1 hung Cefepime IV (antibiotic) to Resident 10. RN 1 disconnected the old IV tubing line and attached the 10 milliliters (ml, a unit of volume) of normal saline (NS, a mixture of water and salt) syringe flush on the midline catheter infusion port (a device used to draw blood and give treatments, including intravenous fluids, blood transfusions, or antibiotics) and flushed without scrubbing the hub/infusion port with an antiseptic solution (a chemical agent that slows or stops the growth of microorganisms on external surfaces of the body and helps to prevent infection) and let the port rest on the resident's bare skin and attached the new tubing of the antibiotic Cefepime IV infusion to the midline catheter infusion port without scrubbing the hub/infusion port with an antiseptic solution. RN 1 stated she should have scrubbed the midline catheter infusion port prior to attaching the 10 ml normal saline syringe to flush the port and prior to attaching the new antibiotic IV line to prevent infection to set in on the resident. During a concurrent interview and record review on 4/24/2025, at 8:38 a.m., with RN 3, reviewed Resident 10's Order Summary Report, Medication Administration Report (MAR) and Care Plan. RN 3 stated there was an order to flush with NS 5-10 ml before and after medication administration and every shift of the midline catheter for IV maintenance and to change the peripheral IV line and dressing every 48 hours. RN 3 stated RN 1 should have scrubbed the infusion port of the midline catheter before flushing and attaching a new antibiotic IV line on the resident to prevent infection. During a concurrent observation and interview on 4/24/2025, at 9:49 a.m., with RN 4, inside Resident 10's room, observed Resident 10's midline catheter dressing dated 4/20/2025. RN 4 stated the midline catheter dressing should have been changed on 4/22/2025 and that day, 4/24/2025 by the licensed nurses. RN 4 stated the failure of the staff to change the dressing per physician's order predisposed the resident to infection. During an interview on 4/25/2025, at 8:22 a.m., with Director of Staff Development (DSD) 2, DSD 2 stated they did a March and April 2025 record sweep for RN 1 and her competency should have been completed within 90 days of working in the facility. DSD 2 stated her (RN 1) 90th day was on 2/14/2025. DSD 2 stated there was no IV Skills check on RN 1's file. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 4/25/2025, at 9:49 a.m., with RN 1, RN 1 stated she had an IV administration of medication competency with the previous DON of the facility. RN 1 stated she started working in the facility in 11/2025. During an interview on 4/25/2025, at 12:37 p.m., with the Director of Nursing (DON), the DON stated RN 1 should have had a competency on IV administration of medications. The DON stated RN 1 should have completed her competencies by that this time. The DON stated RN 1 should have wiped the infusion port of the midline catheter of Resident 10 prior to flushing the infusion port with 10 ml of normal saline and prior to attaching the new IV antibiotic line of the resident to prevent infection to set in. The DON also stated the dressing should have been changed by RN 1 every 48 hours per physician's order to prevent infection and to assess for the site of insertion. During a review of the facility-provided Peripherally Inserted Central Line (PICC, is a long, thin tube that's inserted through a vein in the arm and passed through to the larger veins near the heart) Line Care Competency Validation, dated 4/22/2025, the PICC Line Care Competency Validation indicated on flushing and locking preparation: If a disinfectant-containing end cap is covering the needleless connector, remove and discard it. Perform vigorous mechanical scrub of the needleless connector for at least 5 seconds using an antiseptic pad; allow it to dry completely. During a review of the facility-provided IV Continuous Quality Improvement (CQI) Monitor for Registered Nurses, undated, the IV Continuous Quality Improvement (CQI) Monitor for Registered Nurses indicated for physician's orders: 5. Dressing and cap change for central lines ordered. IV Medication Record: 7. Central line dressings and cap changes recorded. During a review of the facility's recent policy and procedure (P&P) titled Universal Precautions, last reviewed on 1/29/2025, the P&P indicated all personnel involved with administering IV therapy will comply with universal precautions guidelines on all patients during any and all IV therapy procedures. Strict aseptic technique shall be used when assessing all injection ports, peripheral or central. All injection ports, peripheral and central, shell be disinfected with a sterile alcohol swab using a vigorous rub for no less than 30 seconds. All peripheral IV sites shall be monitored closely for signs of phlebitis. All peripheral occlusive dressings shall be changed with the peripheral site change. During a review of the facility provided P&P titled Infusion Therapy Medication Administration, last reviewed on 1/29/2025, the P&P indicated to provide for safe, accurate, and effective administration of parenteral medications directly into the vascular system. Equipment Required C. Alcohol wipes. Procedures (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	E. Wipe rubber stopper of infusion therapy solution container with alcohol swab.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43455 Based on interview and record review the facility failed to account for two (2) doses of Controlled Substances (also known as Narcotics, Controlled Drug and Controlled Medications [CS, N, CD, CM]- medications which have a potential for abuse and may also lead to physical or psychological dependence) for Residents 139 and 153 in one (1) of three (3) inspected medication carts (Medication Cart Station 2 Cart A.). As a result, control and accountability of medications and CS's did not follow state and federal regulations and facility policy and procedures. These deficient practices increased the opportunity for CS diversion (the transfer of a controlled medication or other medication from a lawful to an unlawful channel of distribution or use), the risk that Residents 139 and 153 and other residents in the facility could have accidental overdose (administering more than the prescribed dose causing adverse drug reactions [unwanted, uncomfortable, or dangerous effects that a medication may have, such as coma (a state of deep unconsciousness) and exposure to harmful medications, and delayed medication treatment during emergencies possibly leading to physical and psychosocial harm, and hospitalization . Findings: During a review of Resident 139's Admission Record (a document containing demographic and diagnostic information), dated 4/22/2025, the Admission Record indicated Resident 139 was originally admitted to the facility on [DATE] with diagnoses including muscle weakness, difficulty in walking and surgical aftercare. During a review of Resident 139's (Medication Administration Record ([MAR] - a record of mediations administered to residents), for April 2025, the MAR indicated Resident 139 was prescribed oxycodone (a CS used for pain) five (5) milligram ([mg] - a unit of measure of mass) to take 1/2 tablet (=2.5 mg) by mouth every four (4) hours as needed for severe pain. During a review of Resident 153's Admission Record dated 4/22/2025, the Admission Record indicated Resident 153 was originally admitted to the facility on [DATE] with diagnosis including epilepsy (seizure). During a review of Resident 153' s MAR for April 2025, the MAR indicated Resident 153 was prescribed lacosamide (a CM used for seizure [bursts of uncontrolled electrical activity between brain cells that causes temporary abnormalities in muscle movements, behaviors, sensations, or states of awareness]) 100 mg to take one (1) tablet by mouth twice a day for seizure at 9 a.m. and 5 p.m. During a concurrent observation and interview, on 4/22/2025, at 1:28 p.m., with Licensed Vocational Nurse (LVN) 3, in Medication Cart Station 2 Cart A, there was a discrepancy in the count between the Individual Narcotic Record and the amount of medication remaining in the medication bubble pack (a medication packaging system that contains individual doses of medication per bubble) for the following residents: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1) One (1) dose of oxycodone 2.5 milligram tablet was missing from the medication bubble pack compared to the count indicated on the Individual Narcotic Record accountability log for Resident 139. The Individual Narcotic Record accountability log indicated the medication bubble pack should have contained a total of 10 oxycodone 2.5 mg tablets, after the last administration of oxycodone 2.5 mg tablet documented/signed-off on 4/21/2025, at 9:55 a.m., however the medication bubble pack contained nine (9) oxycodone 2.5 mg tablets and contained no other documentation of subsequent administrations. 2) One (1) dose of lacosamide 100 mg tablet was missing from the medication bubble pack compared to the count indicated on the Individual Narcotic Record accountability log for Resident 153. The Individual Narcotic Record accountability log for lacosamide indicated the medication bubble pack should have contained a total of seven (7) lacosamide 100 mg tablets, after the last administration of lacosamide 100 mg tablet documented/signed-off on 4/21/2025, at 9 a.m., however the medication bubble pack contained six (6) lacosamide 100 mg tablet and contained no other documentation of subsequent administrations. LVN 3 stated LVN 3 administered oxycodone 2.5 mg tablet to Resident 139, and lacosamide 100 mg tablet to Resident 153 earlier that day and forgot to sign off the Individual Narcotic Record accountability log for each CS. LVN 3 stated LVN 3 failed to follow the facility's policy of signing each CS dose on the Individual Narcotic Record accountability log after preparing the doses for the residents. LVN 3 stated LVN 3 understood it was important to sign each dose once administered to ensure accountability, prevention of CS diversion, and accidental exposures of harmful substances to residents. LVN 3 stated if documentation was not accurate then it can lead to overdose (receiving more than the prescribed dose) harming Residents 139 and 153 leading to respiratory depression (stoppage of breathing) and potential hospitalization . During an interview, on 4/23/2025, at 2:32 p.m., with the Director of Nursing (DON), the DON stated LVN 3 failed to follow the policy of documenting the preparation of CS immediately on the accountability records for Resident 139 and 153. The DON stated not documenting the Individual Narcotic Record accountability log timely can lead to accountability failures, CM diversion, inaccurate clinical records, and accidental use and overdose of harmful substances for residents. During a review of the policy and procedures (P&P) titled, Controlled Medications, last reviewed 1/29/2025, the P&P indicated Medications included in the Drug Enforcement Administration classification as CS are subject to special handling, storage, disposal, and recordkeeping at the facility, in accordance with federal and state laws and regulations. A. The DON and the Consultant Pharmacist maintain the facility's compliance with federal and state laws and regulations in the handling of CMs. D. When a CS is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and/or the MAR: 1. Date and time of administration (MAR, Accountability Record) 2. Amount administered (Accountability Record) 3. Remaining quantity (Accountability Record) (continued on next page)

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	055932	A. Building B. Wing	04/25/2025

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Signature of the nurse administering the dose on the accountability record at the time the medication is removed from the supply.

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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. 44376 Based on interview and record review, the facility failed to ensure each resident's drug regimen are free from unnecessary drugs for one of two sampled residents (Resident 10) reviewed for antibiotic use by failing to ensure the antibiotic (Cefepime HCl) had monitoring for adverse effect (unwanted undesirable effects that are possibly related to a drug). This deficient practice placed the residents at risk for unnecessary medication and undetected adverse/side effects. Findings: During a review of Resident 10's Admission Record, the Admission Record indicated the facility admitted the resident on 12/30/2024, with diagnoses including local infection of the skin and subcutaneous tissue (the layer of tissue that underlies the skin) and type 2 diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing) with other skin ulcer (open sores caused by poor blood circulation). During a review of Resident 10's History and Physical (H&P), dated 12/30/2024, the H&P indicated the resident was alert, oriented to person, place, time, and communicated clearly without evidence of cognitive impairment (having difficulty with thinking, learning, remembering, or making decisions) or language barrier. During a review of Resident 10's Minimum Data Set (MDS, a resident assessment tool), dated 4/7/2025, the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (a participant who has sufficient judgment, planning, organization, self-control, and the persistence needed to manage the normal demands of the participant's environment). During a review of Resident 10's Order Summary Report, dated 4/16/2025, the Order Summary Report indicated an order of Cefepime HCl intravenous solution reconstituted 2 grams (gm, a unit of weight) (Cefepime HCl). Use 1 dose intravenously (IV, within a vein) one time a day for osteomyelitis (an infection in a bone) for 14 days. The Order Summary Report did not indicate an order to monitor for adverse effect on the use of antibiotic Cefepime. During a concurrent interview and record review on 4/24/2025, at 8:38 a.m., with Registered Nurse (RN) 3, reviewed Resident 10's Order Summary Report and Medication Administration Record (MAR). RN 3 stated Cefepime is an antibiotic medication, and it is considered as a significant medication needing monitoring for adverse effects on its use. RN 3 stated it is important to monitor for adverse effects of the antibiotic Cefepime to ensure negative effects are mitigated by reporting to the physician for management. During an interview on 12/25/2025, at 12:37 p.m., with the Director of Nursing (DON), the DON stated Resident 10's Cefepime, an antibiotic is considered as a significant medication. The DON stated the Cefepime should have monitoring for adverse effect on its use so that the licensed nurses can report immediately to the physician the adverse effect of the drug to intervene. The DON also stated the monitoring for adverse effects helps to decrease the use of unnecessary medications on residents. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's recent policy and procedure (P&P) titled Antibiotic Stewardship, last reviewed on 1/29/2025, the P&P indicated to optimize use of antibiotics by improving prescribing practices and reduce inappropriate antibiotic use. The IP will provide results of tracking antibiotic use, outcomes and adverse effects to the clinical staff. During a review of the facility's recent P&P titled Adverse Drug Reactions, last reviewed on 1/29/2025, the P&P indicated to monitor the resident's reaction to prescribed medications. The resident will be monitored by Nursing Staff for any side effects or allergic reactions when starting a new medication. Nursing Staff will monitor the resident for any signs of adverse reaction to new medications. This includes any allergic reaction or side effect to the medication as described in the manufacturer's information or current literature. Documentation of the observed reaction, notification of the Attending Physician and his or her response will be fully documented by a Licensed Nurse.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43455 Based on observation, interview, and record review, the facility failed to ensure that its medication error rate was less than five (5) percent (%). Two (2) medication errors out of 30 total opportunities contributed to an overall medication error rate of 6.67% affecting two (2) of five (5) residents observed for medication administration (Resident 30 and 181.) The medication errors were as follows: 1. Resident 30 did not receive ceftriaxone (an antibiotic [medication used to treat infections caused by bacteria]) as ordered by Resident 30's physician. 2. Resident 181 received docusate (a medication used for bowel [intestine] management) at a different time than ordered by Resident 181's physician. These failures had the potential to result in Resident 30 and 181 receiving suboptimal (less than standard) care and resulting in Residents 30's and 181's health and well-being negatively impacted. Findings: During a review of Resident 30's Admission Record (a document containing demographic and diagnostic information), the record indicated Resident 30 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including immunodeficiency (decreased ability of the body to fight infections and diseases). During a review of Resident 30's Order Summary Report, dated 4/22/2025, indicated Resident 30 was prescribed ceftriaxone 1 gram ([GM] - a unit of measure of mass) intravenous ([IV] - into the vein) once a day for left pleural effusion (an abnormal buildup of fluid in the space between the lungs and chest cavity [pleural space] caused by bacteria) for 10 days, starting 4/22/2025. During a review of Resident 30's IV Administration Record ([IVT] - a record of IV medications administered to residents), for April 2025, the IVT indicated Resident 30 was prescribed ceftriaxone to be given 1 GM IV once a day for left pleural effusion for 10 days, at 9 a.m. During a review of Resident 181's Admission Record, the record indicated Resident 181 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including gout (buildup of crystals in the joints causing pain), hypertension (high blood pressure), depression (a mental illness characterized by persistent feelings of sadness, loss of interest, and other symptoms that significantly impact daily life), and muscle weakness. During a review of Resident 181's Medication Administration Record (MAR), for April 2025, the MAR indicated Resident 181 was prescribed docusate 100 milligrams (mg - a unit of measure for mass) capsule to give one (1) capsule twice a day orally for bowel management, at 8 a.m. and 5 p.m. During an observation, on 4/22/2025, at 9:05 a.m., in Medication Cart Station 2 Cart B, Licensed Vocational Nurse (LVN) 11 prepared several medications for Resident 30. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation, on 4/22/2025, at 9:25 a.m., LVN 11 administered several medications to Resident 30. LVN 11 did not administer ceftriaxone. During an observation, on 4/22/2025, at 10:15 a.m., in Medication Cart Station 1 Cart 1, LVN 6 administered gabapentin (a medication used for neuropathy [a condition that can cause muscle weakness]), carvedilol (a medication used for hypertension), allopurinol (a medication used for gout), sertraline (a medication used for depression), and docusate orally to Resident 181. Resident 181 swallowed the gabapentin, carvedilol, allopurinol, sertraline, and docusate with a glass of water. During an interview, on 4/22/2025, at 12:13 p.m., with LVN 6, LVN 6 stated that LVN 6 administered several medications including docusate during the morning medication administration at 10:15 a.m. to Resident 181. LVN 6 acknowledged the physician's order specified to administer docusate at 8 a.m. LVN 6 stated per facility policy there was a 60-minute window for medication administration and LVN 6 administered the docusate later than that timeframe. LVN 6 stated this was considered a medication error. During an interview, on 4/22/2025, at 12:20 p.m., with LVN 11 and Registered Nurse (RN) 1, LVN 11 stated RNs were responsible for administering IV antibiotics. RN 1 stated that RN 1 did not administer the ceftriaxone IV at 9 a.m. to Resident 30 that morning because the resident did not have IV line access. RN 1 stated that RN 1 did not have time until 11 a.m. that morning to try to get IV line access for Resident 30. RN 1 stated it was not acceptable to delay antibiotic administration and it was considered a medication error. RN 1 stated not administering antibiotics timely can harm Resident 30 by worsening the infection. During an interview, on 4/23/2025, at 2:32 p.m., with the Director of Nursing (DON), the DON stated RN 1 failed to administer ceftriaxone to Resident 30 and LVN 6 failed to administer docusate to Resident 181, and at the scheduled times and according to the physician orders. The DON stated licensed nurses should follow facility medication administration guidelines to ensure physician orders are followed and the right medications are administered at the right times to residents. The DON stated these were considered medication errors. The DON stated not administering medications as ordered by the physician does not provide optimal care and treatment for Resident 30's and 181's health conditions. During a review of facility's policy and procedures (P&P) titled, Medication - Administration, last reviewed on 1/29/2025, the P&P indicated To ensure the accurate administration of medications for residents in the Facility. B.i. Medications may be administered one (1) hour before or after the scheduled medication administration time. VI.A. Nursing staff will keep in mind the send (7) rights of medication when administering medication. VI.B. The seven (7) rights of medication are: iv. The right time. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of facility's P&P titled, Medication Guidelines, last reviewed on 1/29/2025, the P&P indicated: 1. Antibiotic medications shall be available for administration within the state regulated time frames. During a review of the facility's P&P titled Medication Administration-General Guidelines, last reviewed 1/29/2025, the P&P indicated that Medications are administered as prescribed in accordance with good nursing principles and practices . Preparation 4. FIVE RIGHTS - Right resident, right drug, right dose, right route, and right time, are applied for each medication being administered. A triple check of these five (5) Rights is recommended at three (3) steps in the process of preparation of a medication for administration: (1) when the medication is selected, (2) when the dose is removed from the container, and finally (3) just after the dose is prepared and the medication put away. Administration 2. Medications are administered in accordance with written orders of the prescriber. 12. Medications are administered within 60 minutes of scheduled time, except before, with or after meals, which are administered based on mealtimes.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44376 Based on observation, interview, and record review, the facility failed to ensure residents were free of any significant medication errors (means the observed or identified preparation or administration of medications or biologicals which is not in accordance with the prescriber's order, manufacturer's specifications, and accepted professional standards) by failing to: 1. rotate (a method to ensure repeated injections are not administered in the same area) subcutaneous ([SQ] - beneath the skin) insulin (a hormone that lowers the level of glucose [a type of sugar] in the blood) administration sites for three (3) of three (3) sampled residents (Residents 52, 159, 390) reviewed for insulin. 2. remove expired insulin from the medication cart and administering expired insulin by several Licensed Vocational Nurses (LVN)s to Resident 90 in one (1) of three (3) inspected medication carts (Medication Cart Station 2 Cart A). As a result, Resident 90 received four (4) doses of expired insulin between [DATE] and [DATE] not in accordance with standards of practice. These deficient practices had the potential to cause Residents 52, 159, and 390 adverse effects (unwanted, unintended result) of same site SQ administration of insulin such as excessive bruising, lipodystrophy (abnormal distribution of fat) and cutaneous amyloidosis (is a condition in which clumps of abnormal proteins called amyloids build up in the skin), and the potential to cause Resident 90 to experience serious complications such as hyperglycemia (a condition in which the level of sugar in the blood is higher than normal) and diabetic coma (a life-threatening complication that can result from very high blood sugar or very low blood sugar levels) resulting in potential hospitalization and/or death. Cross References F658 and F761 Findings: 1. During a review of Resident 52's Admission Record (a document containing demographic and diagnostic information,) the Admission Record indicated the facility admitted the resident on [DATE], and readmitted the resident on [DATE], with diagnoses including type 2 diabetes mellitus ([DM2] - a disorder characterized by difficulty in blood sugar control and poor wound healing), long term use of insulin, and metabolic encephalopathy (a change in how your brain works due to an underlying condition). During a review of Resident 52's History and Physical (H&P), dated [DATE], the H&P indicated the resident was unable to make decisions. During a review of Resident 52's Minimum Data Set ([MDS] - a resident assessment tool), dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had moderate cognitive impairment (more pronounced deficits emerge, interfering with daily activities). The MDS indicated the resident was on a high-risk drug class hypoglycemic (agents that lower glucose levels in the blood) medication. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 52's Order Summary Report, the Order Summary Report indicated the following physician orders dated: [DATE] - Insulin glargine solution 100 unit per milliliter (unit/ml, a milliliter is a unit of fluid volume equal to one-thousandth of a liter). Inject 5 units subcutaneously at bedtime for DM, rotate sites. Hold (do not administer) if blood sugar (BS) less than (<)100 milligrams per deciliter (mg/dL, a milligram is one-thousandth of a gram). [DATE] - Humulin R (a short acting insulin) injection solution 100 unit/ml (Insulin Regular [Human]). Inject as per sliding scale (increasing administration of the pre?meal insulin dose based on the blood sugar level before the meal): if ,d+[DATE]=0; ,d+[DATE]=4; ,d+[DATE]=8; ,d+[DATE]=10; ,d+[DATE]=12; ,d+[DATE]=14. Notify physician (MD if BS <70 or greater than (>) 400, subcutaneously one time a day every Monday, Wednesday, Friday for diabetes mellitus. Finger stick blood sugar (a method of drawing drops of blood for at-home medical tests) using test strips (small, plastic strips used with a meter to measure the amount of sugar [glucose] in the blood) and lancets (finger-stick blood samplers) with diagnosis of diabetes mellitus. During a review of Resident 52's Location of Administration Report of insulin for ,d+[DATE] to ,d+[DATE], the Location of Administration of insulin indicated that: Insulin Glargine Solution 100 unit/ml was administered on: [DATE] at 10:15 p.m. at the Arm-left [DATE] at 11:45 p.m. at the Arm-left [DATE] at 10:51 p.m. at the Abdomen-Right Lower Quadrant (RLQ) [DATE] at 9:12 a.m. at the Abdomen-RLQ Humulin R injection R injection solution 100 unit/ml was administered on: [DATE] at 6:09 a.m. at the Arm-left [DATE] at 9:59 a.m. at the Arm-left [DATE] at 11:59 a.m. at the Arm-left [DATE] at 5:34 p.m. at the Arm-left 43455 2. During a review of Resident 90's Admission Record dated [DATE], the Admission Record indicated Resident 90 was originally admitted to the facility on [DATE] with diagnoses including DM2. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 90's MAR ([MAR] - a document of the medications administered to a resident that is part of the resident's permanent medical record], for [DATE], the MAR indicated Resident 90 was prescribed insulin Lispro (a fast-acting insulin) Kwikpen (type of injection pen) to be administered SQ per sliding scale before meals and at bedtime for DM, at 6:30 a.m., 11:30 a.m., 4:30 p.m. and 9 p.m. The MAR also indicated that Resident 90 received the following doses of insulin Lispro Kwikpen by the following LVNs on the following dates/times: LVN 3 - 8 un SQ on [DATE] at 11:30 a.m. LVN 7 - 8 un SQ on [DATE] at 4:30 p.m. LVN 8 - 8 un SQ on [DATE] at 4:30 p.m. LVN 3 - 10 un SQ on [DATE] at 11:30 a.m. 43988 3. During a review of Resident 159's Admission Record, the Admission Record indicated the facility originally admitted the resident on [DATE] and readmitted the resident on [DATE] with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness of the arm, leg, and trunk on the same side of the body) following cerebral infarction (also known as stroke, loss of blood flow to a part of the brain) affecting left non-dominant side, DM 2, and anxiety disorder (a mental health condition where excessive fear and worry interfere with daily life, causing significant distress). During a review of Resident 159's H&P dated [DATE], the H&P indicated Resident 159 did not have the capacity to understand and make decisions. During a review of Resident 159's MDS dated [DATE], the MDS indicated Resident 159 had severely impaired cognition (mental action or process of acquiring knowledge and understanding). The MDS further indicated Resident 159 had impairment on one side of the upper and lower extremity and required total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 159 received insulin. During a review of Resident 159's care plan (CP) on risk for hypoglycemia (a condition in which the blood sugar levels drop below normal) and hyperglycemia initiated on [DATE], the CP indicated to administer insulin lispro (a short acting insulin) for sliding scale as one of the interventions to keep Resident 159 free from hypoglycemia/hyperglycemia. During a review of Resident 159's Order Summary Report, the Order Summary Report indicated the following physician's order dated [DATE]: - Insulin lispro (1 unit dial) subcutaneous solution pen-injector 100 unit/ml. inject as per sliding scale: if , d+[DATE] = 0 units; 150 - 199 = 3; 200 - 249 = 4; 250 - 299 = 7; 300 - 349 = 10; 350 - 399 = 12. Call MD if BS <70 or >400, SQ 3 times a day for DM 2. Rotate sites. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. During a review of Resident 390's Admission Record, the Admission Record indicated the facility originally admitted the resident on [DATE] and readmitted the resident on [DATE] with diagnoses including schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), DM 2, and anxiety disorder. During a review of Resident 390's H&P dated [DATE], the H&P indicated the resident was alert and aware of her identity, location, and the time. During a review of Resident 390's MDS dated [DATE], the MDS indicated Resident 390 had an intact cognition (mental action or process of acquiring knowledge and understanding) and was able to understand others and make herself understood. The MD further indicated Resident 390 had impairment on one side of the upper extremity and required total assistance from staff with all ADLs. During a review of Resident 390's CP on risk for hypoglycemia/hyperglycemia initiated on [DATE], the CP indicated to administer Humulin R (a short acting insulin) insulin for sliding scale as one of the interventions to keep Resident 390 free from hypoglycemia/hyperglycemia. During a review of Resident 390's Order Summary Report, the Order Summary Report indicated the following physician's order dated [DATE] and last revised on [DATE]: - Humulin R injection solution 100 unit/ml inject as per sliding scale: if 71 - 150 = 0 units; BS below 70 = MD; 151 - 200 = 2; 201 - 250 = 4; 251 - 300 = 6; 301 - 350 = 8; 351 - 400 = 10; 401 plus give 12 units then call MD, SQ before meals and at bedtime for DM 2. FSBS check four (4) times daily. Give Humulin R insulin for sliding scale as coverage. Rotate sites. During an observation on [DATE] at 1:28 p.m., in Medication Cart Station 2 Cart A, in the presence of Licensed Vocational Nurse (LVN) 3, the following medications were found either stored in a manner contrary to their respective manufacturers' requirements, expired and not discarded contrary to facility policies, currently accepted laws and professional principles: 1. One (1) open Lispro Kwikpen for Resident 90 was found stored at room temperature and labeled with a sticker indicating use began on [DATE] and an expiration date of [DATE]. According to the manufacturer's product labeling, opened Lispo Kwikpens should be stored at room temperature up to 86 degrees Fahrenheit (F) and used or discarded within 28 days of opening or once storage at room temperature began. During a concurrent interview, LVN 3 stated the Lispo Kwikpen for Resident 90 was opened on [DATE] and expired on [DATE]. LVN 3 stated insulins are usually good for 28 days once opened and lose potency (effectiveness) and expire beyond that date. LVN 3 stated four (4) expired dose of insulin Lispro were administered to Resident 90 between [DATE] and [DATE]. LVN 3 stated administering expired insulin will not be effective in treating residents blood sugar levels and can harm Resident 90 by causing high blood sugar levels leading to coma, hospitalization , and death. LVN 3 stated the Lispo Kwikpen needed to be removed from the medication cart on [DATE] to prevent administration of expired insulin to Resident 90. LVN 3 stated she will immediately discard the expired Lispo Kwikpen and replace it with a new one from pharmacy. (continued on next page)

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	055932	A. Building B. Wing	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 2:32 p.m., with the Director of Nursing (DON), the DON reviewed Resident 90's MAR for [DATE]. The DON stated insulin Lispro Kwikpen for Resident 90 was expired and needed to be removed from Medication Cart Station 2 Cart A and replaced with a new pen from pharmacy. The DON acknowledged that several LVNs failed to remove the expired insulin Lispro Kiwkpen for Resident 90 from the medication cart, and according to the MAR, Resident 90 was administered four (4) doses of expired insulin between [DATE] and [DATE], resulting in significant medication errors. The DON stated administering expired insulin to Resident 90 will not be effective in controlling the blood sugar levels and can harm the resident by causing high blood sugar levels, leading to DKA ([DKA] - a condition that develops when the body doesn't have enough insulin resulting in the buildup of acid in the blood to levels that can be life threatening), and hospitalization . During a concurrent interview and record review on [DATE], at 9:36 a.m., with Registered Nurse (RN) 3, reviewed Resident 52's Order Summary Report, Location of Administration Report, and CP. RN 3 stated there were multiple instances that the licensed staff did not rotate the insulin administration sites on Resident 52 from ,d+[DATE] to ,d+[DATE] on the Location of Administration Report for insulin. RN 3 stated the sites of administration should be rotated to prevent lipodystrophy on residents. RN 3 stated injecting insulin on sites with lipodystrophy will affect its absorption (the passage of a drug from its site of administration into the systemic circulation) causing hypoglycemia/hyperglycemia. RN 3 stated not rotating insulin administration sites is considered as a medication error. During a concurrent interview and record review on [DATE] at 9:46 a.m., reviewed Resident 159's physician's order, CP, and SQ administration sites for insulin lispro from [DATE] to [DATE] with the MDS Coordinator (MDSC.) The MDSC stated Resident 159 received insulin, had a physician's order for insulin lispro, and were administered as follows: - [DATE] 12:00 p.m. - right arm - [DATE] 5:34 a.m. - right arm - [DATE] 7:12 a.m. - left lower quadrant (LLQ) - [DATE] 6:34 a.m. LLQ - [DATE] 9:46 p.m. - left arm - [DATE] 8:02 a.m. - left arm - [DATE] 6:20 a.m. - LLQ - [DATE] 8:31 p.m. - LLQ During a concurrent interview and record review on [DATE] at 9 a.m., reviewed Resident 390's physician's order, CP, and subcutaneous administration sites for Humulin R from [DATE] to [DATE] with the MDSC. The MDSC stated Resident 390 received insulin, had a physician's order for Humulin R, and were administered as follows: - [DATE] 12:21p.m. - left lower quadrant (LLQ) (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- [DATE] 4:46 p.m. - LLQ - [DATE] 6:06 p.m. - LLQ - [DATE] 7:10 p.m. LLQ - [DATE] 9:17 pm LLQ - [DATE] 4:30 p.m. LLQ The MDSC stated the administration sites for insulin should be rotated per standards of practice, manufacturer's guideline, and per physician's order to prevent hardening or lumps in the skin. The MDSC stated Residents 159 and 390 had a physician's order to rotate administration sites. The MDSC stated the location of administration sites for Resident 159's and 390's insulin was not rotated. The MDSC stated Resident 159's and 390's administration sites should have been rotated to prevent pain, redness, irritation, and lumps on the resident's skin which can affect the absorption of the insulin. The MDSC stated not following the MD order to rotate sites, not following the manufacturer's guideline and professional standards of practice can be considered a medication error. During an interview on [DATE], at 12:37 p.m., with the DON, the DON stated licensed staff should have rotated the sites of insulin administration of Resident 52 to prevent lipodystrophy. The DON stated injecting medications on the same site where lipodystrophy occurred decreases the absorption of the medication. The DON stated not rotating insulin administration sites is considered a medication error. During an interview on [DATE] at 12:40 p.m. with the DON, the DON stated the nurses are supposed to rotate insulin administration sites according to physician's order, standards of practice, and as indicated in the manufacturer's guideline. The DON stated the location of administration sites for Residents 159 and 390 was not rotated. The DON stated Resident 159's and 390's administration sites for the Humulin R should have been rotated to prevent adverse effects such as bruising, skin irritation, skin pits, lipodystrophy and amyloidosis which can affect absorption of insulin. The DON stated not rotating the insulin administration sites can be considered a medication error as the staff was not following the MD order to rotate sites, not following the manufacturer's guidelines and professional standards of practice. During a review of the facility's policy and procedures (P&P) titled, Storage of Medications, last reviewed on [DATE], the P&P indicated that Medications and biologicals ae stored safely, and properly, following manufacturer's recommendations or those of the supplier. M. Outdated, contaminated, or deteriorated medications .are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy if a current order exists. During a review of the manufacturer's guide Instructions for use for Lispro Kwikpen, dated ,d+[DATE], the guide indicated to store used pens at room temperature up to 86 F and to throw away the Insulin Lispro Pen after 28 days, even if it still has insulin left in it. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled Administration Procedures for All Medications, last reviewed on [DATE], the P&P indicated: To administer medication in a safe and effective manner. H. Check expiration date on package/container before administering any medication. When opening a multi-dose container, place the date on the container. During a review of the facility's recent P&P titled Medication- Errors, last reviewed on [DATE], the P&P indicated to ensure the prompt reporting of errors in the administration of medications and treatments to residents. Medication Error means the administration of medication: A. To the wrong resident; B. At the wrong time; C. At the wrong dose; D. Via the wrong route; or E. Which is not currently prescribed. During a review of the facility's recent P&P titled Subcutaneous Injection, last reviewed on [DATE], the P&P indicated medications are administered via subcutaneous injection appropriately and safely as ordered by an Attending Physician when a rapid and systemic effect is desired and also to administer medications that cannot be given orally. During a review of the facility-provided Highlights of Prescribing Information titled Insulin Glargine-YGFN injection, for Subcutaneous use, with initial U.S. Approval in 2021, the Highlights of Prescribing Information indicated to rotate injection sites to reduce risk of lipodystrophy and localized cutaneous amyloidosis. During a review of the facility-provided Highlights of Prescribing Information titled Humulin R (insulin human) injection, for Subcutaneous or intravenous use, with initial U.S. approval in 1982, the Highlights of Prescribing Information indicated to inject SQ 30 minutes before a meal into the thigh, upper arm, abdomen, or buttocks. Rotate injection sites to reduced risk of lipodystrophy and localized cutaneous amyloidosis. During a review of the facility-provided Highlights of Prescribing Information titled insulin lispro injection solution, for subcutaneous or intravenous use, with initial U.S. approval in 1996, the Highlight of Prescribing Information indicated to administer insulin lispro by subcutaneous injection into the abdominal wall, thigh, upper arm, or buttocks within 15 minutes before a meal or immediately after a meal. Rotate injection sites to reduce risk of lipodystrophy and localized cutaneous amyloidosis.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 43455 Based on observation, interview, and record review the facility failed to: 1. Label one (1) artificial tears (a medication used for eye dryness) eye drop bottle for Resident 68, in accordance with facility policies, in one (1) of three (3) inspected medication carts (Medication Cart Station 3). 2. Remove and discard from use one (1) expired insulin (a medication used to regulate blood sugar levels) Lispro (fast-acting insulin) Kwikpen (type of injection pen) pen for Resident 90 from one (1) of three (3) inspected medication carts (Medication Cart Station 2 Cart A.) These deficient practices increased the risk that Residents 68 and 90 could have received medications that had become ineffective or toxic due to improper storage or labeling, and to experience serious complications such as eye infections and hyperglycemia (elevated blood sugar levels) diabetic coma (a life-threatening complication that can result from very high blood sugar or very low blood sugar levels) resulting in potential hospitalization and/or death. Cross reference F760 Findings: During a concurrent observation and interview, on [DATE], at 1:28 p.m., in Medication Cart Station 2 Cart A, with Licensed Vocational Nurse (LVN) 3, the following medications were found either stored in a manner contrary to their respective manufacturers' requirements, expired and not discarded contrary to facility policies, currently accepted laws and professional principles: 1. One (1) open Lispro Kwikpen for Resident 90 was found stored at room temperature and labeled with a sticker indicating use began on [DATE] and an expiration date of [DATE]. The manufacturer's product labeling indicated opened Lispo Kwikpen should be stored at room temperature up to 86 degrees Fahrenheit (F) and used or discarded within 28 days of opening or once storage at room temperature began. LVN 3 stated the Lispo Kwikpen for Resident 90 was opened on [DATE] and expired on [DATE]. LVN 3 stated insulins are usually good for 28 days once opened and lose potency (effectiveness) and expire beyond that date. LVN 3 stated four (4) expired dose of insulin Lispro were administered to Resident 90 between [DATE] and [DATE]. LVN 3 stated administering expired insulin will not be effective in treating residents blood sugar levels and can harm Resident 90 by causing high blood sugar levels leading to coma, hospitalization , and death. LVN 3 stated the Lispo Kwikpen needed to be removed from the medication cart on [DATE] to prevent administration of expired insulin to Resident 90. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview, on [DATE], at 1:03 p.m., in Medication Cart Station 3, with LVN 10, the following medication was found stored in a manner contrary to their respective manufacturers' requirements and not labeled with an open date as required by their respective manufacturers' specifications and contrary to facility policies, currently accepted laws and professional principles: 1. One (1) open artificial tears eye drop bottle for Resident 68 stored at room temperature and not labeled with a date indicating when use began. LVN 10 stated the artificial tears eye drop bottle for Resident 68 was not labeled with a date indicating when use began. LVN 10 stated eye drop medications are usually good for 28 days after opening. LVN 10 stated without knowing a date of use, it was unknown when the eye drop would expire. LVN 10 stated without knowing the expiration date, potentially expired eye drop can be administered to Resident 68. LVN 10 stated administering expired artificial tear to Resident 68 will not be effective in treating the resident's eye dryness and lead to worsening of the dryness, and causing eye infections since the eye drop was no longer sterile (free of infections) beyond the expiration date. LVN 10 stated the artificial tear eye drop needed to be discarded and replaced with a new one. During a concurrent interview and record review, on [DATE], at 2:32 p.m., with the Director of Nursing (DON), Resident 90's MAR, for [DATE], was reviewed. The DON stated insulin Lispro Kwikpen for Resident 90 was expired and needed to be removed from Medication Cart Station 2 Cart A and replaced with a new pen from pharmacy. The DON acknowledged that several LVN's failed to remove the expired insulin Lispro Kiwkpen for Resident 90 from the medication cart, and according to the MAR, Resident 90 was administered four (4) doses of expired insulin between [DATE] and [DATE], resulting in significant medication errors. The DON stated administering expired insulin to Resident 90 will not be effective in controlling the blood sugar levels and can harm the resident by causing high blood sugar levels, leading to DKA ([DKA] - a condition that develops when the body doesn't have enough insulin resulting in the buildup of acid in the blood to levels that can be life threatening), and hospitalization . During an interview, on [DATE], at 2:32 p.m., with the DON, the DON stated the artificial tears eye drop bottle for Resident 68 was not labeled with a date indicating when use began. The DON stated eye drop bottles are multi-dose (containing more than one [1] dose) containers and are usually good for 28 days once it is opened. The DON stated opened eye drops should be dated with an open date to know when they should be disposed of, otherwise they are considered expired. The DON stated that using expired eye artificial tears will not be effective in treating eye dryness due to decreased potency and lead to possible infections due to decreased sterility. During a review of facility's policy and procedures (P&P) titled, Storage of Medications, last reviewed on [DATE], the P&P indicated Medications and biologicals are stored safely, and properly, following manufacturer's recommendations or those of the supplier. M. Outdated, contaminated, or deteriorated medications .are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy if a current order exists. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of manufacturer's guide titled, Instructions for use for Lispro Kwikpen, dated ,d+[DATE], the guide indicated to store used pens at room temperature up to 86 F and to throw away the Insulin Lispro Pen after 28 days, even if it still has insulin left in it. During a review of the facility's P&P titled, Administration Procedures for All Medications, last reviewed on [DATE], the P&P indicated: To administer medication in a safe and effective manner. H. Check expiration date on package/container before administering any medication. When opening a multi-dose container, place the date on the container.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 47441 Based on observation, interview, and record review, the facility failed to ensure kitchen staff were routinely trained and evaluated for competency skills when two (2) of 2 staff (Cook 1 and [NAME] 2) were not able to verbalize the correct cool-down process (a method to safely reduce the temperature of cooked food and prevent bacterial growth) of food. This failure resulted in improper cooling of roast turkey and roast beef which had the potential to result in harmful bacterial growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness (a disease caused by consuming food or drinks that are contaminated by germs or chemicals) in 164 of 176 medically compromised residents who received food from the kitchen. Findings: 1. During an interview on 4/22/2025 at 11:18 a.m. with [NAME] 1, [NAME] 1 stated she started cooking the roast turkey this morning. During a concurrent interview and record review on 4/23/2025 at 8:46 p.m. with [NAME] 1, the cooling log dated 4/2025 was reviewed. The cooling log indicated there was a record of roast turkey cooled on 4/22/202025 and finished cooling at 9 p.m. [NAME] 1 stated she did not cook the roast turkey yesterday but [NAME] 2 did it last Monday (4/21/2025). During a concurrent interview and record review on 4/23/2025 at 9 a.m. with [NAME] 2, the cooling log dated 4/2025 was reviewed. The cooling log indicated, the roast turkey was cooked on 4/22/2025 and started cooling with a temperature of 195 degrees Fahrenheit (F - unit of measurement for temperature) at 1 p.m. then cooled at 3 p.m. at 95 F and temperature went down at 67 F at 5 p.m. The cooling log further indicated the roast turkey was cooled at 49 F at 7 p.m., and 36 F at 9 p.m. [NAME] 2 stated she committed an error on the date and recorded 4/22/2025 instead of 4/21/2025. [NAME] 2 stated she started cooling the turkey when it came out of the oven at 1 p.m. on 4/21/2025 with a temperature of 195 F then rechecked the temperature at 3 p.m. and it was at 95 F. [NAME] 2 stated she rechecked the temperature at 5 p.m. and it went down to 67 F. [NAME] 2 stated there was a total of two (2) hours for the turkey to cool down to 70 F and below. [NAME] 2 stated she tempted the roast turkey again at 7 p.m. and then it was at 49 F hence she decided to continue cooling it down to 36 F for a total of eight (8) hours cooling. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/23/2025 at 9:15 a.m. with the Dietary Supervisor (DS), the DS stated the proper cooling of food starts with cooking the food. The DS stated the roast turkey was cooked on Monday and the starting temperature was at 195 F. The DS stated the cook was supposed to slice the roast turkey into small portions to make it cool faster in a room temperature and wait for it to go down to 135 F. The DS stated the staff was supposed to log the time and temperature of 135 F then within 2 hours the roast turkey needed to go down to 70 F and below. The DS stated the roast turkey needed to further cool down to 40 F within four (4) hours for a total of six (6) hours of the cooling process. The DS stated if the roast turkey did not cool down to 40 F in a total of 4 hours then they needed to reheat the roast turkey to 165 F for 15 seconds or throw it away. The DS stated it was important to follow time and temperature in cooling to prevent the risk of bacterial growth in food. The DS stated residents could get sick if food was not cooled properly. During a concurrent interview and record review on 4/23/2025 at 9:30 a.m. with the DS and the Assistant Dietary Supervisor (ADS), the cooling log was reviewed. The cooling log indicated the food cooled, the time and temperature record as follows: 4/12/2025 Roast Pork with cooking temperature was at 200 F at 2:20 p.m., 93 F at 3:20 p.m., 67 F at 4:25 p.m., 48 F at 5:25 p.m. and 36 F at 6:20 p.m. 4/13/2025 Roast Turkey with cooking temperature was at 185 F at 12 noon, 97 F at 2 p.m., 64 F at 4 p.m., 50 F at 6 p.m. and 35 F at 8 p.m. 4/22/2025 Roast Beef with cooking temperature was at 198 F at 11 p.m., 89 F at 3:30 p.m. The cooling log further indicated, Procedure: Remove item to be cooled from the oven, take temperature ensuring that the internal temperature meets the required minimum for that item. Cut the item into small pieces and remove all the broth or juice from the pan. Loosely cover the pan with foil, allowing air vents for the steam to escape. Place the item into the freezer and closely monitor, when the temperature hits 41 degrees, begin the cooling process. Log the time at 41 degrees on the log, place the item back into the freezer, and remove after 1 hour, take down the temperature. ADS stated the 41 F may have been a typographical error. During an interview on 4/23/2025 at 9:30 a.m. with the DS, the DS stated the staff did not properly cool the meats on 4/12/2025, 4/13/2024, 4/21/2025 and 4/22/2025 as it exceeded the 6 hours total cooling time and on 4/22/2025 the food should have been discarded. During a review of the facility's P&P titled, Hazardous Foods Cooling Monitor, reviewed 1/29/2025, the P&P indicated Purpose: To provide the dietary department with guidelines for service, storage and reheating of hazardous foods. Procedure: 1. Transfer cooked product to a container(s) with a depth no greater than two inches. 2. Label and date containers. 3. Place container(s) in the refrigerator or freezer for cooling. a. Leave the container uncovered or loosely covered during the cooling process. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Hot food should be cooled from 140 F to 70 F within two hours and cooled from 70 F to 41 F or lower in an additional four hours. a. If temperature is not dropping adequately, consider using an ice bath. b. If it is a roast, cut into small pieces. c. If the temperature does not reach 70 F within two hours, reheat to 165 F and start the cooling process again. During a review of the Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 3-501.14 Cooling. (A) Cooked time/temperature control for safety food shall be cooled: (1) Within 2 hours from 57 C (135 F) to 21 C (70 F); P and (2) Within a total of 6 hours from 57 C (135 F) to 5 C (41 F) or less. P (B) TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be cooled within 4 hours to 5 C (41 F) or less if prepared from ingredients at ambient temperature, such as reconstituted FOODS and canned tuna. During a review of the facility's job description (JD) titled [NAME] dated and signed by [NAME] 1 on 1/2/2025, the document indicated Technical: Performs duties in a safe and sanitary manner. During a review of the facility's checklist titled Orientation Checklist dated 1/2/2025, the checklist indicated there were no topics about proper cooling of foods. During a review of the facility's checklist titled Orientation Checklist dated 4/23/2025, the checklist indicated there were no topics about proper cooling of foods. During a review of the facility's competency checklist titled Competency Verification- Dietary Cooks dated 4/23/2025, the checklist indicated the DS verified competencies for using of cool down log but did not indicate the verification methods. During a review of the facility's checklist titled Competency Skills Check dated signed by the DS 4/23/2025, the checklist indicated the DS was able to ensure cool log utilized effectively on 4/23/2025. During a review of the facility's JD titled Dietary Services Supervisor/Certified Dietary Manager date 8/19/2024, the JD indicated, Supervisory: Monitors staff performance and addresses any needs. During a review of the facility's orientation checklist, titled Suggested Topics for Orientation Checklist' dated 8/19/2024, the checklist did not indicate cooling log topic.

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 47441 Based on observation, interview, and record review, the facility failed to follow the menu and did not meet nutritional needs of residents when [NAME] 1 did not follow the recipe for gravy on 4/22/2024 for lunch. This failure had the potential to result in salty food item resulting to excessive nutrient intake of sodium (a nutrient naturally found in salt), ineffective therapeutic diet provisions, increased blood pressure, water retention, and poor food intake to 50 of 176 residents on consistent carbohydrate diet (CCHO, a diet with the same amount or servings of carbohydrates in each meal for blood sugar control) and CCHO, renal diet (a diet low in salt, potassium, phosphorus and limited in protein) residents including Resident 157 getting food from the kitchen. Findings: During a review of Resident 157's Admission Record, the Admission Record indicated the facility initially admitted Resident 157 on 10/23/2024 and readmitted the resident on 1/8/2025 with diagnoses that included type two (2) diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing) with foot ulcer (a small open sore or wound), end stage renal disease (ESRD, irreversible kidney failure), and hypertensive chronic kidney disease (kidney problems that occur because of high blood pressure that is present over a long time). During a review of Resident 157's Minimum Data Sheet (MDS - a resident assessment tool) dated 3/8/2025, the MDS indicated Resident 157 understood others and made self understood. The MDS indicated the resident required set-up or clean up assistance when eating. During a review of Resident 157's Physician Orders dated 1/8/2025, the Physician Orders indicated to provide renal diabetic diet (CCHO, renal diet) regular texture (texture with no restriction). During an interview on 4/22/2025 at 10:28 a.m. with Resident 157, Resident 157 stated the food at the facility was too salty and he was already on a special diet but the food the facility served was still too salty. During a review of the facility's daily spreadsheet (a list of food, amount of food that each diet would receive) titled Spring Cycle Menus, dated 4/22/2025, the spreadsheet indicated residents on CCHO diet would include the following foods on the tray: Roast turkey three (3) ounces (oz, a unit of measurement) Gravy 1 oz Bread dressing 1/3 cup (c., a household measurement) Seasoned peas 1/2 c. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Three bean salad - drain 1/2 c. Vanilla mousse with no chocolate chips Milk 4 oz The spreadsheet further indicated residents on CCHO renal diet would include the following foods on the tray: Roast turkey 3 oz Gravy 1 oz Seasoned peas 1/2 c Wheat roll 1 piece Margarine 1 teaspoon Diet apple sauce 1/2 c Milk 4 oz/diet punch 8 oz During an interview on 4/22/2025 at 12:03 p.m. with [NAME] 1, [NAME] 1 stated the regular and therapeutic diets got the same roast turkey meat and the only difference was the sauce as she prepared a cranberry-ginger citrus sauce for regular diet and gravy for residents on renal and diabetic diets (CCHO). During a concurrent observation and interview on 4/22/2025 at 12:54 p.m. of the test tray (a process of tasting, temping [using a thermometer to check its internal temperature to ensure it's cooked to a safe and desired level], and evaluating the quality of food) of a renal CCHO diet with the Dietary Supervisor (DS) and the Assistant Supervisor (ADS), tasted the roasted turkey with gravy and it was salty. The ADS stated renal diet should not be salty and the cook followed recipes and maybe the amount of base the cooks used made it salty. The ADS stated [NAME] 1 prepared everything for lunch. The ADS stated it was important to follow the recipe because if the food was salty the residents would not eat and enjoy their food. The DS stated renal diet should not be salty as it would be contraindicated in the diet making them sick and retain water as a potential outcome. During an interview on 4/23/2025 at 8:46 p.m. with [NAME] 1, [NAME] 1 stated she did not follow the recipe for the gravy for the renal CCHO diet because they do not have too many residents on it. [NAME] 1 stated she just guessed the ingredients and added the juice of the turkey, flour, and some seasonings. [NAME] 1 stated she did not follow the recipe of the gravy because it was not available in the recipe binder; however, it was important that they follow the exact recipe to ensure the food of the residents would taste good. [NAME] 1 stated the residents would not eat if the food did not taste good. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/23/2025 at 9:46 a.m. with the DS, the DS stated they could not find the recipe for gravies, but all the food has standardized recipes, and it was important to follow the recipes to ensure residents would get the right amount of nutrition. The DS stated [NAME] 1 did not follow the recipe for gravy and residents on renal diet could get sick by not getting proper nutrition causing malnutrition (a condition where a person does not receive or absorb enough nutrients from their diet) if the recipes were not accurately followed. The DS stated [NAME] 1 should not have prepared gravy as all the diets gets the same sauce and the spreadsheet was confusing as it was indicating gravy. During a review of the facility's policies and procedures (P&P) titled Menus dated 1/29/2025, the P&P indicated, To ensure that the facility provides meals to residents that meet the requirements of the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. During a review of the facility's P&P titled Standardized Recipes, dated 1/29/2025, the P&P indicated To provide the dietary department with guidelines for the use of standardized recipes. Food products prepared and served by the dietary department will utilize standardized recipes. I. Standardized recipes are provided with the menu cycle. III. Standardized recipes will have adjustments or separate recipes for therapeutic and consistency modifications. IV. Recipes will have diet modifications noted. During a review of the facility's standardized recipe titled Gravies dated 2024, the recipe indicated, ingredients included salt 1 Tablespoon for 120 servings and Worcestershire sauce 3 tablespoon plus 2 1/4 tsp for 120 servings. The recipe further indicated turkey juice was not part of the ingredient. During a review of the facility's product specification titled Turkey Breast boneless Raw Bag 15%, undated, the product specification indicated the turkey used for all the diets including renal and CCHO diets contained the following ingredients: contains up to 15% solution of turkey broth, salt, sugar, sodium phosphate.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47441 Based on observation, interview, and record review, the facility failed to prepare food by methods that conserved temperature, flavor and appearance when: a. The temperature of the roast turkey was at 125 degrees Fahrenheit (F, a scale of temperature), apple sauce at 51 F, vanilla mousse at 46 F and grape juice was at 46 F. b. Roast Turkey for renal (a diet low in salt, potassium, phosphorus and limited in protein) consistent carbohydrate (CCHO, a diet with the same amount or servings of carbohydrates in each meal for blood sugar control) diets was salty. c. Puree mashed potatoes and puree roast turkey did not hold its shape on the plate. This deficient practice placed 164 of 176 facility residents including Residents 173 and 157 who are on regular, therapeutic diets (a meal plan that controls the intake of certain food and nutrients) and puree diets (food with soft pudding like consistency) at risk of unplanned weight loss, a consequence of poor food intake, getting food from the kitchen. Cross Reference F803 and F805 Findings: a. During a review of Resident 173's Admission Record, the Admission Record indicated the facility initially admitted Resident 173 on 1/9/2025 and readmitted the resident on 2/17/2025 with diagnoses that included type two (2) diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), end stage renal disease (ESRD, irreversible kidney failure), and hypertensive heart and chronic kidney disease (heart and kidney problems that occur because of high blood pressure that is present over a long time). During a review of Resident 173's Minimum Data Sheet (MDS - a resident assessment tool) dated 3/18/2025, the MDS indicated Resident 173 understood others and made self understood. The MDS indicated the resident required supervision and touching assistance (helper provides verbal cues and/or touching /steadying and or contact guard assistance as resident completes the activity) when eating. During a review of Resident 173's Physician Orders dated 3/30/2025, the Physician Orders indicated to provide CCHO, standard portion diet, mechanical soft texture (diet with soft, and chopped meats), regular, thin consistency. During an interview on 4/22/2025 at 11:42 a.m. with Resident 173, Resident 173 stated the food at the facility was terrible as it was sometimes cold when it arrives. Resident 173 stated the food should be 165 F and wants steam coming from the food. Resident 173 stated he notified the facility staff as it was their responsibility to serve hot food. Resident 173 stated the facility used warmers, but it was not hot; hence, the food comes out cold. Resident 173 stated he has lost weight and did not want to eat in the facility. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's daily spreadsheet (a list of food, amount of food that each diet would receive) titled Spring Cycle Menus, dated 4/22/2025, the spreadsheet indicated residents on CCHO renal diet would include the following foods on the tray: Roast turkey 3 ounces (oz, a unit of measurement) Gravy 1 oz Seasoned peas 1/2 cup (c., household measurement Wheat roll 1 piece Margarine 1 teaspoon Diet apple sauce 1/2 c Milk 4 oz/ diet punch 8 oz During a review of the facility's menu spreadsheet (a sheet containing the kind and amount of food each diet would receive) titled Spring Cycle Menus, dated 4/22/2025, the spreadsheet indicated residents on puree diet would include the following foods on the tray: Puree roast turkey half (1/2) c Puree cranberry-ginger-citrus sauce 1 oz Puree bread dressing number 12 scoop (1/3 c) Puree three bean salad 1/3 c Vanilla mousse (no chocolate chips) 1/3 c. Milk 4 fluid oz. During a puree test tray (a process of tasting, temping [using a thermometer to check its internal temperature to ensure it's cooked to a safe and desired level], and evaluating the quality of food) observation on 4/22/2025 at 12:51 p.m.with the Dietary Supervisor (DS), observed vanilla mousse temperature was at 46 F when the DS took the temperature of the food using the facility thermometer. During a test tray observation on 4/22/2025 at 12:54 with the DS, observed the following temperatures when the DS took the food temperatures using the facility thermometer: Roast Turkey 125 F Grape juice 46 F Apple sauce 51 F (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/22/2025 at 12:57 p.m. with the DS and the Assistant Dietary Supervisor (ADS), the DS stated the temperatures of milk and milk products needed to be lower than 50 F. The ADS stated 130 F was standard they used for palatable temperature for hot food; however, the food was at 125 F. The DS stated 125 F for hot food was acceptable food temperature. The DS stated they have complaints in the facility regarding food temperatures and they talked to the residents and to the staff to ensure that they take the tray to the residents right away as their action plan. The DS stated the residents might not eat the food or enjoy it if the food was not hot or cold as they expect them to be. The DS stated residents may potentially lose weight because of not eating. During an interview on 4/24/2025 at 4:05 p.m. with the Administrator (ADM), the ADM stated they do not have a policy regarding food preparation for palatability, flavor, appearance, and temperature. During a review of the facility's standardized recipe titled Recipe: Roast Turkey dated 2024, the recipe indicated serve on trayline at a recommended temperature of 160 F-180 F. During a review of the facility's standardized recipe titled Recipe: Vanilla Mousse, dated 2024, the recipe indicated (4) serve on trayline at a recommended temperature of 41 F or less. During a review of the facility's policies and procedures (P&P) titled P-DS16 Food Temperatures dated 1/29/2025, the P&P indicated acceptable serving temperatures are follows for the following food: Meat and entrees less more than 140 F Hazardous salad, dessert less than 41 F Milk, juice less than 41 F b. During a review of Resident 157's Admission Record, the Admission Record indicated the facility initially admitted Resident 157 on 10/23/2024 and readmitted the resident on 1/8/2025 with diagnoses that included type 2 DM with foot ulcer (a small open sore or wound), ESRD, and hypertensive chronic kidney disease (kidney problems that occur because of high blood pressure that is present over a long time). During a review of Resident 157's MDS, dated [DATE], the MDS indicated Resident 157 understood others and made self understood. The MDS indicated the resident required set-up or clean up assistance when eating. During a review of Resident 157's Physician Orders, dated 1/8/2025, the Physician Orders indicated to provide renal diabetic diet (CCHO, renal diet) regular texture (texture with no restriction). During an interview on 4/22/2025 at 10:28 a.m. with Resident 157, Resident 157 stated the food at the facility was too salty and he was already on special diet but the food the facility served was still too salty. During a review of the facility's daily spreadsheet titled Spring Cycle Menus, dated 4/22/2025, the spreadsheet indicated residents on CCHO diet would include the following foods on the tray: Roast turkey 3 oz (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Gravy 1 oz Bread dressing 1/3 c. Seasoned peas 1/2 c. Three bean salad - drain 1/2 c. Vanilla mousse with no chocolate chips Milk 4 oz The spreadsheet further indicated residents on CCHO renal diet would include the following foods on the tray: Roast turkey 3 oz Gravy 1 oz Seasoned peas 1/2 c Wheat roll 1 piece Margarine 1 teaspoon Diet apple sauce 1/2 c Milk 4 oz/ diet punch 8 oz During an interview on 4/22/2025 at 12:03 p.m. with [NAME] 1, [NAME] 1 stated the regular and therapeutic diets got the same roast turkey meat and the only difference was the sauce as she prepared a cranberry-ginger citrus sauce for regular diet and gravy for residents on renal and diabetic diets. During a concurrent observation and interview on 4/22/2025 at 12:54 p.m. of the test tray of a renal CCHO diet with the DS and the ADS, tasted the roasted turkey with gravy and it was salty. The ADS stated renal diet should not be salty and the cook followed recipes and maybe the amount of base the cooks used made it salty. The ADS stated [NAME] 1 prepared everything for lunch. The ADS stated it was important to follow the recipe because if the food was salty the residents would not eat and enjoy their food. The DS stated renal diet should not be salty as it would be contraindicated in the diet making them sick and retain water as a potential outcome. During an interview on 4/23/2025 at 8:46 p.m. with [NAME] 1, [NAME] 1 stated she did not follow the recipe for the gravy for renal CCHO diet because they do not have too many residents on it. [NAME] 1 stated she just guessed the ingredients and added the juice of the turkey, flour and some seasonings. [NAME] 1 stated she did not follow the recipe of the gravy because it was not available in the recipe binder however it was important that they follow the exact recipe to ensure the food of the residents would taste good. [NAME] 1 stated the residents would not eat if the food did not taste good. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/23/2025 at 9:46 a.m. with the DS, the DS stated they could not find the recipe for gravies, but all the food has standardized recipes, and it was important to follow the recipes to ensure residents would get the right amount of nutrition. The DS stated [NAME] 1 did not follow the recipe for gravy and residents on renal diet could get sick by not getting proper nutrition causing malnutrition if the recipes were not accurately followed. The DS stated [NAME] 1 should have not prepared gravy as all the diets gets the same sauce and the spreadsheet was confusing as it was indicating gravy. During a review of the facility's P&P titled Menus dated 1/29/2025, the P&P indicated, To ensure that the facility provides meals to residents that meet the requirements of the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. During a review of the facility's P&P titled Standardized Recipes, dated 1/29/2025, the P&P indicated To provide the dietary department with guidelines for the use of standardized recipes. Food products prepared and served by the dietary department will utilize standardized recipes. I. Standardized recipes are provided with the menu cycle. III. Standardized recipes will have adjustments or separate recipes for therapeutic and consistency modifications. IV. Recipes will have diet modifications noted. During a review of the facility's standardized recipe titled Gravies dated 2024, the recipe indicated, ingredients included salt 1 Tablespoon for 120 servings and Worcestershire sauce 3 tablespoon plus 2 1/4 tsp for 120 servings. The recipe further indicated turkey juice was not part of the ingredient. During a review of the facility's product specification titled Turkey Breast boneless Raw Bag 15% undated, the product specification indicated the turkey used for all the diets including renal and CCHO diets contained the following ingredients: contains up to 15% solution of turkey broth, salt, sugar, sodium phosphate. c. During a review of the facility's menu spreadsheet titled Spring Cycle Menus, dated 4/22/2025, the spreadsheet indicated residents on puree diet would include the following foods on the tray: Puree roast turkey 1/2 c Puree cranberry-ginger-citrus sauce 1 oz Puree bread dressing number 12 scoop (1/3 c) Puree three bean salad 1/3 c Vanilla mousse (no chocolate chips) 1/3 c. Milk 4 fluid oz. During an observation on 4/22/2025 at 11:49 p.m. of the puree mashed potato on the plate in trayline (an area where foods were assembled from the steamtable to resident's plate), observed the puree mashed potato did not hold its shape on the plate. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 4/22/2025 at 11:54 a.m. of the puree roast turkey, observed puree roast turkey was flat on the plate when served. During a concurrent test tray observation and interview on 4/22/2025 at 1:15 p.m. with the DS and the ADS, the DS stated puree diet preparation and presentation were combination of form and smoothness of the food. The DS stated the puree food passed the spoon tilt test (a test used to determine the stickiness of the sample and the ability of the sample to hold together), meeting the proper texture of food, however it would not hold its shape on the plate when achieving the correct food texture. The DS stated if the puree food held its shape on the plate, then it would not pass the spoon tilt test; hence, they needed to follow the one thing which was the food texture. The ADS stated the International Dysphagia Standardization Initiative (IDDSI, is a global standard with terminology and definitions to describe texture modified foods and thickened liquids used for individuals with difficulty of swallowing for all ages, in all care settings, and for all culture) standards was newly implemented, and puree diet should have baby foods, soft texture but not watery and should be able to pass a spoon tilt test. The ADS stated the puree mashed potatoes and puree roast turkey did not hold their shapes on the plate as they were a little bit flat on the plate and residents might not eat them causing poor food intake as a potential outcome. During a review of the facility's diet manual (a manual containing all the diets the facility has for residents and its description, foods allowed and avoided in each diet) titled Regular Pureed Diet reviewed 1/29/2025, the diet manual indicated Description: The pureed diet is a regular diet that has been designed for residents who have difficulty chewing and/or swallowing. The texture of the food should be smooth and moist consistency and able to hold its shape. Portions given will account for the addition of fluids and be specified in the spreadsheet. Detailed recipes and procedures for pureeing foods maybe found in binder 1, under the food safety/miscellaneous section. During a review of the facility's standardized recipe titled RECIPE: Pureed (IDDSI Level 4) dated 2024, the recipe indicated (5) The finished pureed item should be smooth and free of lumps, hold its shape, while not being too firm or sticky, and should not weep. The finished pureed items must pass IDDSI level 4 testing requirements (i.e. the fork drip, fork pressure and spoon tilt test). During a review of the facility's standardized recipe titled RECIPE: Mashed potato (Packaged) dated 2024, the recipe indicated Dysphagia: smooth with no lumps. Puree if needed following the pureed recipes. During a review of the IDDSI guideline website titled IDDSI, dated 7/2019, the IDSSI guideline indicated, Level 4 Pureed is usually eaten with spoon, falls off spoon in a single spoonful when tilted and continues to hold shape on the plate, no lumps, not sticky, and liquid must not separate from solid. Food testing method: Spoon tilt test and Fork drip test.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 47441 Based on observation, interview, and record review, the facility failed to prepare foods in a form designed to meet individual needs when puree (foods that are smooth with pudding like consistency) roast turkey and puree mashed potato did not hold their shapes and were flat on the plates. These failures had the potential to result in difficulty in swallowing, chewing, decreased in food intake and nutrient intake to 12 of 176 residents on puree diet, resulting to unintended (not planned) weight loss and chocking (when food gets stuck in your airway, blocking the flow of air to the lungs). Findings: During a review of the facility's menu spreadsheet (a sheet containing the kind and amount of food each diet would receive) titled Spring Cycle Menus, dated 4/22/2025, the spreadsheet indicated residents on puree diet would include the following foods on the tray: Puree roast turkey half (1/2) number 8 scoop (1/2 cup [c] a household measurement) Puree cranberry-ginger-citrus sauce 1ounces (oz, a unit of measurement) Puree bread dressing number 12 scoop (1/3 c) Puree three bean salad 1/3 c Vanilla mousse (no chocolate chips) 1/3 c. Milk 4 fluid oz. During an observation on 4/22/2025 at 11:49 p.m. of the puree mashed potato on the plate in trayline (an area where foods were assembled from the steamtable to resident's plate), observed mashed potato did not hold its shape on the plate. During an observation on 4/22/2025 at 11:54 a.m. of the puree roast turkey, observed puree roast turkey was flat on the plate when served. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent test tray (a process of tasting, temping, and evaluating the quality of food) observation and interview on 4/22/2025 at 1:15 p.m. with the Dietary Supervisor (DS) and the Assistant Dietary Supervisor (ADS), the DS stated puree diet preparation and presentation were combination of form and smoothness of the food. The DS stated the puree food passed the spoon tilt test (a test used to determine the stickiness of the sample and the ability of the sample to hold together), meeting the proper texture of food; however, it would not hold its shape on the plate when achieving the correct food texture. The DS stated if the puree food held it shape on the plate, then it would not pass the spoon tilt test; hence, they needed to follow the one thing which was the food texture. The ADS stated the International Dysphagia Standardization Initiative (IDDSI, is a global standard with terminology and definitions to describe texture modified foods and thickened liquids used for individuals with difficulty of swallowing for all ages, in all care settings, and for all culture) standards was newly implemented, and puree diet should have baby foods, soft texture but not watery and should be able to pass a spoon tilt test. The ADS stated the puree mashed potatoes and puree roast turkey did not hold their shapes on the plate as they were a little bit flat on the plates and residents might not eat them causing poor food intake as a potential outcome. During a review of the facility's policies and procedures (P&P) titled Menus dated 1/29/2025, the P&P indicated, To ensure that the facility provides meals to residents that meet the requirements of the Food and Nutrition Board of the National Research Council of the National Academy Sciences. During a review of the facility's diet manual (a manual containing all the diets the facility has for residents and its description, foods allowed and avoided in each diet) titled Regular Pureed Diet reviewed 1/29/2025, the diet manual indicated Description: The pureed diet is a regular diet that has been designed for residents who have difficulty chewing and/or swallowing. The texture of the food should be a smooth and moist consistency and able to hold its shape. Portions given will account for the addition of fluids and be specified in the spreadsheet. Detailed recipes and procedures for pureeing foods maybe found in binder 1, under the food safety/miscellaneous section. During a review of the facility's standardized recipe titled RECIPE: Pureed (IDDSI Level 4) dated 2024, the recipe indicated (5) The finished pureed item should be smooth and free of lumps, hold its shape, while not being too firm or sticky, and should not weep. The finished pureed items must pass IDDSI level 4 testing requirements (i.e. the fork drip [testing method that assesses the thickness and cohesiveness of food], fork pressure [method to assess the softness and moisture of food by applying pressure with a fork], and spoon tilt test). During a review of the facility's standardized recipe titled RECIPE: Mashed potato (Packaged) dated 2024, the recipe indicated Dysphagia: smooth with no lumps. Puree if needed following the pureed recipes. During a review of the IDDSI guideline website titled IDDSI, dated 7/2019, the IDSSI guideline indicated, Level 4 Pureed is usually eaten with spoon, falls off spoon in a single spoonful when tilted and continues to hold shape on the plate, no lumps, not sticky, and liquid must not separate from solid. Food testing method: Spoon tilt test and Fork drip test.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. 47441 Based on observation, interview, and record review, the facility failed to ensure one (1) of 1 sampled resident (Resident 182) received and consumed foods in the appropriate nutritive content as prescribed by a physician when staff did not update the diet for Resident 182. Resident 182, who was on renal (a diet low in salt, potassium, phosphorus and limited in protein) diabetic diet ([consistent carbohydrate diet] CCHO, a diet with the same amount or servings of carbohydrates in each meal for blood sugar control) regular portion, received diabetic, renal large portion diet instead. This deficient failure had the potential to cause unplanned weight gain and ineffective therapeutic diet (a meal plan that controls the intake of certain food and nutrients) for Resident 182. Findings: During a review of Resident 182's Admission Record, the Admission Record indicated the facility admitted Resident 182 on 10/23/2024 with diagnoses that included type two (2) diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), end stage renal disease (ESRD, irreversible kidney failure), and hypertensive heart and chronic kidney disease (heart and kidney problems that occur because of high blood pressure that is present over a long time). During a review of Resident 182's Minimum Data Sheet (MDS - a resident assessment tool), dated 1/28/2025, the MDS indicated Resident 182 understood others and made self understood. The MDS indicated Resident 182 was independent when eating. During a review of Resident 182's Physician Orders, dated 11/8/2024, the Physician Orders indicated to provide renal diabetic (CCHO, renal), regular texture, regular thin consistency. During an observation on 4/22/2025 at 11:54 a.m., of Resident 182's meal tray, observed the meal ticket indicated Resident 182 was on renal, diabetic, large portion diet, disliked milk. Observed Resident 182 received roast turkey three (3) ounces (oz, unit of measurement), gravy one (1) oz, bread dressing 1/2 cup (c. , household measurement), wheat roll 1 piece and water. During a review of the facility's diet list titled Diet Type Report dated 4/22/2025, the diet list indicated Resident 182 was on renal diabetic (CCHO renal) regular portion diet. During a review of the facility's daily spreadsheet (a list of food, amount of food that each diet would receive) titled Spring Cycle Menus, dated 4/22/2025, the spreadsheet indicated residents on CCHO diet would include the following foods on the tray: Roast turkey three (3) ounces (oz, a unit of measurement) Gravy 1 oz Bread dressing 1/3 cup (c., a household measurement) (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Seasoned peas 1/2 c. Wheat roll 1 piece Margarine 1 teaspoon Diet apple sauce 1/2 c Milk 4 oz During a concurrent interview and record review on 4/24/2025 at 2:30 p.m. with the Dietary Supervisor (DS), the physician diet order for Resident 182 was reviewed. The diet order indicated Resident 182's diet was renal diabetic on 11/8/2025. The DS stated the diet order was revised to renal diabetic, regular texture and thin consistency with regular portion on 3/14/2025. During a concurrent interview and record review on 4/24/2025 at 2:33 p.m. with the DS, the quarterly assessment was reviewed. The quarterly assessment done by the DS on 4/21/2025 indicated Resident 182's diet was renal, regular, thin liquid, regular portion diet. The DS stated the large portion diet was for residents who needed more protein and calories, and it included extra meat and vegetables. The DS stated it was not okay Resident 182's diet was not updated as he was not getting the right nutrition and nutrients for his health and treatment. The DS stated Resident 182 might have gone to the hospital and got the large portion order, but they were not able to update in their system. During an interview on 4/24/2025 at 4:30 p.m. with the DS, the DS stated Resident 182's diet was renal, CCHO, regular portion. The DS stated they did not update their system which was still indicating large portions in Resident 182's meal ticket. The DS stated it was not okay to give large portions to Resident 182 as he could be getting more nutrients not appropriate to his treatment and diet. During a review of the facility's diet manual titled Renal, 80 Gram Protein, Low Salt, Low Potassium, in Combination of Carbohydrate Diet (CCHO) reviewed 1/29/2025, the diet manual indicated Description: This diet is used for diabetic resident with renal insufficiency at the 80 grams level of protein, low salt, and low potassium. It is then combined with CCHO. Nutritional breakdown: Calories: 1800-1900 Protein: 76-80 grams Carbohydrates: 190-200 grams Sodium 2100-2200 grams Potassium 2400-2500 grams Phosphorus 1400-1450. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policies and procedures (P&P) titled Therapeutic Diets, reviewed 1/29/2025, the P&P indicated To ensure that the facility provides therapeutic diets to residents that meet nutritional guidelines and physician orders. Therapeutic diets that deviate from the regular diet and require a physician order. Per the physician order, therapeutic diets are planned, prepared and served in consultation with the Dietitian. V. The dietary manager will periodically review the resident's tray card and the physician's dietary orders to ensure that the information is consistent.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47441 Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices in the kitchen when: 1. Kitchen equipment and utensils were not maintained in their proper condition (smooth and easy to clean). a. The shelves in the reach-in refrigerator by the supervisor's office had chips and cracks b. The shelves in the reach-in refrigerator by the exit door had amber discoloration, cracks, chips and rust. c. Fifty (50) of 50 residents cracked trays. 2. A broken thermometer was found in the vegetable freezer. 3. A tub of cottage cheese was at 51.8 degrees Fahrenheit (F, a scale of temperature), mocha mix was at 48 F inside the milk reach-in refrigerator. 4. Improper cooling was observed for the following food items: a. 4/13/2025 roast turkey was cooled for a total of eight (8) hours. b. 4/21/2025 roast turkey was cooled for a total of 8 hours c. 4/22/2025 roast beef was cooled for more than four hours without reaching 40 F. 5. Staff wiped the preparation table during salad preparation and left the green wiping cloth near the uncovered salad. 6. Five dented cans were stored with non-dented cans. 7. Kitchen equipment and kitchen areas were not cleaned and sanitized. a. Mixer shaft had dried food batter and food residues. b. Plate warmer where clean plates were stored had dirt debris. c. The clean food container had sticker residues. These failures had the potential to result in harmful bacterial growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness (a disease caused by consuming food or drinks that are contaminated by germs or chemicals) in 164 of 176 medically compromised residents who received food and ice from the kitchen. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Findings: 1. a. During an observation on 4/22/2025 at 8:22 a.m., of the reach-in refrigerator by the office, observed cracked and chipped shelves. During an interview on 4/22/2025 at 8:30 a.m. with the Dietary Supervisor (DS), the DS stated the refrigerator shelves had cracks and needed replacements. The DS stated they got a quote, but he was unsure why they did not order them. The DS stated bacteria could grow in the cracks of the racks and cross-contamination of resident's food could happen as they store food using the racks. The DS stated residents could get sick as a potential outcome of having cracked racks in the refrigerator. b. During an observation on 4/22/2025 at 8:59 a.m., of the reach-in refrigerator, observed shelves had chips and amber discoloration. The DS stated the shelves were rusted and it was not okay as it could cause foodborne illnesses to the residents. During a review of the facility's policy and procedures (P&P) titled, P-DS52 Food Storage and Handling, reviewed 1/29/2025, the P&P indicated (d) Shelving should be sturdy with a surface which is smooth and easily cleaned. During a review of the Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 4-202.11 Food-Contact Surfaces. (A) Multiuse Food-contact surfaces shall be (1) Smooth (2) Free of breaks, open seams, cracks, chips, inclusions, pits, and similar imperfections. (3) Free of sharp internal angles, corners, and crevices, (4) Finished to have smooth welds and joints. 2. a. During a concurrent initial kitchen tour observation and interview on 4/22/2025 at 8:34 a.m., of the vegetable freezer with the DS, observed thermometer dial after pulling it out in room temperature. The DS stated the thermometer glass came off and it was broken. The DS stated they should have two (2) thermometers inside the freezer to keep track of the accurate temperature of the freezer. The DS stated if the thermometer was not working inside the freezer, they would not know the right temperature and the food might be out of temperature which may cause food poisoning if residents consumed the food. During a review of the facility's P&P titled Refrigerator/Freezer temperature Records, reviewed 1/29/2025, the P&P indicated, To establish guidelines to record the temperatures of refrigerated and frozen storage areas. A daily temperature record is to be kept for refrigerated and frozen storage areas. Procedure: The Dietary Manager or designee is to record daily all refrigerator and freezer temperatures on Form A-Refrigerator/Freezer Temperature Log during AM and PM shifts. During a review of the Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated 4-204.112 Temperature Measuring Devices. (A) In a mechanically refrigerated or hot FOOD storage unit, the sensor of a TEMPERATURE MEASURING DEVICE shall be located to measure the air temperature or a simulated product temperature in the warmest part of a mechanically refrigerated unit and in the coolest part of a hot FOOD storage unit. (B) Except as specified in (C) of this section, cold or hot holding EQUIPMENT used for TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be designed to include and shall be equipped with at least one integral or permanently affixed TEMPERATURE MEASURING DEVICE that is located to allow easy viewing of the device's temperature display. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/23/2025 at 9:15 a.m. with the DS, the DS stated the proper cooling of food started with cooking the food. The DS stated the roast turkey was cooked on Monday and the starting temperature was at 195 F. The DS stated the cook was supposed to slice the roast turkey into small portions to make it cool faster in a room temperature and wait for it to go down to 135 F. The DS stated the staff was supposed to log the time and temperature of 135 F then within 2 hours the roast turkey needed to go down to 70 F and below. The DS stated the roast turkey needed to further cool down to 40 F within four (4) hours for a total of six (6) hours of the cooling process. The DS stated if the roast turkey did not cool down to 40 F in a total of 4 hours then they needed to reheat the roast turkey to 165 F for 15 seconds or throw it away. The DS stated it was important to follow time and temperature in cooling to prevent the risk of bacterial growth in food. The DS stated residents could get sick if food was not cooled properly. During a concurrent interview and record review on 4/23/2025 at 9:30 a.m. with DS and the Assistant Dietary Supervisor (ADS), the cooling log was reviewed. The cooling log indicated the food cooled, the time and temperature record as follows: 4/12/2025 Roast Pork with cooking temperature was at 200 F at 2:20 p.m., 93 F at 3:20 p.m., 67 F at 4:25 p. m., 48 F at 5:25 p.m. and 36 F at 6:20 p.m. 4/13/2025 Roast Turkey with cooking temperature was at 185F at 12:00 noon, 97 F at 2PM, 64 F at 4:00, 50 F at 6PM and 35 F at 8PM. 4/22/2025 Roast Beef with cooking temperature was at 198 F at 11PM, 89F at 3:30PM. The cooling log further indicated Procedure: Remove item to be cooled from the oven, take temperature ensuring that the internal temperature meets the required minimum for that item. Cut the item into small pieces and remove all the broth or juice from the pan. Loosely cover the pan with foil, allowing air vents for the steam to escape. Place the item into the freezer and closely monitor, when the temperature hits 41 degrees, begin the cooling process. Log the time at 41 degrees on the log, place the item back into the freezer, and remove after 1 hour, take down the temperature. The ADS stated the 41 F may have been a typographical error. During an interview on 4/23/2025 at 9:30 a.m. with the DS, the DS stated the staff did not properly cool the meat on 4/12/2025, 4/13/2024, 4/21/2025 and 4/22/2025 as it exceeded the 6 hours total cooling time and on 4/22/2025 the food should have been discarded. During a review of the facility's P&P titled Hazardous Foods Cooling Monitor, reviewed 1/29/2025, the P&P indicated Purpose: To provide the dietary department with guidelines for service, storage and reheating of hazardous foods. Procedure: 1. Transfer cooked product to a container(s) with a depth no greater than two inches. 2. Label and date containers. 3. Place container(s) in the refrigerator or freezer for cooling. a. Leave the container uncovered loosely covered during the cooling process. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Hot food should be cooled from 140 F to 70 F within two hours and cooled from 70 F to 41 F or lower in an additional four hours. a. If temperature is not dropping adequately, consider using an ice bath. b. If it is a roast, cut into small pieces. c. If the temperature does not reach 70 F within two hours, reheat to 165 F and start the cooling process again. During a review of the Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 3-501.14 Cooling. (A) Cooked time/temperature control for safety food shall be cooled: (1) Within 2 hours from 57 C (135 F) to 21 C (70 F); P and (2) Within a total of 6 hours from 57 C (135 F) to 5 C (41 F) or less. P (B) TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be cooled within 4 hours to 5 C (41 F) or less if prepared from ingredients at ambient temperature, such as reconstituted FOODS and canned tuna. 5. During a concurrent observation and interview on 4/22/2025 at 11:21 a.m. of the salad preparation with the DS, observed Dietary Aide 1 (DA 1) took a green wipe towel and wiped the preparation table during the salad preparation. Observed DA 1 leave the green towel on top of the preparation table near the uncovered salads. The DS stated their process of cleaning and sanitizing surfaces was before and after use of the preparation table and not during use to prevent cross-contamination of chemicals to food. During a review of the facility's P&P titled DS52 Food Storage and Handling, reviewed 1/29/2025, the P&P indicated Food items will e stored, thawed, and prepared in accordance with standard sanitary practices. Purpose: To properly store, thaw, and prepare food to avoid foodborne illnesses. During a review of the Food Code 2022, dated 1/18/2023 the Food Code 2022 indicated, 3-307.11 Miscellaneous Sources of Contamination. Food shall be protected from contamination that may result from a factor or source not specified under subparts 3-391 - 3-306. 6. During a concurrent observation and interview on 4/23/2025 at 10:25 a.m. of the dry storage area with the DS, observed 5 dented cans stored with non-dented cans. The DS stated it was important to separate dented cans from non-dented cans to avoid using dented cans as it could be a hazard. The DS stated dented cans could be leaking for possible food contamination. The DS stated one can of dry mashed potato had bulking and could cause botulism (a rare illness caused by a toxin that attacks the body's nerves causing difficulty breathing, muscle paralysis and death) to the residents. During a review of the facility's P&P titled P-DS52 Food Storage and Handling, reviewed 1/29/2025, the P&P indicated Canned fruit storage (c) Place dented cans in a separate storage area and return for credit. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 3-101.11 Safe Unadulterated, and Honestly Presented. Food shall be safe, unadulterated, and, as specified under 3-601. 12, honestly presented. 3-201.11 Compliance with Food Law. A primary line of defense ensuring that food meets the requirements of S3-101.11 is to obtain food from approved sources, the implications of which are discussed below. However, it is also critical to monitor food products to ensure that, after harvesting, processing, they do not fail victim to conditions that endanger their safety, make them adulterated, or compromise their honest presentation. The regulatory community, industry, and consumers should exercise vigilance in controlling the conditions to which foods are subjected and be alert to signs of abuse. FDA considers food in hermetically sealed containers that are swelled or leaking to be adulterated and actionable under the Federal Food, Drug, and Cosmetic Act. Depending on the circumstances, rusted, and pitted or dented cans may also present a serious potential hazard. 7. a. During a concurrent observation and interview on 4/24/2025 at 9:03 a.m. of the mixer with the DS and [NAME] 1, observed dried up food residue on mixer shaft. The DS stated the mixer was last used this morning for the corn bread and [NAME] 1 was about to clean it. [NAME] 1 stated she did not use the mixer today and none of the food preparation staff used it. The DS stated the mixer was not cleaned after use and it was important to maintain the cleanliness of the mixer to prevent food contamination. b. During a concurrent observation and interview on 4/24/2025 at 9:12 a.m. of the plate warmer with the DS, observed dirt debris inside the plate warmer. The DS stated there were dirt debris in the plate warmer where cleaned plates were stored. The DS stated he would have to rewash the plates and sanitize the plate warmer to prevent cross-contamination. c. During an observation on 4/24/2025 at 9:17 a.m. of the drying racks, observed 5 food containers with sticker residues. During an interview on 4/24/2025 at 9:33 a.m. in the drying rack area with the DS, the DS stated the dry rack was for drying clean food containers and the containers had stickers the staff needed to remove. The DS stated the staff needed to scrub the stickers out of the container so it would not contaminate food. During a review of the facility's P&P titled Mixer-Operation and Cleaning dated 1/29/2025, the P&P indicated, The dietary staff will operate the mixer according to the manufacturer's guidelines. The mixer will be cleaned after each use. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 4-601.11 (A) Equipment Food Contact Surfaces and utensils shall be cleaned: (1) Except as specified in (B) of this section, before use with a different type of raw animal food such as beef, fish, lamb, pork or poultry; (2) Each time there is a change from working with raw foods to working with ready-to-eat food; (3) Between uses with raw fruits and vegetables and with time/temperature control for safety food. (4) Before using or storing a food temperature measuring device, and (5) At the time during the operation when contamination may have occurred. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 4-602.13 Nonfood-Contact Surfaces. Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues.

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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 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** 44376 Based on interview and record review, the facility failed to: A. Document a change of condition (COC, is a sudden, clinically important deviation from a resident's baseline in physical, cognitive, behavioral, or functional domains) for two of two sampled residents (Residents 40 and 98) reviewed for hospitalization s for: 1. Resident 40, who went to General Acute Care Hospital (GACH) 1 for gastrostomy tube (GT, a tube inserted through the belly that brings nutrition directly to the stomach) placement on 12/16/2024. 2. Resident 98, who went to GACH 2 for seizure (a sudden, temporary disruption of the brain's normal electrical activity, often causing changes in awareness, movement, or behavior) on 2/24/2025. The deficient practice had potential for delays in the provision of care and services to the residents and failure to accurately account for events that triggered the residents' change in condition. B. Maintain accurate documentation of wounds for one of one sampled resident (Resident 166) reviewed under Pressure Ulcer/Injury (localized damage to the skin and/or underlying tissue usually over a bony prominence) care area. This deficient practice had the potential to result in inaccurate assessment and inaccurate tracking of the number of wounds present on Resident 166. Findings: 1. During a review of Resident 40's Admission Record, the Admission Record indicated the facility admitted the resident on 5/3/2016, and readmitted the resident on 12/9/2024, with diagnoses including dysphagia (difficulty swallowing), gastro-esophageal reflux disease (GERD, a condition where stomach acid flows backward into the esophagus [food pipe], causing heartburn and other symptoms), and gastrostomy (GT). During a review of Resident 40's History and Physical (H&P), dated 12/27/2024, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 40's Minimum Data Set (MDS, a resident assessment tool), dated 1/24/2025, the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (a participant who has sufficient judgment, planning, organization, self-control, and the persistence needed to manage the normal demands of the participant's environment). During a review of Resident 40's Progress Notes, dated 12/16/2024, the Progress Notes indicated at 8:20 a.m., the facility received a call from primary medical doctor (PMD) 1 to transfer the resident to GACH 1 for GT placement. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 4/24/2025, at 9:06 a.m., with Registered Nurse (RN) 3, reviewed Resident 40's Progress Notes and Change of Condition. RN 3 stated she saw a progress note written on 12/16/2024 that the resident was transferred to GACH 1 for GT placement but there was no complete account of what happened during that incident. RN 3 stated there was no assessment done on the resident prior to transfer and what education or other interventions provided by PMD 1 documented on the chart. RN 3 stated it was important to do a change of condition documentation to capture the events that happened that day to communicate to other healthcare team and resident representative what transpired during that day and what interventions were provided to the resident. During an interview on 4/25/2025, at 12:37 p.m., with the Director of Nursing (DON), the DON stated the licensed nurses should have documented a Situation, Background, Assessment, and Recommendation (SBAR, is a verbal or written communication tool that helps provide essential, concise information, usually during crucial situations)/COC on 12/16/2024, including the diagnosis, assessments, physician's orders, and informing of resident/representatives of the change of condition. The DON stated the SBAR/COC records the adverse events (any unwanted or harmful outcome that happens to a patient as a result of medical care, including treatment or procedures) that happened to Resident 40 and what diagnosis, assessments, interventions provided to the resident during the crisis. The SBAR/COC serves as a communication tool to all healthcare providers and resident representatives of what transpired during the incident to better understand the situation. During a review of the facility's recent policy and procedure (P&P) titled Change of Condition Notification, last reviewed on 1/29/2025, the P&P indicated to ensure residents, family, legal representatives, and physicians are informed of changes in the resident's condition in a timely manner. The facility will promptly inform the resident, consult with the resident's Attending Physician, and notify the resident's legal representative or an interested family member, if known, when the resident endures a significant change in their condition caused by, but not limited to: B. A significant change in the resident's physical, mental, or psychosocial status; and/or C. A significant change in treatment. The Licensed Nurses will assess the change of condition and determine what nursing interventions are appropriate. A. Before notifying the Attending Physician, the Licensed Nurse must observe and assess the overall condition utilizing physical assessment and chart review. i. Notification to the Attending Physician will include a summary of the condition change and an assessment of the resident's vital signs and system review focusing on the condition and/or signs and symptoms for which the notification is required. IV. Documentation A. A Licensed Nurse will document the following: i. Date, time, and pertinent details of the incident and the subsequent assessment in the Nursing Notes. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ii The time the Attending Physician was contacted, the method by which he was contacted, the response time, and whether or not orders were received. iii. The time the family/responsible person was contacted. iv. Update the Care Plan to reflect the resident's current status. v. The incident and brief details in the 24-Hour Report. vi. If the resident is transferred to an acute care hospital, complete an inter-facility transfer form. vii. Complete an incident report per Facility policy. 2. During a review of Resident 98's Admission Record, the Admission Record indicated the facility admitted the resident on 10/26/2022, and readmitted the resident on 8/6/2024, with diagnoses including epilepsy (a brain condition that causes recurring seizures), dementia (a progressive state of decline in mental abilities), and depression (a mood disorder that causes persistent feelings of sadness, emptiness, or loss of interest in activities). During a review of Resident 98's H&P, dated 8/8/2024, the H&P indicated the resident was unable to make decisions. During a review of Resident 98's MDS, dated [DATE], the MDS indicated the resident sometimes had the ability to make self-understood and understand others and had severe cognitive impairment (a person has a significant problem with their ability to think, learn, remember, and make decisions). During a review of Resident 98's Progress Notes, dated 2/24/2025, the Progress Notes indicated that at 9:45 p.m., the resident was transferred to GACH 2 for seizure. The Progress Notes indicated the resident had 2 seizure episodes in the facility. During a concurrent interview and record review on 4/24/2025, at 9:33 a.m., with RN 3, reviewed Resident 98's Progress Notes and COC. RN 3 stated she saw a progress note written on 2/24/2025 that the resident was transferred to GACH 2 for seizure but there was no complete account of what happened during that incident. RN 3 stated there was no assessment done on the resident prior to transfer and what education or other interventions provided by PMD 1 documented on the chart. RN 3 stated it was important to do a change of condition documentation to capture the events that happened that day to communicate to other healthcare team and resident representative what transpired during that day and what interventions were provided to the resident. During an interview on 4/25/2025, at 12:37 p.m., with the DON, the DON stated the licensed nurses should have documented an SBAR/COC on 2/24/2025, including the diagnosis, assessments, physician's orders, and informing of resident/representatives of the change of condition on Resident 98. The DON stated the SBAR/COC records the adverse events that happened to the resident and what diagnosis, assessments, interventions provided to the resident during the crisis. The SBAR/COC serves as a communication tool to all healthcare providers and resident representatives of what transpired during the incident to better understand the situation. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's recent P&P titled Change of Condition Notification, last reviewed on 1/29/2025, the P&P indicated to ensure residents, family, legal representatives, and physicians are informed of changes in the resident's condition in a timely manner. The facility will promptly inform the resident, consult with the resident's Attending Physician, and notify the resident's legal representative or an interested family member, if known, when the resident endures a significant change in their condition caused by, but not limited to: B. A significant change in the resident's physical, mental, or psychosocial status; and/or C. A significant change in treatment. The Licensed Nurses will assess the change of condition and determine what nursing interventions are appropriate. A. Before notifying the Attending Physician, the Licensed Nurse must observe and assess the overall condition utilizing physical assessment and chart review. i. Notification to the Attending Physician will include a summary of the condition change and an assessment of the resident's vital signs and system review focusing on the condition and/or signs and symptoms for which the notification is required. IV. Documentation A. A Licensed Nurse will document the following: i. Date, time, and pertinent details of the incident and the subsequent assessment in the Nursing Notes. ii The time the Attending Physician was contacted, the method by which he was contacted, the response time, and whether or not orders were received. iii. The time the family/responsible person was contacted. iv. Update the Care Plan to reflect the resident's current status. v. The incident and brief details in the 24-Hour Report. vi. If the resident is transferred to an acute care hospital, complete an inter-facility transfer form. vii. Complete an incident report per Facility policy. 38552 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. During a review of Resident 166's Admission Record, the Admission Record indicated the facility originally admitted the resident on 12/8/2024 and readmitted the resident on 2/13/2025 with diagnoses including urinary tract infection (UTI- an infection in the bladder/urinary tract), pressure ulcer of sacral (a large, triangular bone at the base of the spine) region, stage 4 (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone), and contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion) of muscle at multiple sites. During a review of Resident 166's H&P, dated 12/13/2024, the H&P indicated the resident had the capacity to understand and make medical decisions. During a review of Resident 166's MDS, dated [DATE], the MDS indicated the resident had adequate hearing, clear speech, made self understood, and had the ability to understand others. The MDS indicated the resident had intact cognitive mental status (mental action or process of acquiring knowledge and understanding). The MDS indicated the resident required assistance in activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily) and with mobility including rolling left and right while in bed, sitting to lying, lying to sitting on side of bed, chair/bed-to-chair transfer, toilet transfer, and tub/shower transfer. During a review of Resident 166's nursing progress notes, the nursing progress notes indicated: A. On 12/9/2024: #1 location: spine, mid-back, surgical wound. #2 location: right gluteus (buttock), unstageable (are persistent non-blanchable deep red, purple or maroon areas of intact skin, non-intact skin or blood-filled blisters). #3 location: right lower back, unstageable. #4 location: left gluteal fold (buttock), unstageable. Skin issues notes: resident readmitted to facility with mid-back surgical incision that appeared healed and scarred with a slight opening. B. On 12/19/2024. #1 location: buttocks-generalized, left and right groin moisture-associated skin damage (moisture associated skin damage [MASD] caused from prolonged exposure to moisture). #2 location: sacrococcyx PU, stage 4. #3 location: rear left trochanter (hip), stage 3 PU (full-thickness loss of skin. Dead and black tissue may be visible), medical device-related PU. #4 location: genital urinary catheter. #5 location: left lateral foot, unstageable. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#6 location: left heel, medial, unstageable. #7 location: right heel, unstageable. #8 location: front right knee, stage 3 PU. #9 location: right plantar (bottom) foot, unstageable. #10 location: front right lateral lower leg, unstageable. During a review of Resident 166's Wound Assessment and Plan, the Wound Assessment and Plan indicated: Visit date: 12/12/2024 #1 wound location: sacrococcyx, stage 2 PU (partial-thickness loss of skin, presenting as a shallow open sore or wound), onset date: 11/27/2024. #2 wound location: midline back, surgical, onset date: 11/27/2024. Visit date: 12/19/2024 #1 wound location: sacrococcyx, stage 2 PU. #2 wound location: midline back, surgical. Visit date: 12/26/2024 #1 wound location: sacrococcyx, stage 4. #2 wound location: midline back, surgical. Visit date: 1/2/2025 #1 wound location: sacrococcyx, stage 4. #2 wound location: midline back, surgical. #3 wound location: left hip, deep tissue injury, onset date 1/1/2025. Visit date: 1/9/2025 #1 wound location: sacrococcyx, stage 4. #2 wound location: midline back, surgical. #3 wound location: left hip, deep tissue injury. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Visit date: 1/16/2025 #1 wound location: sacrococcyx, stage 4. #2 wound location: midline back, surgical. #3 wound location: left hip, deep tissue injury. Visit date: 1/30/2025 #1 wound location: sacrococcyx, stage 4. #2 wound location: midline back, surgical. #3 wound location: left hip, deep tissue injury. Visit date: 2/14/2025 #1 wound location: sacrococcyx, stage 4. #2 wound location: midline back, surgical. #3 wound location: left hip, deep tissue injury. #4 wound location: right lateral leg, deep tissue injury, onset date 2/13/2025. #5 wound location: right lateral foot, deep tissue injury, onset date 2/13/2025. #6 wound location: right knee, stage 3 PU, onset date 2/13/2025. #7 wound location: right heel, deep tissue injury, onset date 2/13/2025. #8 wound location: left medial heel, deep tissue injury, onset date 2/13/2025. #9 wound location: left lateral foot, deep tissue injury, onset date 2/13/2025. #10 wound location: groin, perineum, and buttocks bilateral, MASD. During a concurrent interview and record review on 4/24/2025 at 9:15 a.m. with Treatment Nurse (TX) 1, reviewed Resident 166's nursing wound progress notes and physician wound assessment and plan, from 12/9/2024 to 2/14/2025, TX 1 stated on 12/9/2024 Resident 166 had two wounds at the sacral and midline back which was a surgical wound. TX 1 stated she did the skin issues progress notes on 12/9/2024 and 12/19/2024. TX 1 stated she does not know why the wounds present on Resident 166's readmitted on 2/13/2025 was showing on her 12/19/2024 progress notes. TX 1 stated she did not document that this, and it must be an electronic system issue because the resident's wound on the hip had an onset date of 1/1/2025; the right and left foot and leg onset was on 2/13/2025. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 4/24/2025 at 10:00 10 a.m. with the Medical Records Director (MRD), reviewed Resident 166's nursing progress notes and physician wound assessment and plan. The MRD stated the wound assessment forms on their electronic health record had been revised a few times. The MRD stated there could have been a glitch in the system and showed the rest of the resident's wounds. The MRD stated she would need to check and find out what happened. During an interview on 4/25/2025 at 3:24 p.m. with the Director of Nursing (DON), the DON stated the treatment nurses complete the weekly wound assessment and documentation. The DON stated wound documentation should reflect the correct number of wounds the resident has to ensure accuracy for tracking. The DON stated the purpose was to see if the resident's treatment plan is helping improve the wound. The DON stated the accuracy of wound documentation also influences Resident 166's care plan and if it is not accurate, they might not meet the resident's current needs. During a review of the facility's P&P titled, Skin Integrity Management, revised on 1/29/2025, the P&P indicated licensed nurses will document the effectiveness of current treatment for skin integrity problems in the resident's medical record on a weekly basis. During a review of the facility's P&P titled, Skin Integrity Management, revised on 1/29/2025, the P&P indicated the purpose of this policy is to ensure that medical records and complete and accurate. The P&P indicated entries will be recorded promptly as the events or observations occur; entries will be complete, legible, descriptive and accurate. The P&P indicated documentation will reflect medically relevant information concerning the resident and will be documented in a professional manner. The P&P indicated correcting an error in an electronic/computerized medical record system follows the same principles as correcting a paper record, the system must have the ability to track corrections or changes to the entry once the entry has been entered or authenticated.

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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. 43988 Based on observation, interview, and record review the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections by failing to ensure Resident 389 was placed on enhanced barrier precautions (EBP - targeted steps taken by healthcare staff in nursing homes to prevent the spread of multidrug resistant organisms [MDROs - resistant germs] during high-contact care activities) who had a urinary catheter (FC - also known as an indwelling catheter, a hollow tube inserted into the bladder to drain or collect urine). This deficient practice had the potential to spread infections and illnesses among residents. Findings: During a review of Resident 389's Admission Record, the Admission Record indicated the facility admitted the resident on 2/27/2025 with diagnoses including urinary tract infection (UTI- an infection in the bladder/urinary tract), obstructive (blockage in the urinary tract) and reflux (urine flows backward from the bladder and kidneys) uropathy, and generalized muscle weakness. During a review of Resident 389's History and Physical (H&P), dated 2/9/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 389's Minimum Data Set (MDS - a resident assessment tool), dated 3/10/2025, the MDS indicated Resident 389 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) and was able to understand others and make herself understood. The MDs further indicated Resident 389 had impairment on one side of the lower extremity and required supervision or touching assistance with eating and oral hygiene; total assistance with transfers; substantial/maximal assistance with toileting hygiene, bathing, and lower body dressing; partial/moderate assistance with all other activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). The MDS indicated Resident 389 had an indwelling catheter. During a review of Resident 389's Order Summary Report, dated 2/27/2025, the Order Summary Report indicated the resident had the following physician's orders: - Change FC per schedule every month and as needed every day shift starting on the 27th and ending on the 27th every month. - Change FC per schedule every month and as needed for leaking, occlusion, dislodgement, excessive sedimentation. - FC care to be provided every shift. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview, on 4/22/2025, at 9:35 a.m., inside Resident 389's room, the resident was up on a wheelchair, alert, and responds appropriately, with a urinary catheter connected to a drainage bag. Resident 389 stated she had the urinary catheter since prior to admission to the facility in February 2025. During an observation, on 4/22/2025, at 9:40 a.m., outside Resident 389's room, there was no sign posted for EBP or a personal protective equipment (PPE - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) cart placed by the entrance to Resident 389's room. During an interview, on 4/22/2025, at 9:44 a.m., with the Infection Preventionist (IP), outside Resident 389's room, the IP stated she was aware that the resident had a urinary catheter and that there was no sign outside the entrance to the room for an EBP. The IP stated residents with wounds, any device care or use such as a urinary catheter should be placed on EBP and staff should perform hand hygiene by washing their hands or use hand sanitizers and put on PPE during high contact activities such as dressing, bathing, transferring changing linens, providing hygiene, toileting, and changing of briefs. The IP stated it was an oversight on her part and that there should have been an EBP sign and a PPE cart by the entrance to Resident 389's room so the staff would be aware to perform hand hygiene and put on PPEs to prevent spread of infection or illnesses among residents. The IP stated not placing a PPE cart and an EBP sign at the placed Resident 389 at risk for acquiring infection if staff did not perform hand hygiene and put on the proper PPEs while providing care. During an interview, on 4/25/2025, at 2:30 p.m., with the Director of Nursing (DON), the DON stated all residents with wounds and any device care should have an EBP sign and a PPE cart by the entrance to the room to remind staff to perform hand hygiene and put on the proper PPE prior to entering the room. The DON stated there should have been a PPE cart outside Resident 389's room by the door and a sign to remind staff to put on the proper PPE after performing hand hygiene to protect the resident from acquiring infection and prevent the spread of infection and/or illnesses among other residents. During a review of the facility's policy and procedure (P&P) titled, Enhanced Barrier Precautions, last reviewed on 1/29/2025, the P&P indicated: - When transmission-based precautions (TBP - infection control practices in the healthcare setting to help stop the spread of germs from one person to another) are not appropriate and in addition to standard precautions (a set of basic safety rules used for all types of patient care), EBP will be used in the facility to reduce the risk of transmission of microorganisms by direct or indirect contact. - For residents for whom EBP is indicated, EBP is observed when performing the following high-contact resident care activities for those at risk of transmitting or acquiring MDROs: Dressing Bathing/showering Transferring within the resident room (continued on next page)

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	055932	A. Building B. Wing	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Four Seasons Healthcare & Wellness Center, LP	5335 Laurel Canyon Blvd. North Hollywood, CA 91607

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Providing hygiene Changing linens Changing briefs or assisting with toileting Device care or use such as but not limited to urinary catheter Wound care - EBPs are to be utilized for the duration of the patient's stay unless the reason is resolved. - Post the appropriate EBP sign on the resident's room door to inform caregivers of the appropriate tasks requiring the use of PPE. - To facilitate compliance with EBP: Make PPE, including gowns and gloves, available immediately outside of the resident room. PPE stations may be positioned between adjacent rooms and ensure access to alcohol-based hand rub in every resident room.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 44244 Based on interview and record review, the facility failed to implement the facility's Antibiotic Stewardship Program (ASP - a set of commitments and actions designed to improve the use of antibiotics [a medication used to treat bacterial infections]) for one of five sampled residents (Resident 99) reviewed during the Infection Control task by failing to monitor and include Resident 99's use of methenamine hippurate (a type of antibiotic) in the ASP infection surveillance data. This deficient practice had the potential to place the resident at risk for microbial resistance and reduced resident outcomes. Findings: During a review of Resident 99's Admission Record, the Admission Record indicated the facility admitted the resident on 9/17/2024, with diagnoses including urinary tract infection (UTI - an infection in the bladder/urinary tract), extended spectrum beta lactamase (ESBL - an enzyme that makes bacteria resistant to a broad range of antibiotics) resistance, resistance to multiple antibiotics, and overactive bladder. During a review of Resident 99's Minimum Data Set (MDS - a resident assessment tool), dated 3/26/2025, the MDS indicated the resident sometimes had the ability to make self-understood and sometimes had the ability to understand others. The MDS further indicated the resident was dependent on staff for toileting, bathing, dressing, and mobility. During a review of Resident 99's Order Summary Report, the Order Summary Report indicated orders for the following: - Methenamine hippurate oral tablet one gram (gm - a unit of measurement), give one tablet by mouth one time a day for UTI prophylaxis, dated 3/24/2025. During a review of the facility provided Infection Surveillance Monthly Report, dated 4/24/2025, the report indicated Resident 99 was not included in the ASP surveillance report. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review, on 4/24/2025, at 12:41 p.m., with the Infection Preventionist (IP), Resident 99's physician orders, Medication Administration Record (MAR), and the Infection Surveillance Monthly Report, dated 4/24/2025, were reviewed. The IP stated the facility has an ASP to make sure antibiotics are administered appropriately in the facility in order to prevent the misuse of antibiotics that may result in antibiotic resistance. The IP stated all antibiotics must be ordered with a stop date, monitored for effectiveness and side effects of the medication. The IP stated the IP keeps track of every antibiotic administered in the facility and tracks the clinical appropriateness and ensures the antibiotics are monitored. The IP stated it was important to have a stop date on the antibiotics to ensure the antibiotics are assessed and monitored and not administered over a prolonged period of time unnecessarily. The IP stated for every antibiotic administered in the facility; the IP tracks the signs and symptoms of infection, the date of onset, the type of infection, the etiology of the infection, any lab results, and the if the antibiotic meets the criteria for administration. The IP stated if the antibiotic does not meet the criteria, they physician is notified to discontinue the medication. The IP stated Resident 99 was administered methenamine hippurate, an antibiotic. The IP stated Resident 99's physician order for methenamine hippurate did not include a stop date. The IP stated even antibiotics used for prophylaxis should be ordered with a stop date, be monitored for effectiveness and side effects, and be included in the IP's Infection Surveillance Monthly Report. The IP reviewed the Infection Surveillance Monthly Report and stated the IP overlooked Resident 99's methenamine hippurate and the resident was not included in the ASP data surveillance, but it should have been. The IP stated it was important to include Resident 99's methenamine hippurate in the ASP because the resident was already susceptible to infections and the antibiotic should be monitored to ensure the medication was working appropriately, there were no side effects, and was clinically appropriate. During an interview, on 4/25/2025, at 9:08 a.m., with the Director of Nursing (DON), the DON stated antibiotics are considered a high-risk medication because the overuse of antibiotics can lead to drug resistance. The DON stated the facility P&P indicated it is important to include all antibiotics in the ASP to properly evaluate the continued need for the medication. The DON stated the facility IP follows all antibiotics prescribed and administered to residents in the facility. The DON stated Resident 99's prescribed methenamine hippurate is an antibiotic and should have been included in the ASP but was not. The DON stated the facility P&P was not followed when Resident 99's prescribed methenamine hippurate was not included in the ASP, potentially resulting in the medication not being timely and effectively evaluated for the continued need. During a review of the facility's P&P titled, Antibiotic Stewardship, last reviewed 1/29/2025, the P&P indicated the purpose of the policy was to optimize use of antibiotics by improving prescribing practices and reduce inappropriate antibiotic use. The Facility will implement an Antibiotic Stewardship Program (ASP) to promote appropriate use of antibiotics optimizing the treatment of infection, reducing the threat of antibiotic resistance, reducing adverse events associated with antibiotic use and improve outcomes for Residents. An Infection Preventionist (IP) oversees the ASP ensuring that policies regarding stewardship are monitored and enforced. The IP will collect and analyze infection surveillance data, coordinate data collection and monitor adherence to infection control policies and procedures. The IP is responsible for tracking the following antibiotic stewardship processes: A. Surveillance and MDRO tracking B. The antibiotic ordered, dose, route and ordering physician as well as the cost of the drug (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	C. Whether or not the Resident's condition met McGeer's Criteria (a resource for antibiotic administration) when the antibiotic was ordered D. If cultures were ordered E. Any changes in antibiotic orders during therapy F. Outcomes of antibiotic therapy Reporting: A. The IP will coordinate the collection and reporting of data for the Infection Control Committee meetings from all members of the team B. Data on prescribing patterns, cultures and antibiograms will be shared quarterly with individual physicians as a method of feedback on prescribing practices C. The IP will maintain a list of all Residents with MDROs and active infections for room placement, monitoring of infection control practices and surveillance During a review of the facility job description manual titled, Infection Preventionist, undated, the job description manual indicated the Infection Preventionist (IP) serves as the facility's Infection Prevention and Control Officer, with oversight of the facility Infection Prevention and Control program. The IP serves as a practitioner, resource, consultant, educator, and facilitator focusing on the following areas: Infection Prevention and Control Activities as outlined in the Infection Prevention and Control Program summary. Outcome and process surveillance, including identifying, investigating, analyzing, and reporting infections. The IP conducts ongoing quality assurance performance improvement monitoring to insure adherence with the organizational standards, evidence-based practice, professional guidelines, and state, local and federal regulations. The IP oversees the facility antimicrobial stewardship program that includes antibiotic use & prescribing protocols, laboratory communication, and a system for monitoring antimicrobial use.