STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055960	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Crescenta Healthcare Center	3050 Montrose Ave LA Crescenta, CA 91214

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47882 Based on observation, interview, and record review, the facility failed to obtain an informed consent for psychotropic/psychotherapeutic (any drug that affects behavior, mood, thoughts, or perception) drugs for one of one sampled resident (Resident 39) who was prescribed Sertraline (medication used to treat depression [a persistent feeling of sadness and loss of interest]), and Divalproex (medication used to treat certain types of seizures (epilepsy) and mood disorder (a disorder manifested by severe feeling of sadness and no interest with ADLs [activity of daily living]). This deficient practice had violated Resident 39 ' s rights to be informed and choose the type of care or treatment to be received, make decisions on alternative measures the resident or responsible party preferred, which can negatively affect Resident 39 ' s quality of life. Findings: A review of the admission record indicated Resident 39 was originally admitted on [DATE] and readmitted on [DATE] with diagnoses that included dementia (a group of related symptoms associated with an ongoing decline of the brain and its abilities), psychotic disorder (affect the mind, where there has been some loss of contact with reality), and depression (mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your daily). A review of Resident 39 ' s History and Physical (H&P), dated 3/5/2024, the H&P indicated Resident 39 had the capacity to understand and make healthcare decision. A review of Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 2/10/2024, indicated Resident 39 ' s was usually able to make self-understood (difficulty communicating some words or finishing thoughts but is able if prompted or given time) and usually understands others (misses some part/intent of message but comprehends most conversation). The MDS indicated Resident 39 was independent with eating, supervision or touching assistance (helper provides verbal cues and/or touching/steadying and or contact guar assistance as resident completes activity) with oral hygiene, substantial/maximal assist (helper does more than half the effort) with upper and lower body dressing, and dependent (helper does all the effort) bathing and personal hygiene. A review of the Physician's Order Report dated 4/1/2024 to 4/ 23/2024 indicated to give Resident 39 the following: (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055960	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER LA Crescenta Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3050 Montrose Ave LA Crescenta, CA 91214	

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Sertraline 12.5 milligrams (mg-a unit of measurement) once daily for depression manifested by inability to sleep. 2. Divalproex 275 mg in the AM (morning) and 375 mg at bedtime for mood disorder manifested by no interest with ADLs. During an observation on 4/22/2024 at 11:15 AM in Resident 39 ' s room, Resident 39 was putting on a sweater and was able to verbalize simple needs. During a concurrent interview and record review, on 4/23/2024, at 3:15 AM, with Medical Data Set Nurse (MDS), the Facility Verification of Informed Consent to Psychotherapeutic Drugs(IC), dated 9/29/23 (date of Resident readmission to the facility) for Resident 39 did not include the name of the physician, the signature, signature of the physician who obtained the consent and the date the consent was obtained for medications Sertraline and Divalproex. MDS nurse stated, the informed consent should be signed and dated, and he was not sure why it ' s not. During a concurrent interview and record review, on 4/24/2024, at 9 AM, with Registered Nurse (RN) 1, Resident 39 ' s electronic medical records (EMR) and physical chart was reviewed. RN 1 stated the IC did not have a physician's name who obtained the consent, physicians ' signature, and date it was signed. RN 1 also stated that there was no documentation in the resident ' s medical record or physician ' s progress notes about obtaining informed consent on 9/29/2023. During an interview on 4/24/2024 at 9:20 AM with the DON, DON stated, if an informed consent was not signed, then it was not complete. The DON stated, the informed consent should be signed by the physician who obtained the consent as soon as possible. DON stated, she does not have a policy on how to complete an informed consent, but IC needed to be signed by the physician as soon as possible. During an interview on 4/25/2024 at 8:10 AM with the DON, DON stated, after checking Resident 39 ' s EMR and physical chart she was unable to find any type of documentation that informed consent for the use of psychotropic/psychotherapeutic drug was obtained by the physician for Resident 39. DON stated, the physician should have had obtained informed consent for the use of psychotropic/psychotherapeutic drug for Resident 39 so that risks and benefits and alternatives options, were discussed with the resident, since it is a violation of Resident 39 ' s rights. A review of the facility's policy and procedure (P&P) titled, Health Information/Record Manual under Behavior Drugs/ Psychotropic, dated 2015, indicated; a) when physician orders use of a psychotropic/ psychotherapeutic drug, the physician will obtain the informed consent from the resident or resident representative, b) The Licensed Nurse carrying out the physician order for use of the psychotropic will verify with the physician to make certain that an informed consent has been obtained by the physician with the resident or resident representative. c) The Licensed Nurse will document such information as a telephone order [i.e., Informed consent was obtained by the physician (state name) for the use of (identify the psychotropic) with the resident ' s representative (may state relationship to resident) and in the Informed Consent form, d) before administration of psychotherapeutic drugs, the facility staff will verify the resident ' s/patient health record contained documentation that the resident/patient had received informed consent.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48219 Based on observation, interview, and record review, the facility failed to provide reasonable accommodations of need for resident needs and preferences for 2 out of 22 sampled residents (Resident 22 and 35) by not ensuring the overhead light cord was within resident (22 and 35) ' s reach that prevented resident 22 and 35 from having the ability to turn the light on or off as needed. This deficient practice is not in line with the resident ' s right to have adequate lighting and reasonable accommodation of needs and preferences which limits the resident's ability to see clearly and adjust the lighting to their individual needs. In addition, this deficient practice could also result in accident that results in injury to the residents. Findings: 1. A review of an admission information indicated Resident 22 was admitted to the facility on [DATE], with diagnoses that included atrial fibrillation (abnormal irregular heartbeat), rheumatoid arthritis (swelling and stiffness of joints) and Dry eye syndrome (eyes do not produce enough tears). A review of History and physical dated [DATE], indicated Resident 22 has the capacity to understand and make own decisions. A review of Minimum set data (MDS- assessment and care planning tool), dated [DATE] indicated Resident 22 requires partial assistance with upper body tasks. A review of Resident 22 ' s care plan dated [DATE], indicated Resident 22 will have an environment appropriate for residents ' cognition and needs. A review of admission record indicated Resident 35 was admitted to the facility on [DATE] with diagnoses which included Myocardial infarction (heart attack), angina (chest pain), chronic kidney disease (kidneys are damaged and cannot filter blood as well as they should). A review of History and Physical dated [DATE] indicated Resident 35 has the capacity to understand and make own decisions. A review of Minimum set data (MDS - Assessment and care planning tool) Dated [DATE] indicated Resident 35s preference to have books, newspapers, and magazines to read was very important and indicated resident 35 requires partial assistance with functional abilities. During concurrent observation and interview on [DATE] at 9:45 am, Resident 35 stated she was not able to reach the overhead light cord to turn on and off light. Resident 35 stated, I am not an able-bodied person, and I cannot reach the cord. During concurrent observation and interview on [DATE]-24 at 10:am, LVN2 stated Resident 35 was not able to reach the cord for above bed lighting. When asked what can happen if the resident cannot reach the string, LVN2 stated they are not able to turn the light on or off with out calling for help. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on [DATE] at 10:31 am, Resident 22 observed in bed, lying supine to right side with overhead light cord was hanging down behind bed, that was not in reach of the resident. During concurrent observation and interview on [DATE] at 11:23 am, CNA 2 verified Resident 22 was not able to reach overhead light string. A review of facility Policy and Procedure Titled Quality of life - Dignity Policy no. OP2 0304.07 No Date, indicates that each resident shall be cared for in a manner that promotes and enhances his or her sense of well being by supporting and encouraging the individuals ' choices and preferences such as bed position and lighting preferences.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44429 Based on interview and record review, the facility failed to ensure an Advance Directives (AD-a written statement of a person's wishes regarding medical treatment to ensure those wishes are carried out should the person be unable to communicate his/her needs to the doctor) and the Physician Orders for Life-Sustaining Treatment (POLST: medical order forms that indicate to the medical staff what to do in an event of medical emergency) were offered and/or obtained and accessible in the residents medical records for 4 of 5 sampled residents (Resident 187, 30, 25 & 74). The facility failed to ensure: 1. Resident's 187 Advance Directive acknowledgement form was not located in the paper chart and POLST was not completed. 2. Resident's 30, 25, and 74 medical records did not include and Advance Directive acknowledgement form. This deficient practice had the potential for residents' medical treatment provisions to not be carried out, according to the resident's request during emergency situations and/or when a resident was incapacitated (the clinical state in which a patient is unable to participate in a meaningful way in medical decisions). Findings: 1. A review of Resident 187's Admission Record indicated the resident was initially admitted to the facility on [DATE] with a diagnosis of sepsis (the body ' s extreme reaction to an infection that can lead to death) and myocardial infarction (caused by decrease or complete cessation of blood flow to a portion of the heart). A review of Resident 187's General Acute Care Hospital (GACH) History and Physical dated 4/13/2024, indicated Resident 187 demonstrated good judgement and reason. A review of Resident 187's Minimum Data Set (MDS, a standardized resident assessment and care screening tool) dated 4/27/2024, indicated Resident 187 ' s cognition (the mental action or process of acquiring knowledge and understanding) was moderately impaired. A review of Resident 187 ' s POLST, dated 4/19/2024, indicated Resident 187 ' s information and signatures for the AD was not completed. 2. A review of Resident 30's Admission Record indicated the resident was initially admitted to the facility on [DATE] with a diagnosis of cerebral infarction (damage to tissue in the brain due to loss of oxygen) and atrial fibrillation (irregular heartbeat). A review of Resident 30's History and Physical dated 4/19/2024, indicated Resident 30 did not have the capacity to understand and make decisions. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 30's MDS dated [DATE], indicated Resident 30 ' s cognition was moderately impaired. 3. A review of Resident 25's Admission Record indicated the resident was initially admitted to the facility on [DATE] and was readmitted on [DATE] with a diagnosis of cerebral infarction (damage to tissue in the brain due to loss of oxygen) and psychosis (a collection of symptoms that affect the mind and loss of contact with reality). A review of Resident 25's History and Physical dated 9/21/2023, indicated Resident 25 did not have the capacity to understand and make decisions. A review of Resident 25's MDS dated [DATE], indicated Resident 30 ' s cognition was severely impaired. 4. A review of Resident 74's Admission Record indicated the resident was initially admitted to the facility on [DATE] with a diagnosis of). Heart failure (a condition that develops when the heart doesn ' t pump enough blood for the body ' s needs) and Hypertension (high blood pressure). A review of Resident 74's History and Physical dated 1/10/2024, indicated Resident 74 did have the capacity to understand and make decisions. A review of Resident 74's MDS dated [DATE], indicated Resident 30 ' s cognition was intact. During a concurrent interview and record review on 4/24/2024 at 11:35 AM with the Case Manager/Quality Assurance Nurse (CM), stated Resident 187, 30, 25 and 74 ' s active paper charts of medical records were reviewed. The CM stated Resident ' s 187, 30, 25 and 74 AD acknowledgement form was not in the paper chart. CM also stated Resident 187 ' s POLST was not completed, and facility staff would not know what Resident 187 ' s wishes were regarding treatment and care during a medical emergency. CM stated the AD acknowledgement form should be kept in the paper chart of resident's current medical record so that the AD was always easily accessible. During a concurrent interview and record review on 4/24/2024 at 12:30 PM with the Director of Nursing (DON), Resident 187, 30, 25 and 74 paper charts were reviewed. the DON stated that a copy of AD acknowledgement form should be kept in the residents' paper chart, so the staff could easily retrieve the information and know about the resident's wishes regarding treatment during an emergency. The DON stated that Residents 187 ' s POLST was not completed in the paper chart. A review of the facility ' s policy and procedure titled, Advance Directive, dated 8/16/2021, indicated the AD the company ' s copy of the AD must be filed in the resident ' s clinical record.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48219 Based on observation, interview, and record review, the facility failed to provide adequate lighting suitable to perform tasks that the resident chooses to perform, or the facility staff must perform to assist one of twenty-two sampled residents (Resident 48). This deficient practice violated the resident ' s right to reasonable accommodation of needs and preferences which was essential to creating and individualized, home- like environment to include adequate and comfortable lighting levels. This deficient practice could also result in resident falls or accidents in the room which could lead to injury. Comfortable light means lighting that minimizes glare and provides maximum resident control, where feasible, over the intensity, location, and direction of lighting to meet their needs or enhance independent functioning. Findings: A review of Resident 48 ' s Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included fracture of neck, right femur (thigh bone), right tibial spine (top of thigh bone), and vertebra in cervical region (the neck area of spine). A review of Resident 48 ' s History and Physical, dated 1/29/2024 indicated, Resident 48 has capacity to understand and make decisions. A review of Resident 48 ' s Minimum Set Data (MDS- that measures health status in nursing home residents) dated 1/31/2024 indicated Resident 48 can complete functional activity independently, by themselves. A review of Resident 48 ' s Care Plan, dated 1/29/2024 indicated Resident 48 is high risk for falls due balance issue and muscle weakness, with goal is to decrease resident's risk of fall and injury with intervention to keep environment free of hazards, obtaining information of patient's preference and history that may contribute to promoting safety and comfort during inpatient stay. During an observation on 4/22/24 at 8:14 am, Resident 48 observed sitting at end of hallway in front of a window with bedside table and sitting on an aluminum folding chair. During an interview on 4/22/2024 at 8:14 am, Resident 48 stated she cannot stay in the dark and went on to say her roommate likes it dark and I like it light, that is why I stay in hallway all day. Resident 48 stated, I do not like the atmosphere in my room, it ' s too dark, I eat all my meals in hallway. During an interview on 4/22/2024 at 9:00 am, CNA1 stated Resident 48 told her she does not like to be in the room because it was always dark. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/22/2024 At 09:15 am, LVN2, stated Resident 48 likes to be outside of the room. LVN 2 stated when Resident 48 was in her previous room, she would spend most of her time in her room and not in the hallway., Now resident 48 is always outside her room. During an interview on 4/22/2024 at 10:35 am, the DON, stated Resident 48 likes to eat outside of the room Infront of a big window. During a review of the facility ' s policy no date, titled Quality of life- Dignity, indicated each resident shall be cared for in a manner that promotes and enhances his or her sense of well - being, level of satisfaction with life, feeling of self - worth and self - esteem. The facility culture is one that supports and encourages humanization and individuation of residents, honoring a resident choice in their physical environment, to include but not limited to lighting preferences.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 49881

Based on interview and record review the facility failed to develop an individualized resident-centered care plan (a care plan that prioritizes the unique health needs and desired outcomes of the resident) to meet the resident's' needs for two of 2 sampled residents (Resident 17 and Resident 187).

1. Resident 17 did not have a care plan with a measurable objective to ensure the resident is participating in activities.

2. Resident 187 was unable to attend group activity. The care plan did not indicate the reason the resident was unable to attend activities. The care plan goals indicated Resident 187 will benefit and participate in room/bedside activities: X/week.

This deficient practice had the potential for the residents not to receive the appropriate interventions to achieve the goals to achieve the highest practicable mental and psychosocial (social, cultural, and environmental influences on the mind and behavior) wellbeing and improve in the quality of life.

Findings:

A review of Resident 17 ' s Admission records, the record indicated the resident was admitted to the facility on [DATE] with diagnoses that included cerebral infraction (damage to tissues in the brain due to a loss of oxygen to the area), dysphagia (difficulty in swallowing), anxiety disorder (disorder involves persistent and excessive worry that interferes with daily activities), major depressive disorder (a mental health condition that causes a persistently low or depressed mood and a loss of interest in activities that once brought joy), primary osteoarthritis (a condition involving the deterioration of a joint), and paraplegia (the condition of being unable to move the lower half of your body).

During a review of Resident 17 ' s comprehensive care plan (a plan that outlines resident-specific interventions used to guide a resident's care for a given area of concern), initiated on 4/16/24, the care plan indicated Resident 17's goal for activities was to ensure the resident participate in room/bedside activities for X times out of the week.

During a concurrent interview and record review with the Minimum Data Set Coordinator (MDS) on 4/24/24 at 3:12 PM, the MDS stated the goal of X/week was not specific or resident centered. MDS stated it important to have a timeframe for goals to determine if the goal has been met. MDS further stated that if the goal was not met, the facility needs to consider different interventions. MDS stated the goal needs to be specific and attainable by setting a specific timeframe.

During a concurrent interview and record review with the Director of Nursing (DON) on 4/25/24 at 8:58 AM, the DON stated Resident 17's activity care plan did not have a resident-centered goal. DON stated the resident ' s goal should be clear, so staff understand the resident's plan of care. DON stated it is important for the resident to have a specific goal to ensure it was being met.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	44429 2. A review of Resident 187's Admission Record indicated the resident was initially admitted to the facility on [DATE] with a diagnosis that included of sepsis (a life threatening and severe infection in the blood) and myocardial infarction (caused by decrease or complete cessation of blood flow to a portion of the heart). A review of Resident 187's General Acute Care Hospital (GACH) History and Physical, dated 4/13/2024, indicated Resident 187 demonstrated good judgement and reason. A review of Resident 187's Minimum Data Set (MDS, a standardized resident assessment and care screening tool) dated 4/27/2024, indicated Resident 187's cognition (the mental action or process of acquiring knowledge and understanding) was moderately impaired. A review of Resident 187's Care Plan under category of Activities, dated 4/17/2024 indicated Resident 187 was unable to attend group activity. The care plan did not indicate the reason the resident was unable to attend activities. The care plan goals indicated Resident 187 will benefit and participate in room/bedside activities: X/week. During a concurrent interview and record review on 4/24/2024 at 11:45 AM, the Case Manager/Quality Assurance Nurse (CM) stated Resident 187 care plan did not indicate the reason why Resident 187 was unable to attend activities. CM stated it was important to indicated what the problem areas were to formulate goals for activities. CM stated care plan under goal of X/week was not specific a goal. CM stated it was important to have a specific time frame for goals to determine if the goal has been met. CM stated that if a problem was not identified along with goals, it would affect Resident 187's psychosocial wellbeing (emotional and mental status) and the goal would not be met. During a concurrent interview and record review on 4/24/2024 at 12:45 PM with the Director of Nursing (DON), DON stated Resident 187's activity care plan did not indicate a problem and had no resident-centered goal. DON stated the resident's problem and goal should have been clear, so staff could understand the resident activity plan of care. DON stated by not having a resident centered care plan for activities for Resident 187 would affect his psych-social needs. During a review of the facility's undated policy Comprehensive Plan of Care indicated Each resident will have a comprehensive care plan developed that includes goals, measurable objectives, and timetables to meet their medical, nursing, mental, and psychosocial needs identified during the comprehensive assessment and The comprehensive care plan must . include treatment goals with measurable objectives.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47882 Based on observation, interview, and record review the facility failed to provide necessary care and services to one of three sampled residents (Resident 46) who was dependent with the staff to carry out activities of daily living (ADL) by not maintaining grooming, and good personal hygiene by not shaving her long facial hairs above the lips and under the chin. This deficient practice had the potential to negatively affect Resident 46 ' s self image, physical appearance, dignity, and quality of life. Findings: A review of Resident 46s admission record indicated the resident was admitted to the facility on [DATE] with diagnoses that included cerebrovascular disease (a group of conditions that affect blood flow and the blood vessels in the brain), Alzheimer ' s disease (a brain disorder that slowly destroys memory, thinking skills, and eventually loose the ability to carry out the simplest tasks), and history of pneumonia (swelling of the tissue in one or both lungs, usually caused by a bacterial infection). A review of Minimum Data Set (MDS, a standardized assessment and care screening tool), date 3/28/2024, indicated Resident 46s cognitive skills (ability to make daily decisions and process information) was severely impaired. The MDS indicated Resident 46 was dependent (helper does all the effort) with all ADLs., which included personal hygiene (combing hair, shaving, washing and drying face and hands). During a concurrent observation and interview on 4/22/2024 at 10:40 AM with Licensed Vocational Nurse (LVN) 4 in Resident 46 ' s room, Resident 46 was observed with long facial hairs above the lips and under the chin. LVN 4 stated, Resident 46 ' s facial hairs should have been shaved during morning care, since it affects Residents dignity and quality of life. LVN 4 stated, there was no restrictions in shaving Resident 46 ' s facial hairs. During an interview on 4/22/2024 at 10:50 AM with Certified Nurse Assistant (CNA) 6, CNA 6 stated, Resident 46 ' s facial hairs should have been shaved during morning care as part of her grooming, and it does not look good for a female resident to have facial hairs. During an interview on 4/24/2024 at 10:46 AM with Registered Nurse (RN) 1, RN 1 stated, as part of daily grooming, unless there was a restriction, female resident hairs should be shaved for physical appearance, dignity, and quality of life. During an interview on 4/25/2024 at 8:06 AM with Director of Nurses (DON), DON stated, Resident 46 ' s facial hair should have been shaved as part of good grooming, for overall appearance, health, and dignity. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 46's care plan (CP), dated 4/3/2024, CP indicated Resident 46 requires extensive assistance and total dependence (helper does all the effort) due to physical limitation and disability. The CP goal is to provide Resident 46 with needed assistance in ADL to maintain comfort and dignity. A review of the facility's policy and procedure (P&P) titled, Morning Care, (undated), the P&P ' s purpose was to facilitate residents' overall comfort, cleanliness, grooming and well-being. A review of the facility's policy and procedure (P&P) titled, Personal Care Needs Policy, (undated), indicated residents who was unable to carry out activities of daily living receives the necessary services to maintain good grooming and personal and oral hygiene.

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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, interviews, and record review, the facility failed to provide treatments and services for three out of six sampled residents (Residents 68, 25, and 17) at risk for decline in range of motion (ROM, full movement potential of a joint) and mobility by failing to: 1a. Provide Resident 68 with Restorative Nursing Aide program (RNA, nursing aide program that help residents to maintain their function and joint mobility) treatments for passive range of motion (PROM, movement at a given joint with full assistance from another person) exercises on both lower extremities (BLE, hip, knee, ankle, feet) five (5) times a week as ordered. 1b. Provide Resident 68 with RNA treatments to apply both knee extension splint (rigid material or apparatus used to support and immobilize a broken bone or impaired joint to keep the knee in straight position) for three (3) hours or as tolerated once a day 5 times a week. 1c. Follow physician RNA treatment orders to apply both knee extension splints for maximum of three hours for Resident 68. 1d. Complete one quarterly rehabilitation screen in 2022 and two quarterly rehabilitation screens 2023 for Resident 68. 2a. Provide Resident 25 with RNA treatments for PROM to left upper extremity (LUE, shoulder, elbow, wrist, hand) and lower left extremity (LLE) five times a week as ordered. 2b. Provide Resident 25 with RNA treatments to apply left resting hand splint five times a week for up to 5 hours as ordered. 2c. Complete three quarterly rehabilitation screens in 2022 and 2 quarterly rehabilitation screens 2023 for Resident 25. 3. Complete one quarterly rehabilitation screen in 2022 and 1 quarterly rehabilitation screen 2023 for Resident 17. These deficient practices had the potential to cause further decline in functional mobility, ROM, and quality of life for Residents 68, 25, and 17. FINDINGS: 1a. A review of Resident 68 ' s Face Sheet indicated Resident 68 was admitted to the facility on [DATE], with diagnoses including but not limited to, osteoarthritis (loss of protective cartilage that cushions the ends of your bones) of the right and left hip and encephalopathy (any damage or disease that affects the brain). (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 68 ' s Minimum Data Set (MDS, a standardized assessment and care-screening tool) dated 2/6/24 indicated Resident 68 was severely impaired in cognitive skills for daily decision making (difficulty with or unable to make decisions, learn, remembering things). The MDS also indicated Resident 68 required dependent assistance with eating, oral hygiene, dressing, chair to bed transfers and walking 10 feet was not attempted. The MDS also indicated Resident 68 received four days each of RNA program for the techniques of passive ROM and splint or brace assistance in the past seven days. A review of Resident 68 ' s physician order report dated 4/1/24 to 4/24/24, indicated an order with start date 3/28/24 and end date 6/26/24, for RNA to provide PROM exercises on BLE 5 times a week for 90 days as tolerated by the resident. The physician order report also indicated an order with start date 4/1/24 and end date 7/7/24 for RNA to provide bilateral knee extension splint for three hours or as tolerated once a day five times a week for 90 days. The physician order report indicated for the licensed nurse to monitor skin integrity for any redness, open area, swelling, circulation and pain before and after application. A review of Resident 68 ' s care plan dated 4/18/24 and edited 4/24/24, indicated Resident 68 was at risk for further contracture (loss of motion of a joint) formation. The care plan goal indicated Resident 68 to maintain/improve functional joint mobility. The care plan approach indicated for RNA to provide bilateral knee extension splint for three hours or as tolerated once a day five times a week for 90 days. The care plan approaches indicated the licensed nurse to monitor skin integrity for any redness, open area, swelling, circulation and pain before and after application. The care plan approach also indicated physical therapy (PT, a rehabilitation profession that restores, maintains, and promotes optimal physical function) and occupational therapy (OT, rehabilitative profession that provides services to increase and/or maintain a person ' s capability to participate in everyday life activities) referral as needed and joint mobility assessment every 3 months and as needed. A review of Resident 68 ' s care plan dated 7/3/23 and edited on 3/29/24, indicated Resident 68 had limitation in ROM and Resident 68 was at risk for developing limitation in ROM and/or functional mobility. The care plan goal indicated for Resident 68 to maintain and/or improve functional mobility and to decrease risk for further limitation in ROM. The care plan approach indicated RNA to provide PROM exercises on BLEs 5x/week for 90 days as tolerated and monitor joint mobility quarterly and as needed. During an observation on 4/23/24 at 12 PM in Resident 68 ' s room, Resident 68 was sitting up in a wheelchair with a high back and slightly reclined backwards. Resident 68 ' s left knee was bent and leaning towards the right side of the body. Resident 68 ' s left foot was resting on top of the right footrest leg support. Resident 68 ' s right knee was bent, and the right foot was resting behind the right footrest. Resident 68 was able to move both arms and bring the right hand to the resident ' s face. During the observation, Resident 68 did not have both knee extension splints applied to both legs. During a concurrent interview and record review of Resident 68 ' s RNA Point of Care History for RNA treatment provided for PROM to BLEs for January 2024, on 4/25/24 at 8:55 AM, the Director of Rehabilitation, Physical Therapist (PT) 1 confirmed the following RNA treatments were missed: -one treatment during week of 1/28/24. (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 concurrent interview and record review of Resident 68 ' s RNA Point of Care History for RNA treatment provided for PROM to BLEs during February 2024, on 4/25/24 at 8:55 AM, PT 1 confirmed the following RNA treatments were missed: -one treatment during week of 2/4/24, -one treatment during week of 2/18/24, -one treatment during week of 2/25/24. During a concurrent interview and record review of Resident 68 ' s RNA Point of Care History for RNA treatment provided for PROM to BLEs during March 2024, on 4/25/24 at 8:55 AM, PT 1 confirmed the following RNA treatments were missed: -one treatment during week of 3/3/24, -one treatment during week of 3/17/24, -three treatments during week of 3/31/24. During a concurrent interview and record review of Resident 68 ' s RNA Point of Care History for RNA treatment provided for PROM to BLEs during April 2024, on 4/25/24 at 8:55 AM, PT 1 confirmed the following RNA treatments were missed: -one treatment during week of 4/14/24. 1b. During a concurrent interview and record review of Resident 68 ' s RNA Point of Care History for RNA treatment provided for both knee extension splints five times a week during January 2024, on 4/25/24 at 8:55 AM, PT 1 confirmed the following RNA treatments were missed: -one treatment during week of 1/28/24. During a concurrent interview and record review of Resident 68 ' s RNA Point of Care History for RNA treatment provided for both knee extension splints five times a week during February 2024, on 4/25/24 at 8:55 AM, PT 1 confirmed the following RNA treatments were missed: -one treatment during week of 2/4/24, -one treatment during week of 2/18/24, -one treatment during week of 2/25/24. During a concurrent interview and record review of Resident 68 ' s RNA Point of Care History for RNA treatment provided for both knee extension splints five times a week during March 2024, on 4/25/24 at 8:55 AM, PT 1 confirmed the following RNA treatments were missed: -one treatment during week of 3/3/24, (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-one treatment during week of 3/10/24, -five treatments during week of 3/17/24, -five treatments during week of 3/24/24, -three treatments during week of 3/31/24. During a concurrent interview and record review of Resident 68 ' s RNA Point of Care History for RNA treatment provided for both knee extension splints five times a week during April 2024, on 4/25/24 at 8:55 AM, PT 1 confirmed the following RNA treatments were missed: -one treatment during week of 4/14/24. During an interview on 4/24/24 at 1:57 PM, PT 1 stated an RNA program was a functional maintenance program for residents once they complete therapy to continue with exercises or walking so that residents could maintain their function. PT 1 stated it was important for residents to receive their RNA treatments as ordered so that residents do not decline in function. During an interview on 4/25/24 at 9:19 AM, the Director of Nursing (DON) stated the RNA program was a restorative nursing program that does range of motion exercises, splinting, walking to help prevent contractures, maintain the resident ' s functional mobility and ROM. DON stated it was important to prevent contractures because contractures caused changes in the body and the resident could be uncomfortable and in pain. DON stated it was important for all residents to receive RNA program as ordered. 1c. During an concurrent interview and record review of Resident 68 ' s RNA Point of Care History for RNA treatment provided for both knee extension splints five times a week for 3 hours from January 2024 to April 2024, on 4/24/24 at 2:28 PM, PT 1 stated RNAs indicated the knee extension splints were put on the resident for four hours, more than 3 maximum hours ordered, on the following dates: 1/4/24, 1/11/24, 1/18/24, 2/13/24, 2/17/24, 2/20/24, 3/2/24, 4/4/24, 4/8/24, 4/12/24, 4/22/24. In the same interview, PT 1 stated RNAs should not put on the splints for more than the time indicated in the RNA orders because the time ordered was what the PT had determined was the maximum time the resident would tolerate the splint. PT 1 stated PT or OT were the only disciplines that had the training and knowledge to assess and determine how long a resident could wear splints. If a splint was put on a resident longer than prescribed, then the resident was at risk for skin issues such as redness, swelling, irritation, and possibly pain. A review of the facility ' s undated policies and procedures titled, Restorative Nursing Program - General Overview, indicated residents will receive restorative nursing care as needed to help promote optimal safety and independence. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1d. During a concurrent interview and record review of Resident 68 ' s quarterly rehabilitation screens from 1/1/22 to present, on 4/24/24 at 2:28 PM, PT 1 stated all residents were screened by rehabilitation at least one discipline upon admission, every 3 months, or as needed. PT 1 stated the rehabilitation screens should be done every 3 months so that rehabilitation staff could identify any change of conditions or if the resident could benefit from therapy services. PT 1 indicated a contracture screen was completed if a resident had a limitation in ROM or contracture and to indicate if the ROM was stable, declined or improved. PT 1 stated if the rehabilitation screens were not completed every 3 months, then residents could possibly have a decline in function. After review of Resident 68 completed rehabilitation screens, PT 1 confirmed one rehabilitation quarterly screen was missed in 2022 and confirmed one quarterly screen was missed in 2023. PT 1 stated Resident 68 had contractures in both legs and was at risk for further ROM decline and it was important to monitor all residents for ROM, mobility and overall decline in function. A review of the facility ' s policy and procedure dated 2/15, titled, Therapy Contracture Assessment Procedure, indicated, at least one discipline of Physical, Occupational, or Speech Therapy will screen a resident for therapy services upon admission, and quarterly thereafter. If a therapy screen identifies joint function is limited by contracture, a contracture screen is used to identify the specific deficits in range of motion. The contracture screen is performed, at least quarterly with range of motion measurements taken. 2a. A review of Resident 25 ' s Face Sheet indicated Resident 25 initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including, but not limited to cerebral infarction (blockage of the flow of blood brain, causing or resulting in brain tissue death) and arthritis left shoulder. A review of Resident 25 ' s MDS dated [DATE] indicated Resident 25 was moderately impaired in cognitive skills for daily decision making. The MDS also indicated Resident 25 required dependent assistance with oral hygiene, dressing, chair to bed transfers and walking 10 feet was not attempted. The MDS also indicated Resident 25 received four days each of RNA program for the techniques of passive ROM and splint or brace assistance. A review of Resident 25 ' s physician order report dated 4/1/24 to 4/24/24 indicated an order with start date 3/24/24 and end date 6/25/24 for RNA to provide LUE and LLE PROM exercises as resident tolerates 5 times a week for 90 days. The physician order report also indicated an order with start date 3/26/24 and end date 6/25/24 for RNA to apply left resting hand orthotic for up to 5 hours or as tolerated once a day 5 times a week for 90 days. A review of Resident 25 ' s indicated a care plan dated 3/27/24 indicated Resident 25 was using a splint for limb support and temporary immobility of a limb for medical and orthotic management: RNA will apply left resting hand orthotic. The care plan goal indicated Resident 25 to minimize risk of decline in ROM for affected extremities and the resident will tolerate the use of a splinting device as scheduled. The care plan approach indicated for RNA splinting order: RNA will apply left resting hand orthotic for up to 5 hours or as resident tolerates once a day, 5 times a week for 90 days, ROM of extremities as ordered, check for discomfort and adjust splinting as necessary. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 25 ' s indicated a care plan dated 3/27/24 for resident with limitation in ROM and Resident 25 was at risk for developing limitation in ROM and/or functional mobility. The care plan goal indicated for Resident 25 to maintain and/or improve functional mobility and maintain physical function despite limited mobility whenever possible. The care plan approach indicated RNA to provide LUE/LLE PROM as resident tolerated once a day, 5 times a week for 90 days, and monitor joint mobility quarterly and as needed. During an observation and interview on 4/23/24 at 9:31 AM in Resident 25 ' s room, Resident 25 was sitting up in bed and had a green hand splint on the left wrist/hand. Resident 25 pointed to the left hand and stated the exercise was so good it was perfect. Resident 25 was able to raise the right arm to about shoulder level, straighten the right elbow and open and close the left hand. Resident 25 ' s left elbow was bent a little and Resident 25 could not move the left arm. Resident 25 was able to move the right leg a little. During a concurrent interview and record review of Resident 25 ' s RNA Point of Care History for RNA treatment provided for PROM to LUE and LLE from January 2024 to April 2024, on 4/24/24 at 1:57 PM, PT 1 confirmed the following RNA treatments were missed: -one treatment during week of 1/28/24, -one treatment during week of 2/12/24, -one treatment during week of 3/3/24, -one treatment during week of 4/14/24. 2b. During a concurrent interview and record review of Resident 25 ' s RNA Point of Care History for RNA treatment provided to apply left resting hand orthotic for up to 5 hours from January 2024 to April 2024, on 4/24/24 at 1:57 PM, PT 1 confirmed the following RNA treatments were missed: -one treatment during week of 2/12/24, -one treatment during week of 3/3/24, -one treatment during week of 4/14/24. During an interview on 4/24/24 at 1:57 PM, PT 1 stated an RNA program was a functional maintenance program for residents once they complete therapy to continue with exercises or walking so that residents could maintain their function. PT 1 stated it was important for residents to receive their RNA treatments as ordered so that residents do not decline in function. PT 1 stated the left resting hand splint was to prevent a contracture in Resident 25 ' s hand because Resident 25 had hemiplegia after a stroke and had a tendency to close the left hand. PT 1 stated it was important to put on the left resting hand splint so that the resident ' s hand would not be in a closed fisted position. (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 4/25/24 at 9:19 AM, DON stated the RNA program was a restorative nursing program that does range of motion exercises, splinting, walking to help prevent contractures, maintain the resident ' s functional mobility and ROM. DON stated it was important to prevent contractures because contractures caused changes in the body and the resident could be uncomfortable and in pain. DON stated it was important for all residents to receive RNA program as ordered. A review of the facility ' s undated policies and procedures titled, Restorative Nursing Program - General Overview, indicated residents will receive restorative nursing care as needed to help promote optimal safety and independence. 2c. During a concurrent interview and record review of Resident 68 ' s quarterly rehabilitation screens from 1/1/22 to present, on 4/24/24 at 1:57 PM, PT 1 stated all residents were screened by rehabilitation at least one discipline upon admission, every 3 months, or as needed. PT 1 stated the rehabilitation screens should be done every 3 months so that rehab staff could identify any change of conditions or if the resident could benefit from therapy services. PT 1 indicated a contracture screen was completed if a resident had a limitation in ROM or contracture and to indicate if the ROM was stable, declined or improved. PT 1 stated if the rehabilitation screens were not completed every 3 months, then residents could possibly have a decline in function. After review of Resident 25 ' s completed rehabilitation screens, PT 1 confirmed 3 rehabilitation quarterly screens were missed in 2022 and confirmed 2 quarterly screens were missed in 2023. PT 1 stated Resident 25 had hemiplegia (weakness or loss of movement in one side of the body) and could not move the left upper extremity and lower extremity and was at risk for further ROM decline and it was important to monitor all residents for ROM, mobility and overall decline in function. A review of the facility ' s policy and procedure dated 2/15, titled, Therapy Contracture Assessment Procedure, indicated, at least one discipline of Physical, Occupational, or Speech Therapy will screen a resident for therapy services upon admission, and quarterly thereafter. If a therapy screen identifies joint function is limited by contracture, a contracture screen is used to identify the specific deficits in range of motion. The contracture screen is performed, at least quarterly with range of motion measurements taken. 3. A review of Resident 17 ' s Face sheet indicated Resident 17 was admitted to the facility on [DATE] with diagnoses that included cerebral infraction, dysphagia (difficulty in swallowing), osteoarthritis, and paraplegia (the condition of being unable to move the lower half of your body). A review of Resident 17 ' s MDS, dated [DATE], the MDS indicated Resident 17 had no speech, rarely expressed ideas and wants, and was severely impaired for cognition (ability to think, understand, learn, and remember). The MDS also indicated Resident 17 had ROM impairment on both sides of the upper and lower extremity. The MDS indicated Resident 17 required dependent assistance with oral hygiene, dressing, eating, rolling from left to right, chair to bed transfers, and walking 10 feet was not attempted. A review of Resident 17 ' s care plan indicated a care plan dated 3/27/24 for resident with limitation in joint mobility and Resident 17 was at risk for further contracture. The care plan goal indicated for Resident 17 to maintain and/or improve functional joint mobility. The care plan approach indicated joint mobility assessment every 3 months and as needed. (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 concurrent interview and record review of Resident 17 ' s quarterly rehabilitation screens from 1/1/22 to present, on 4/24/24 at 10:42 AM, the Physical Therapist (PT 2) stated all residents were screened by rehabilitation at least one discipline on admission, quarterly, or as needed. PT 2 stated the rehabilitation screens should be done once in a quarter so that rehabilitation staff can monitor range of motion and maintain resident ' s joint integrity. After review of Resident 17 ' s completed rehabilitation screens, PT 2 confirmed one rehabilitation quarterly screen was missed in 2022 and confirmed one quarterly screen was missed in 2023. PT 2 stated it was important to conduct the quarterly screenings to prevent contractures. During an interview with the PT 1 on 4/24/24 at 1:57 PM, PT 1 stated all residents were screened by rehabilitation at least one discipline upon admission, every 3 months, or as needed. PT 1 stated the rehabilitation screens should be done every 3 months so that rehab staff could identify any change of conditions or if the resident could benefit from therapy services. PT 1 stated if the rehabilitation screens were not completed every 3 months, then residents could possibly have a decline in function. During a concurrent interview and record review of Resident 17 ' s care plan, with the DON on 4/25/24 at 9:04 AM, the DON stated Resident 17 should have a joint mobility assessment completed every three months. DON stated it was important to monitor Resident 17 ' s current condition and determine if Resident 17 ' s contractures were getting worse. A review of the facility ' s policy and procedure dated 2/15, titled, Therapy Contracture Assessment Procedure, indicated, at least one discipline of Physical, Occupational, or Speech Therapy will screen a resident for therapy services upon admission, and quarterly thereafter. If a therapy screen identifies joint function is limited by contracture, a contracture screen is used to identify the specific deficits in range of motion. The contracture screen is performed, at least quarterly with range of motion measurements taken. 49881

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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. 48219 Based on observation, interview, and record review the facility failed to insure resident's safety through implementation and fire prevention interventions. by identifying and eliminating fire and environmental hazard for two of twelve sampled residents (Residents 35 and 288) by failing to ensure heating units (a machine used that provide heat in the room) were free and clear of potentially flammable (materials that can cause fire) items. This deficient practice had a potential to result in a fire that could lead to burns, injury and death to the facility staffs, residents and visitors. Findings: 1. A review of Resident 35s' Admission Record indicated the facility admitted Resident 35 on 3/29/2024, with diagnoses that included myocardial infarction (heart attack or interruption of blood flow in the heart) and angina (chest pain), A review of Resident 35's History and physical, dated 4/20/24, indicated the resident has the capacity to understand and make decisions. A review of Residents 35's Minimum Data Set (MDS- a standardized assessment and screening tool) dated 3/18/2024, indicated the resident is cognitively intact and performs activities of daily living such as dressing and showering independently. A review of Resident 35's Care plan dated 3/13/2024, indicated to keep environment free of hazards and clutter free. 2. A review of Resident 288's Admission Record indicated the facility admitted Resident 288 on 4/8/2024, with diagnosis of tr aumatic hemorrhage of right cerebrum with loss of consciousness (stroke due to loss of blood supply to an area of the brain) and paralytic syndrome (loss of muscle movement) aphasia (problem with language abilities or inability to speak or express self). A review of Resident 288's History and physical dated 4/4/2024, indicated Resident 288 does not have the capacity to decisions. A review of Resident 288's Minimum Data Set (MDS- a standardized assessment and screening tool) dated 4/9/2024 indicated the resident is cognitively intact and required moderate assistance with transfers and ambulation, requiring a wheelchair for mobility. A review of Resident 288's Care Plan dated 1/3/2024, indicated intervention to keep environment free of hazards by providing a clutter free environment and call light withing reach. During an observation on 4/22/24 at 9:45 am, Resident 35's heating unit had multiple paper books on top surface of the heater unit next to resident's bed. A visible sign posted on heating unit indicated to Keep area clear. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During concurrent observation and interview on 4/22/24 at 10 am, with Licensed Vocational Nurse (LVN) 2 stated the heating unit with the book on the top surface need to be cleared because it can cause a fire, and nothing is to be put on top of unit. During an observation on 4/22/2024 at 12pm, Resident 288's heating unit had plastic containers on top of the unit. During a concurrent observation and interview on 4/22/2024 at 12:05pm, Certified Nursing Assistant (CNA) 3 stated there are plastic container being stored on top of the heating unit. CNA 3 stated , We are not supposed to place anything on top of heating units, it is a fire issue. During a concurrent observation and interview on 4/22/2024 at 4 pm, with the Maintenance Supervisor (MS) stated the area on top of heating /air units are to be clear and free of paper, flowers, or anything. MS stated if the heater was on, it would be a fire hazard. MS stated if water spilled into the heating unit, it could be an electrical hazard. MS stated he was provided with instructions to keep area clear at all times. MS stated again, we should not keep anything on top of the heating unit because it will burn. A review of the facility's undated, policy and procedure (P&P) titled, Fire Prevention, indicated the purpose of the policy was to insure resident's safety through implementation and fire prevention interventions. The fundamental information indicated: It is everyone's responsibility to report any unsafe condition so that corrective measure can be taken promptly. Combustible (a material that can burn). Storage material is not stored in a heat producing area and waste or trash is removed regularly.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48219 Based on observation, interview and record review, the facility failed to provide sufficient hydration to one of 2 sampled residents (Resident 22) who was not provided and offered water at bedside to maintain and promote proper hydration (process of replacing water loss in the body) and health as indicated in resident ' s care plan. This deficient practice had the potential to place the resident at risk for dehydration (a harmful reduction in the amount of water in the body) and poor nutritional outcomes. Findings: A review of Resident 22 ' s Face Sheet (Document that gives a patient ' s information such as contact details and brief medical history) indicated the facility admitted Resident 22 on 3/1/2024, with diagnoses that included proximal atrial Fibrillation (abnormal Heartbeat), Chronic constipation (Not passing stools regularly) rheumatoid arthritis (condition that causes pain and swelling and stiffness in the joints). A review of Resident 22 ' s Minimum Data Set (MDS - comprehensive assessment and care screening tool), dated 3/24/2024, indicated MDS indicated the resident has severe cognitive impairment (ability to remember and process information) and can independently use suitable utensils to bring the food and or liquid to the mouth and swallow food and or liquid once the meal is placed before the resident. A review of Resident 22 ' s care plan dated 3/24/2024, indicated Resident 22 was at risk for dehydration, fluid, and electrolyte imbalance with interventions that included to encourage fluid intake monitoring for thirst and frequent offering of hydration. A review of Resident 22 ' s progress notes dated 4/6/2024, indicated Resident 22 was to allow for PO (per oral or by mouth) diet of Regular NAS to increase metabolic (basic materials needed for important life processes) needs. During a concurrent observation and interview on 4/22/2024 at 10:31 am Resident 22, stated she needed a little water while pointing at her mouth and no water cup or water pitcher available on bedside table. During an interview on 3/22/2024 at 11:23 am, CNA2 stated every resident gets a [NAME] cup at start of shift. During an interview on 4/22/2024 at 11:35 am, LVN 2 Stated Resident 22 can have water and it may be at her bedside. During an interview on 4/23/2024 at 4:55 pm, the Registered Dietician (RD), stated Resident 22 should be on regular diet, with a water pitcher at bedside. Water should be ad lib (as much and as often as desired). (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility ' s policy and procedure titled, Hydration Evaluation & approaches (no date), indicated the purpose of policy is to identify risk factors that lead to dehydration and the facility will develop an appropriate preventative care plan to provide the resident with sufficient fluid intake to maintain proper hydration and health. Observation of care delivery to determine if the interventions identified in the care plan have been implemented. Factors of care delivery indicated staff to observe resident ' s response to the interventions and to provide the necessary fluids as described in the plan, encouraging the resident to drink, providing fluids during and in-between meals.

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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** 28851 Based an observation, interview and record review, the facility failed to: 1. Ensure the activities recorded in the Controlled Drug Records (the accountability record or count sheet for narcotics) had corresponding administration documentations in residents' electronic medication administration records (eMAR) for two (2) of 29 sampled residents (Residents 46 & 64). 2. Ensure there was a policy, developed and implemented, for the accurate usage of the Emergency Medication Supplies (E-kit). There were missing entries in the E-kit logbook. These deficient practices had the potential for drug diversion (medical and legal concept involving the transfer of any legally prescribed controlled substance from the individual for whom it was prescribed to another person for any illicit use) and/or medication errors. Findings: 1. On 4/23/24 at 2:55 PM, during an observation at of Medication (med) Cart 2 with a Registered Nurse (RN 3), there was a bottle of morphine (an opioid and a potent treatment for pain) concentrate solution 20 milligrams (mg, unit to measure mass) per milliliter (ml, unit to measure volume) for Resident 46. On 4/23/24 at 2:55 PM, during a concurrent review of the Controlled Drug Records of Resident 46 ' s Morphine solution, the record indicated there were 18 doses removed for administration since 3/24/2023; 6 of those 18 doses occurred in April 2024 (4/9/24, 4/14/24, 4/15/24, 4/16/24, 4/19/24, and 4/22/24) (6 doses). On 4/23/24 at 2:55 PM, during the same interview and concurrent review of Resident 46 ' s eMAR for April 2024, RN 3 stated there was no documented evidence Morphine was administered in April 2024 (4/9/24, 4/14/24, 4/15/24, 4/16/24, 4/19/24, and 4/22/24). RN 3 stated the e-MAR did not indicate morphine 20 mg/ml were administered on 4/9/24, 4/14/24, 4/15/24, 4/16/24, 4/19/24, and 4/22/24. RN 3 stated Resident 46 could not communicate verbally. A review of Resident 46's physician order dated 3/8/2023, indicated instruction: give Morphine 20 mg/ml, 0. 25 ml sublingual (under the tongue) every 2 hours as needed for shortness of breath or pain. On 4/23/24 at 3:13 PM during an observation at Med Cart 1 with a licensed vocational nurse (LVN 2), there was a bubble pack (a blister pack that is a form of tamper-evident packaging where an individual pushes individually sealed medication through the foil in order to take or administer the medication) of Norco (brand name for hydrocodone/acetaminophen, a potent opioid to treat pain) 5/325 mg for Resident 64. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/23/24 at 3:13 PM, a concurrent review of the controlled drug accountability record indicated there were 10 removal records of Norco, dated from 10/9/2023 to 4/21/2024. Two of those 10 Norco removed occurred in April 2024. LVN 2 reviewed Resident 64 ' s eMAR and stated there was no administration documentation in April 2024. On 4/23/24 at 3:23 PM during an interview with the director of nursing (DON) and concurrent review of Resident 46 ' s eMAR from March 2023 to April 2024, the DON stated Resident 46 ' s eMAR did not indicate any administration documentation. DON stated the administration of PRN meds must also be documented in the residents ' eMAR. During a concurrent of Resident 64 ' s eMAR, DON stated there was one administration record on 3/11/2024 at 12:44 PM for Resident 64 ' s Norco. DON stated nurses must document the administrations of medications in the eMAR, in addition to the controlled drug records. A review of the facility ' s policy and procedures, Medication Administration (January 2021), indicated . The individual who administers the medication dose, records the administration on the resident ' s MAR immediately following the medication being given . When PRN medications are administered, the following documentation is provided: Date and time of administration, dose, route . complaints or symptoms for which the medication was given . Results achieved . Signature or initials of person recording administration . 2. On 4/23/24 at 2:38 PM during an observation in Medication room [ROOM NUMBER] with Registered Nurse (RN) 2, there was an Emergency Kit (E-Kit, an emergency supplies of medications) and a Facility Emergency Kit Log Book. Inside the log book, the first page had 3 entries documented the usage of the E-Kit; other pages were blank. Inside the log book, there were also eight loose filled out yellow slips. During a concurrent interview, RN 2 stated when the facility needs to obtain a medication from the E-Kit, the nurse would contact the pharmacy for permission to use, verify the physician order with the pharmacist on duty, fill out the individual slip. Then the nurse would also create an entry in the log book and keep the yellow carbon copy in the log book. After reviewing the eight yellow slips, RN 2 confirmed that the log book did not have entries for five of the eight E-kit usages. On 4/23/24 at 2:49 PM during an interview, the director of staff development (DSD) stated the nursing staff need to fill out both E-Kit usage slips and the log book for accountability and accuracy of the medication use. On 4/23/24 at 3:35 PM during an interview, the DON could not find a specific policy for the use of the E-Kit, the facility presented the policy and procedures Storage of Medication (January 2021), that did not describe the process of accessing the E-kit, the accountability, and the accuracy of use.

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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. 28851 Based on observation, interview, and record review, the facility failed to ensure one (1) of 3 medication carts were locked when left unattended in the hallway. Registered Nurse 2 (RN2) prepared the medication and did not lock the medication cart before entering the resident ' s room. These deficient practices had the potential to result in misuse or medication loss by providing the unauthorized staff or person an opportunity to access resident ' s medications. Findings: On 4/23/24 at 8:56 AM during an interview, the registered nurse (RN 2) stated the facility has 2 nursing stations and 3 medication carts. On 4/23/24 at 9 AM during an observation, there was a medication Cart (med cart 1) located outside of a resident room, in the hallway which was accessible by other residents, visitors, and staff. RN 2 finished preparing medications and entered the resident's room without locking the med cart; thus, leaving the med cart unattended in the hallway. On top of the med cart, there were 7 over-the-counter medication bottles on top of the med cart and 1 bubble pack (a blister pack that is a form of tamper-evident packaging where an individual pushes individually sealed medication through the foil in order to take or administer the medication). The following medications were accessible to anyone who had access to the hallway. 1. Aspirin (a medication that can treat fever, pain, inflammation, and reduces risk of heart attack) 81 milligram (mg, an unit to measure mass) 2. Vitamin C (a nutrient that is vital to the body ' s healing process) 500 mg 3. Calcium 600mg with vitamin D3 (a combination of nutrients that maintain bone health) 4. Docusate sodium (generic for Colace, a medication to soften stool and prevent constipation) 100mg 5. Multiple vitamins 6. Vitamin D3 (a nutrient that can prevent bone loss) 2000 units 7. Zinc (a nutrient that helps heal wounds and has an important role in immune system) 50 mg 8. Plavix (an antiplatelet medication that can prevent blood clots from forming) 75 mg On 4/23/24 at 9:12 AM during an observation, RN 2 returned to the cart. During a concurrent interview, RN 2 stated she forgot to lock the med cart. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/23/24 at 9:14 AM during an observation and at surveyor's prompt, RN 2 realized there were meds on top of the cart and proceeded to put the medications back into the cart. A review of the facility ' s policy and procedures, Medication Storage (effective 1/2021), indicated . only licensed nurses, pharmacy staff, and those lawfully authorized to administer medications . are allowed access to medication carts . medication supplies should remain locked when not in use or attended by persons with authorized access. A review of the facility ' s policy and procedures, Medication Administration (January 2021), indicated . During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse. No medications are kept on top of the cart .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47441 Based on observations, interviews, and record review the facility failed to ensure the kitchen staff were routinely trained and evaluated for competency and skills sets to carry out functions of the food and nutrition service by failing to: a. Staff failed to demonstrate and verbalize the correct procedures in testing the chlorine (a chemical used for disinfectant) for low temperature dish machine. b. Staff failed to verbalize and follow the manufacturer ' s guidelines of QT-40 test strips (a type of test strip) when checking the Quaternary Ammonium Compounds (Quats, a group of chemicals used to disinfect surfaces and equipment) sanitizer concentration. c. Staff failed to verbalize proper cooling procedures of food. These failures had a potential to result to potential cross-contamination (a transfer of bacteria from one object to another), ineffective dish machine, unsanitized food preparation areas and bacterial growth to food that could lead to food borne illness (an illness caused by contaminated food and beverages) in 85 of 85 medically compromised residents who received food and ice from the kitchen. Findings: During a concurrent observation of the dishwashing process and interview on 4/23/2024 at 9:22 AM, with Diet Aide 2 (DA 2), DA 2 dipped the chlorine test strips into the dish machine water after the sanitizing cycle, slowly counted one, two, three, four, five, then compared it to the color chart. DA 2 stated they used a low temperature dish machine and checked the chlorine concentration before washing the dishes around 8AM to 8:15 AM at the start of dishwashing. DA 2 stated the acceptable concentration was 50 parts per million (ppm, a unit to measure concentration of a solution). During a concurrent review of the chlorine test strips and interview with DA 2 on 4/23/2024 at 9:25 AM, with DA 2, chlorine test strip manufacturer ' s guidelines indicated [NAME] chlorine test strips, date 2/1/2025 Lot 2032238. (1) Dip and remove quickly. (2) Blot immediately with paper towel. (3) Compared to color chart at once. Required chlorine concentration 100ppm. Dip, blot and read at once. DA 2 stated she did not blot the test strip dry with a paper towel and counted five (5) seconds instead of removing the test paper immediately from the solution. DA 2 stated the Dietary Supervisor (DS) did a training last week about how to test the chlorine in the dish machine. DA 2 stated it was important to follow the steps in testing ppm of the chlorine to make sure it was properly sanitizing dishes that they were washing as residents could get sick. During an interview with DS on 4/23/2024 at 9:41 AM, DS stated she provided training to the staff on how to test the dish machine chlorine using the chlorine test strips. DS stated she immerse one test strip in the dish machine water for one (1) second then compare it with the chart and the ppm should be between 50-100ppm. DS stated it was important to follow the manufacturer ' s guidelines to ensure the chlorine concentration was accurate to ensure that dish machine was disinfecting the dishes. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility ' s policy and procedure (P&P) titled Dishwashing Procedures (Dish machine) dated 1/8/2024, indicated (3) Use a chemical sanitizing (process of removing germs using chemicals) rinse to achieve and maintain 50-100ppm of chlorine at the dish surface or according to manufacturer ' s specifications. (4) Obtain test strips from your local chemical distributor for testing PPM on low temperature machines A review of Food Code 2017 indicated 4-501.114 Manual and Mechanical Ware washing Equipment, Chemical Sanitation- Temperature, pH, Concentration, and Hardness. Verifying the adequacy of chlorine-based solutions can be accomplished on an on-going basis by confirming that the concentration, temperature, and pH of the sanitizing solutions comply with paragraphs 4-501.114 (A) using acceptable test methods and equipment. The manufacturer should provide methods (e.g. test strips, kits, etc.) to verify that the equipment consistently generates solution on-site at the necessary concentration to achieve sanitation. During a concurrent observation of red bucket sanitizing solution testing demonstration and interview on 4/23/2023 at 9:31 AM, with DA 2, DA 2 filled the red bucket with sanitizer from the premix station by the three-compartment sink. DA 2 dipped the sanitizer strips in the red bucket with sanitizer, counted ten (10) seconds then compared the test strips to the color chart. DA 2 stated she counted 10 seconds when dipping the test strip in the sanitizer and the ppm had to be 200-400ppm. DA 2 stated the Quat sanitizer intended to disinfect preparation and other area surfaces in the kitchen. DA 2 stated they tested the concentration of the Quat sanitizer to ensure it was effective, it cleaned surfaces and if they do not follow the manufacturer ' s guidelines, it might not be the right or correct concentration that would not disinfect surfaces and dishes. DA 2 stated residents could get sick due to infection if the dishes and kitchen surfaces were not disinfected. During review of the QT-10 tests strips manufacturer ' s guidelines and interview on 4/23/2024 at 9:36 AM with DA 2, QT-10 test strips manufacturer ' s guidelines indicated Testing solution should be at room temperature 65-75 degrees Fahrenheit (F, scale of temperature). Withdraw and tear off appropriate two (2) inches of test paper from dispenser. Dip test water for 10 seconds in the solution. Do not shake. Compare colors immediately with colors on the test paper package to determine ppm. Always compare against package scale. Testing solution should be between 150-400ppm. DA 2 temped the testing water solution and it was at 123 F. DA 2 stated they do not take the temperature of the Quat solution when testing. During an interview with DS on 4/23/2024 at 9:47 AM, DS stated the red bucket was used for the Quat sanitizer to disinfect the whole kitchen areas like tables and preparation areas. DS stated she provided training to the staff regarding Quat sanitizer testing last Friday. DS stated the process of checking the concentration of the Quat sanitizer was to take a piece of the test strip, dip it on the solution for 10 seconds then compare it to the color chart for an acceptable range of 200-400ppm. After reading the test strips for Quat sanitizer manufacturer ' s guidelines, DS stated they did not check the temperature for testing the Quat sanitizer hence they were not following the steps. DS stated it was important to follow the test strips manufacturer ' s guidelines, so they know the Quat sanitizer concentration was accurate to disinfect dishes and surfaces to prevent residents from getting infection. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility ' s P&P titled Sanitizing Equipment and Surfaces with Quaternary Ammonium (Quat) Sanitizer dated 1/18/2024, indicated (1) Buckets or spray bottles will be filled with water (minimum temp of 75 degrees F) or Quat solution per manufacturer. (2) Staff will check for appropriate Quat levels by inserting Quat test strip into the bucket of solution. During an interview on 4/23/2024 at 11:40 AM with Cook 1, Cook 1 stated she cooked the apple cinnamon for today ' s lunch at 6AM and started cooling at 7AM then checked the temperature at 10 AM and it was at 70 F. Cook 1 stated she was not able to check it at 9AM because she got busy. Cook 1 stated if it was not cooled at 70 F at 10 AM, she would wait for more time for the food to cool and if the food was not at 40 F after six (6) hours total then she would have to reheat it or put ice around the food container. Cook 1 stated she forgot the record the temperature as she got busy. During a review of the cool down log on 4/23/2024 at 11:48 AM indicated no entry for apple cinnamon crisp dessert for time and temperature monitoring. During an interview on 4/23/2024 at 11:49 AM with DS, DS stated the process of cooling the apple cinnamon crisp dessert was, for food items with a temperature of 180 F, they would leave the food out for the temperature to come down to 140 F as this was the time bacteria started to grow. DS stated they have two (2) hours for the food temperature to go down to 70 F and if the food temperature did not go down to 70 F, they would have to reheat it up to 165 F for 15 seconds and start the cooling process again. DS stated it was important to cool the food following time and temperature for bacteria not to grow in food. DS stated Cook 1 did not follow the cooling of foods as it passed an hour, she did not check it and it was not recorded in the log for time and temperature monitoring. A review of the facility ' s log titled Cool Down Log for Potentially Hazardous Foods (PHF), dated 4/2024 indicated Food that must be properly cooled and monitored: All leftovers (meats, casserole, soups, starches, potatoes, vegetables) dairy products, meat roast pre-cooked the day before service, custard, tapioca, bread, pudding, tofu, etc. Use four-hour standard for PHF prepared with room temperature ingredients such as salads and sandwich, fillings (tuna, egg, potato, macaroni). Puree leftovers are not saved or re-used. Standard cooling and monitoring PHF: (1) Initial time and temperature - start recording when cooked/hot food reaches 140 F. (2) two hour- temp should be 70 F or less within two hours for cooked/hot foods. If not 70 F or less reheat to 165 F and start the cool down process all over (one time only). (3) Four hour- check temperature (must be 41 F or less). If not 41 F or less, food is unsafe: discard. (4) Six hour- temperature must be 41 F or less within four additional hours (after initial cooling to 70 F in two hours). Check temperature (must be 41 F or less). If not 41 F or less, food is unsafe: discard. A review of the facility ' s P&P titled Cool Down dated 1/18/2024, indicated Food that is cooked and will not be used for immediate service will be cooled to be the appropriate temperatures within the allotted time to prevent microbial growth. PROCEDURES: (1) A cool down log will be maintained to ensure standards are met. (2) Food must be cooled to 70 F within two hours and then to 41 F within the next four hours. (4) Although not advisable, if food does not reach 41 F within 6 hours, reheat until the inner temperature reaches 165 F for at least 15 seconds and re-start the process (allowable one time). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Crescenta Healthcare Center	3050 Montrose Ave LA Crescenta, CA 91214

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility ' s job description titled Cook, signed on 10/13/2021 by Cook 1, indicated Essential Duties and Responsibilities include the following. Other duties may be assigned. Prepares, stores, and disposes of food using proper food handling, labeling, and safety techniques according to established policies and procedures. Maintains the proper temperature of food during preparation and services. Records food temperatures according to established policy. A review of the facility ' s competency checklist titled Competency Checklist for Employee of Department of Nutrition and Food Services signed on 12/12/2023 by Cook 1 and DS, indicated Cook 1 was competent in controlling the time and temperature of food, cooling down foods and completing the cool down log. A review of Food Code 2017, indicated 3.501.14 Cooling. (A) Cooked time and temperature control for food safety shall be cooled: (1) within 2 hours from 135 F to 70 F and (2) within a total of 6 hours from 135 F to 41 F or less. The following guidance may be used for determining the appropriate corrective action for improper cooling. Cooked food may be reheated to 165 F for 15 seconds and cooling process started again using a different cooling method if the food is: above 70 F and two (2) hours or less into the cooling process; and above 41 F and six hours or less into the cooling process.

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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 for 32 of 85 residents on Regular texture diet (diet that has no restriction in texture and consistency) by not following the portion size for paprika chicken based on the facility ' s menu spread sheet. This deficient practice placed the facility residents at risk of unintended (not done on purpose) weight gain or weight loss and not meeting the physician ' s diet orders causing delay of recovery from illness or injury. Findings: During an observation of the lunch tray line (an area where resident ' s food was assembled) on 4/23/2024 at 12:07 PM, pieces of the chicken in the steam well were not consistent in size, some were small, and some were big for a three (3) ounces (oz, a unit of measurement) size. During a concurrent observation of the weight of the chicken and interview with Cook 1 and Cook 2 on 4/23/2024 at 12:35 PM, Cook 1 stated, their practice was to serve 2 small pieces of the chicken as a serving. Cook 1 weigh 2 small chicken pieces using a facility weighing scale and it weighed 5 oz. Cook 1 weigh pieces of chicken and it weigh 2 oz, 3 oz, 4 oz and two (2) small pcs weighed 5 oz. Cook 1 stated serving 2 small pieces was an okay practice because the supervisor said it was better to serve more food than a smaller portion. Cook 2 stated their practice was to follow the menu spreadsheet and there were portion sizes they needed to give the residents. Cook 2 stated giving more food the residents would not be okay because it would affect the health of the residents and they were not following the resident ' s diet order. Cook 2 stated the menu spreadsheet indicated 3-4 oz of chicken was a serving. Cook 1 stated the menu spreadsheet indicated 3 oz was the chicken portion size for everyone. During an interview with Dietary Supervisor on 4/23/2024 at 12:55 PM, DS stated they bought a precut chicken portions of 3 oz however the portions could have shrunk during the cooking process. DS stated they needed to follow the menu spreadsheet for the right portions otherwise it would be too big of portions the residents might be exceeding their needs for sodium restriction, fat and other nutrients that are restricted for them. DS stated it could also cause residents unintentional weight gain. A review of the facilities ' diet spreadsheet titled Fall/Winter 2023 Diet Spreadsheet, dated, week 4, day 23, indicated residents on regular diet (diet with no food restrictions), renal diet (diet used for residents with kidney disease where protein, sodium, potassium, and phosphorus were restricted), 1800 calorie diet (diet that was restricted in calories) would receive 3 oz protein portions. A review of facilities ' Policies and Procedures (P&P) titled, Meal Production, dated 1/18/2024 indicated The menu should be followed as posted. The cook should follow the accurate portion control and use correct scoop sizes per the therapeutic spreadsheets. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facilities ' P&P titled, Standardized Recipes, dated 1/8/2024, indicated Standardized recipes are the most effective tool for the control of food production quality, quantity, consistency, and cost. Standardized recipes will be adjusted by the Director of Food and Nutrition Services to the needed quantity. Resident/patients have a right to expect the product to be the same quality each and every time it is served. Standardized recipes must be used for all food preparations. Best practice is to use a production sheet for each meal stating the amounts of each item to prepare. Department of Food and Nutrition Services staff will only prepare quantities listed on the production sheets. A review of the facilities ' P&P titled, Menus, dated 1/18/2024, indicated Menus are written and approved by Registered Dietitian to meet the nutritional needs of the residents; achieve the dietary standards stated in the diet manual. Menus must meet the nutritional needs of residents in accordance with the recommend dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of sciences; be prepared in advance and be followed.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 in accordance with the facility ' s policy and procedure and standard of practice by failing to ensure: 1. Equipment and kitchen cleanliness were maintained: a. Three of 3 storage racks had rust-looking discoloration and stained in the walk-in refrigerator. b. Storage rack where bananas were stored in the preparation area had dust and dirt buildup. c. Storage container for ketchup, mix jelly, creamer and yellow cake mix had food and dirt residue. d. Dry storeroom floors had dirt debris. e. Kitchen hood had grease and dirt buildup. f. Three of 3 vent by the tray line area (food preparation area in which food trays travel around the production line) had dirt buildup. 2. Ensure measures to prevent cross-contamination was maintained: a. Two (2) dented cans were found in the dry storage area and emergency supply room. b. Scoop and tong handles were not stored in one direction. c. Pots and pans were stacked wet. d. Staff did not check the chlorine solution concentration according to test strips manufacturer ' s guidelines. e. Staff did not check Quaternary ammonium (Quat, a group of chemicals used to disinfect surfaces and equipment) concentration according to test strips manufacturer ' s guidelines. 3. Ensure the twenty resident ' s trays were not cracked and chipped. 4. Ensure proper food storage a. Apple cinnamon dessert was not properly cooled. b. Expired and unlabeled food in the resident ' s refrigerator. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. Resident's freezer had no thermometer. 5. Ensure the staff were wearing jewelries, long nails, and nail polish during meal preparation. These failures had the potential to result in harmful bacteria growth and cross contamination (a transfer of harmful bacteria from one place to another or one object to another) that could lead to foodborne illness (illness caused by food contaminated with bacteria, viruses and other toxins) in 85 of 85 medically compromised residents who received food and ice from the kitchen. Findings: 1a. During a concurrent observation of the walk-in refrigerator and interview with Dietary Supervisor (DS) on [DATE] at 8:26 AM, three (3) of 3 racks had rust-looking discoloration. DS stated she did not know what the discoloration and stain on the 3 racks, however it was not okay to have discoloration on the racks and they were supposed to be clean as it was stainless steel material. DS stated the discolored racks could possibly cause bacteria buildup causing residents to vomit and have diarrhea. 1b. During a concurrent observation of the rack in the preparation area where bananas were stored and interview with DS on [DATE] at 8:35 AM, the storage rack had dirt build up. DS was scraping the surface of the rack using her fingers. DS stated the rack had dirt buildup and the possible outcome was cross-contamination of dirt to food. 1c. During a concurrent observation of the dry storage area and interview with DS on [DATE] at 8:42 AM, the mixed fruit jelly, ketchup, creamer, and yellow cake mix containers had food and dirt residues. DS stated they cleaned and washed these containers every time they had a delivery and as needed. DS stated the dust and food residue in the food containers could cause cross-contamination. DS stated it was important to maintain cleanliness of these containers for safety, sanitation, and pest prevention. 1d. During a concurrent observation of the dry storage floor and interview with the DS on [DATE] at 8:42 AM, the dry storage floor had dirt debris. DS stated the staff swept and mopped every day. DS stated it was important to maintain the floor ' s cleanliness to prevent pest. 1e. During an observation of the kitchen hood on [DATE] at 9:07 AM, the hood had grease and dust buildup. During a concurrent observation of the kitchen hood and interview with DS on [DATE] at 11:35 AM, DS stated the hood had dirt and grease buildup. DS stated the kitchen hood was cleaned by staff once or twice a week and there should not have dirt and grease buildup. DS stated it was important to keep a grease-free hood as it could aggravate fire if there was fire, and it could also fall on the food causing cross-contamination. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1f. During a concurrent observation of the kitchen vents near the tray line area and interview with DS on [DATE] at 8:41 AM, three (3) of 3 vents had dust buildup. DS stated it was more than two (2) weeks since the last time the vents were cleaned as she has been short staffed in the last four (4) months. DS stated they usually cleaned the vent once a week. DS stated that she would have the vents cleaned immediately because the vents were near the serving area and dust could go to food for cross-contamination. DS stated if dirt particles go to the food, it would not be good for the residents they could get sick due to cross-contamination. A review of the facility ' s Policies and Procedures (P&P) titled Cleaning Schedules, dated [DATE], indicated POLICY: The dining services director will develop comprehensive cleaning schedules that staff will follow in order to maintain a sanitary department, prevent cross-contamination and meet state/federal requirements. (10) The following is suggested cleaning schedule for the kitchen and dining areas: Follow manufacturer guidelines if different. Cleaning frequency- after each use/ cleaning areas- all kitchen equipment and surfaces, which come in contact with food, will be cleaned and sanitized after each use. Storage containers and vents will be cleaned monthly. A review of the facility ' s P&P titled Cleaning Small Appliances/Equipment dated [DATE], indicated POLICY: Equipment will be cleaned and sanitized to prevent food borne illness. (6) Food Storage Bins (a) Food storage bin will be cleaned monthly or more often if needed. (b) It is recommended to use a clean, sanitized and air-dried food storage bins for all new products and packets. A review of the facility ' s P&P titled Canned and Dry Goods Storage dated [DATE], indicated Storage area will be cleaned and maintained. A review of the facility ' s P&P titled Cleaning Stove and Hood dated [DATE], indicated POLICY: Stove will be cleaned and sanitized after each use. Hoods (vents) will be cleaned weekly or monthly as needed. A review of Food Code 2017 indicated ,d+[DATE].11 (A) Equipment Food Contact Surfaces and utensils shall be clean to sight and touch. (B) Non-Food-Contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue and other debris. A review of Food Code 2017 indicated ,d+[DATE].13 Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. 2a. During a concurrent observation of the dry storage area, in the emergency supply room and interview with DS on [DATE] at 8:39 AM, there was one (1) dented can stored with the non-dented cans in the dry storage and 1 dented can stored with the non-dented cans in the emergency supply room. DS stated they have a separate area for dented cans so they would not commit mistakes of serving dented cans to residents. DS stated dented cans could hover bacteria. A review of facility ' s P&P titled Canned and Dry Goods Storage, dated, [DATE], indicated, (10) Canned food items should be routinely inspected for damage such as dented, bulging or leaking cans. These items should be set aside in a designated area for return to the vendor or disposed of properly. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Food Code 2017 indicated ,d+[DATE].11 Safe Unadulterated, and Honestly Presented. Food shall be safe, unadulterated, and, as specified under ,d+[DATE].12, honestly presented. ,d+[DATE].11 Compliance with Food Law. A primary line of defense ensuring that food meets the requirements of S, d+[DATE].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 fall 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. 2b. During an observation of the scoop and tongs in the white storage container on [DATE] at 9:15 AM, the scoops sand tongs were stored in different direction. During an observation of the scoop storage container and interview with DS on [DATE] at 11:28 AM, DS stated the scoop handles were not stored in the same direction. DS stated the scoop and tong containers should be in a close container and handle should be smooth and not burnt. DS stated the scoop and tong directions should be stored in the same direction, so they do not touch the lip surface or serving surface of the food with their bare hands. DS stated this could cause cross-contamination. A review of the facility ' s P&P titled Food Handling Practices, dated [DATE], indicated (11) After eating utensils and dishes are sanitized, do not touch any food contact surfaces. This includes the rims of bowls, cups, and glasses, eating surfaces of plates, forks, tines, spoons, bowls, and knife blades. A review of Food Code 2017 indicated ,d+[DATE].11 Kitchenware and Tableware (A) Single-service and Single-use articles and cleaned and sanitized utensils shall be handled, displayed, and dispensed so that contamination of food-and lip-contact surfaces is prevented. 2c. During an observation of the pots and pans stored at the bottom of trayline (an area for food assembly) on [DATE] at 9:16 AM, pots and pans were stacked wet. During an observation and interview on [DATE] at 9:18 AM with Dietary Aide 1 (DA 1), DA 1 stated their process of washing dishes included air drying because it could accumulate bacteria when stored and stacked wet. DA 1 stated the stacked pots and pans were still wet due to water residues in it. DA 1 stated it should be air dried before storing. During an interview with DS on [DATE] at 11:31 AM, DS stated their process of dishwashing included air drying. The DS stated, it was not okay to store the pots and pans stacked wet as it could harbor moisture and bacteria. DS stated the potential outcome would be residents could get sick. A review of facility ' s P&P dated Dishwashing Procedures (Dish machine) dated [DATE], indicated (10) Allow racks of dishes/trays/utensils to air dry. If drying space is not ample for dishes to air dry, use utility carts. Do not use towels to dry dishes. Do not rack and stack wet dishes or trays. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Food Code 2017 indicated ,d+[DATE].11 Equipment and Utensils, air-drying required. After cleaning and sanitizing equipment and utensils: (A) Shall be air-dried or used after adequate draining. (B) May not be cloth dried. 2d. During a concurrent observation of the dishwashing process and interview on [DATE] at 9:22 AM, with Diet Aide 2(DA 2), DA 2 dipped the chlorine test strips into the dish machine water after the sanitizing cycle, slowly counted one, two, three, four, five, then compared it to the color chart. DA 2 stated they used a low temperature dish machine and checked the chlorine concentration before washing the dishes around 8AM to 8:15 AM at the start of dishwashing. DA 2 stated the acceptable concentration was 50 parts per million (ppm, a unit to measure concentration of a solution). During a concurrent review of the chlorine test strips and interview with DA 2 on [DATE] at 9:25 AM, with DA 2, chlorine test strip manufacturer ' s guidelines indicated [NAME] chlorine test strips, date [DATE] Lot 2032238. (1) Dip and remove quickly. (2) Blot immediately with paper towel. (3) Compared to color chart at once. Required chlorine concentration 100ppm. Dip, blot and read at once. DA 2 stated she did not blot the test strip dry with a paper towel and counted five (5) seconds instead of removing the test paper immediately from the solution. DA 2 stated the DS did a training last week about how to test the chlorine in the dish machine. DA 2 stated it was important to follow the steps in testing ppm of the chlorine to make sure it was properly sanitizing dishes that we were washing as residents could get sick. During an interview with DS on [DATE] at 9:41 AM, DS stated she provided training to the staff on how to test the dish machine chlorine using the chlorine test strips. DS stated she would immerse one test strip in the dish machine water for one (1) second then compare it with the chart and the ppm should be between , d+[DATE]ppm. DS stated it was important to follow the manufacturer ' s guidelines to ensure the chlorine concentration is accurate to ensure that dish machine was disinfecting the dishes. A review of the facility ' s policy and procedure (P&P) titled Dishwashing Procedures (Dish machine) dated [DATE], indicated (3) Use a chemical sanitizing rinse to achieve and maintain ,d+[DATE]ppm of chlorine at the dish surface or according to manufacturer ' s specifications. (4) Obtain test strips from your local chemical distributor for testing PPM on low temperature machines A review of Food Code 2017 indicated ,d+[DATE].114 Manual and Mechanical Ware washing Equipment, Chemical Sanitation- Temperature, pH, Concentration, and Hardness. Verifying the adequacy of chlorine-based solutions can be accomplished on an on-going basis by confirming that the concentration, temperature, and pH of the sanitizing solutions comply with paragraphs ,d+[DATE].114 (A) using acceptable test methods and equipment. The manufacturer should provide methods (e.g. test strips, kits, etc.) to verify that the equipment consistently generates solution on-site at the necessary concentration to achieve sanitation. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2e. During a concurrent observation of red bucket sanitizing solution testing demonstration and interview on [DATE] at 9:31 AM, with DA 2, DA 2 filled the red bucket with sanitizer from the premix station by the three-compartment sink. DA 2 dipped the sanitizer strips in the red bucket with sanitizer, counted ten seconds (10) then compared the test strips to the color chart. DA 2 stated she counted 10 seconds when dipping the test strip in the sanitizer and the ppm had to be ,d+[DATE]ppm. DA 2 stated the Quat sanitizer intended to disinfect preparation and other area surfaces in the kitchen. DA 2 stated they tested the concentration of the Quat sanitizer to ensure it was effective, it cleaned surfaces and if they do not follow the manufacturer ' s guidelines, it might not be the right or correct concentration that would not disinfect surfaces and dishes. DA 2 stated residents could get sick due to infection if the dishes and kitchen surfaces were not disinfected. During review of the QT-10 tests strips manufacturer ' s guidelines and interview on [DATE] at 9:36 AM with DA 2, QT-10 test strips manufacturer ' s guidelines indicated Testing solution should be at room temperature , d+[DATE] degrees Fahrenheit (F, scale of temperature). Withdraw and tear off appropriate two (2) inches of test paper from dispenser. Dip test water for 10 seconds in the solution. Do not shake. Compare colors immediately with colors on the test paper package to determine ppm. Always compare against package scale. Testing solution should be between ,d+[DATE]ppm. DA 2 temped the testing water solution and it was at 123 F. DA 2 stated they do not take the temperature of the Quat solution when testing. During an interview with DS on [DATE] at 9:47 AM, DS stated the red bucket was used for the Quat sanitizer to disinfect the whole kitchen areas like tables and preparation areas. DS stated she provided training to the staff regarding Quat sanitizer testing last Friday. DS stated the process of checking the concentration of the Quat sanitizer was to take a piece of the test strip, dip it on the solution for 10 seconds then compare it to the color chart for an acceptable range of ,d+[DATE]ppm. After reading the test strips for Quat sanitizer manufacturer ' s guidelines, DS stated they did not check the temperature for testing the Quat sanitizer hence they were not following the steps. DS stated it was important to follow the test strips manufacturer ' s guidelines, so they know the Quat sanitizer concentration was accurate to disinfect dishes and surfaces to prevent residents from getting infection. A review of the facility ' s P&P titled Sanitizing Equipment and Surfaces with Quaternary Ammonium (Quat) Sanitizer dated [DATE], indicated (1) Buckets or spray bottles will be filled with water (minimum temp of 75 degrees F) or Quat solution per manufacturer. (2) Staff will check for appropriate Quat levels by inserting Quat test strip into the bucket of solution. A review of Food Code 2017 indicated ,d+[DATE].11 Miscellaneous Sources of Contamination. Food shall be protected from contamination that may result from a factor or source not specified under Subparts [DATE]-306. During a concurrent observation of the resident ' s tray and interview on [DATE] at 11:21 AM, with DS, 20 of 81 resident ' s tray were cracked and chipped. DS stated she replaced trays as needed gradually as she sees chipped trays. DS stated it was not okay to have chipped trays as food can enter in it and residents could get cut with the sharp edges of the tray that would cause injury. A review of the facility ' s P&P titled Machine Dishwashing Racking Procedures dated [DATE], indicated Dishes that are sanitary area free from cracks and chips that harbor bacteria. Stacking: (5) Separate out cracked, chipped and dishes without glaze and report to the Dietary Manager (continued on next page)

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NAME OF PROVIDER OR SUPPLIER LA Crescenta Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3050 Montrose Ave LA Crescenta, CA 91214	

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of facility ' s P&P titled Waste Control and Disposal dated [DATE] indicated PROCEDURES: (5) Damaged or dangerous objects will be handled carefully or immediately into an outside receptacle (a) All broken or chipped china, glass and tableware. A review of Food Code 2017 indicated ,d+[DATE].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. 4a. During an interview on [DATE] at 11:40 AM with Cook 1, Cook 1 stated she cooked the apple cinnamon for today ' s lunch at 6AM and started cooling at 7AM then checked the temperature at 10 AM and it was at 70 F. Cook 1 stated she was not able to check it at 9AM because she got busy. Cook 1 stated if it was not cooled at 70 F at 10 AM, she would wait for more time for the food to cool down and if the food was not at 40 F after six (6) hours total then she would have to reheat it or put ice around the food container. Cook 1 stated she was not able to log the time and temperature for the apple cinnamon crisp as she got busy. During a review of the cool down log on [DATE] at 11:48 AM indicated no entry for apple cinnamon crisp dessert for time and temperature monitoring. During an interview on [DATE] at 11:49 AM with DS, DS stated they have two (2) hours for the food temperature to go down to 70 F and if the food temperature did not go down to 70 F, they would have to reheat it up to 165 F for 15 seconds and start the cooling process again. DS stated it was important to cool the food following time and temperature for bacteria not to grow in food. DS stated Cook 1 did not follow the cooling of foods as it passed an hour, and she did not check it and it was not recorded in the log for time and temperature monitoring. A review of the facility ' s log titled Cool Down Log for Potentially Hazardous Foods (PHF), dated ,d+[DATE] indicated Food that must be properly cooled and monitored: All leftovers (meats, casserole, soups, starches, potatoes, vegetables) dairy products, meat roast pre-cooked the day before service, custard, tapioca, bread, pudding, tofu, etc. Use four-hour standard for PHF prepared with room temperature ingredients such as salads and sandwich, fillings (tuna, egg, potato, macaroni). Puree leftovers are not saved or re-used. Standard cooling and monitoring PHF: (1) Initial time and temperature - start recording when cooked/hot food reaches 140 F. (2) two hour- temp should be 70 F or less within two hours for cooked/hot foods. If not 70 F or less reheat to 165 F and start the cool down process all over (one time only). (3) Four hour- check temperature (must be 41 F or less). If not 41 F or less, food is unsafe: discard. (4) Six hour- temperature must be 41 F or less within four additional hours (after initial cooling to 70 F in two hours). Check temperature (must be 41 F or less). If not 41 F or less, food is unsafe: discard. A review of the facility ' s P&P titled Cool Down dated [DATE], indicated Food that is cooked and will not be used for immediate service will be cooled to be the appropriate temperatures within the allotted time to prevent microbial growth. PROCEDURES: (1) A cool down log will be maintained to ensure standards are met. (2) Food must be cooled to 70 F within two hours and then to 41 F within the next four hours. (4) Although not advisable, if food does not reach 41 F within 6 hours, reheat until the inner temperature reaches 165 F for at least 15 seconds and re-start the process (allowable one time). (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Food Code 2017, indicated 3.501.14 Cooling. (A) Cooked time and temperature control for food safety shall be cooled: (1) within 2 hours from 135 F to 70 F and (2) within a total of 6 hours from 135 F to 41 F or less. The following guidance may be used for determining the appropriate corrective action for improper cooling. Cooked food may be reheated to 165 F for 15 seconds and cooling process started again using a different cooling method if the food is: above 70 F and two (2) hours or less into the cooling process; and above 41 F and six hours or less into the cooling process. 4b. During a concurrent observation of the resident ' s refrigerator inside the utility room and interview on [DATE] at 9:08 AM, with Registered Nurse 1 (RN 1), pasta in a container was dated [DATE] with no name, salad dressing had a date of [DATE] which was expired. RN 1 stated the process of storing resident ' s food from home was to label it with name, date of storage and room number in a sealed container and they were allowed to keep the food in 24 hours. RN 1 stated it was important to label the food to make sure it would be consumed by the right person who owns it to avoid potential chocking and allergic reactions. RN 1 stated they checked for expired products, and they throw it right away because it could cause residents diarrhea, gastrointestinal discomforts, and allergic reactions. A review of facility ' s P&P titled Waste Control and Disposal dated [DATE] indicated PROCEDURES: (4) These foods should be disposed of immediately: (c) Outdated food. A review of facility ' s P&P titled Food Brought from Outside the Facility dated [DATE], indicated Containers will be labeled with the resident ' s name, the item and the use by date. (5) The nursing staff will discard perishable foods on or before the use by date. (6) The nursing and/or food service staff will discard any foods prepared for the resident that show obvious signs of potential foodborne danger (for example, mold growth, foul odor, past due package expiration dates) A review of Food Code 2017 indicated ,d+[DATE].17 Commercially processed food, open and hold cold, (B) except specified in (E) - (G) of this section, refrigerated, ready-to-eat time/temperature control for food safety food prepared and packed by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacture ' s use-by- date if the manufacturer determined the use-by date based on food safety. 4c. During an observation of the resident ' s freezer inside the utility room and interview on [DATE] at 9:08 AM with RN 1, there was no thermometer in the freezer where breads were stored. RN 1 stated there should be a thermometer in the freezer for them to be able to monitor freezer temperature. RN 1 stated it was important to monitor freezer temperature to ensure food items remain frozen. A review of facility ' s P&P titled Freezer Storage dated [DATE], indicated POLICY: All the perishable frozen food will be stored in freezer storage. The freezer areas will be managed so that proper time temperature is maintained to avoid food spoilage and time temperature abuse. Each freezer must have a thermometer that is easily visible. Place the thermometer halfway in the freezer to record the most accurate reading. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Food Code 2017 indicated, ,d+[DATE].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 measurer the air temperature or a simulated product temperature in the warmest part of the mechanical refrigerated unit and in the coolest part of a hot food storage unit. During an observation of tray line on [DATE] at 11:38 AM, DA 1 was wearing a gold bracelet while placing cold food items on the resident ' s trays. During an observation of lunch tray line on [DATE] at 12:07 AM, Cook 2 was wearing a rubber bracelet while serving hot food, Cook 1 was wearing earrings long fingernails and nail polish while serving main entree. During a concurrent observation of lunch tray line and interview on [DATE] at 12:26 PM, with DS, DS stated staff were not allowed to wear jewelries, long nails, and nail polishes because it could get into the food. DS stated DA 1 was wearing gold bracelet, Cook 2 was wearing rubber bracelet and Cook 1 was wearing earrings, long nails and nail polish was not okay due to infection control for the residents. A review of facility ' s P&P titled Food Handling Practices dated [DATE], indicated PROCEDURE: Keep nails short and unpolished. Limit jewelry to wedding bands. A review of Food Code 2017 indicated ,d+[DATE].11 Prohibition. Except for a plain ring such as wedding band, while preparing food, food employees may not wear jewelry including medical information jewelry on their arms and hands.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 47882 Based on observation, interview, and record review, the facility failed to dispose garbage and refuse (food waste, scraps) properly by not covering three of three metal dumpsters (large trash container designed to be emptied into a truck) due to overflowing garbage bags leaving more than 5 trash bags, broken sofa, broken chair, and boxes on the ground next to the dumpster. This deficient practice had a potential to attract birds, flies, insects, pest and possibly spread infection to 87 of 87 facility residents and staffs in the facility. Findings: During an observation on 4/22/2024 at 8:30 AM, three metal dumpsters were not covered due to overflowing garbage bags leaving more than 5 trash bags, broken sofa, broken chair, and boxes on the ground next to the dumpster. During a concurrent observation of the dumpster area located at the back of the facility and with Housekeeping Supervisor (HS) accompanied by Maintenance Supervisor (MS) dated 4/22/2024 at 8:50 AM. HS and MS stated the three-metal dumpster are overflowing with trash bags. HS stated, the three-metal dumpster should not be left open with overflowing trash bags, and trash bags should not be left on the ground, it could attract animals and pest and affect everyone ' s health. MS stated, I informed the administrator today so it will be cleaned up right away. During an interview on 4/22/2024 at 9 AM with Dietary Supervisor (DS), DS stated, having insects and other pest in the kitchen can negatively affect the health of the resident ' s and staff. During an interview on 4/22/2024 at 9:30 AM with the Director on Nurses (DON), DON stated, insects and pest can bring bacteria and viruses in the facility and negatively affect the health of the residents and staff. During an interview on 4/22/2024 at 9:35 AM with the Administrator (ADM), ADM stated, it is not healthy for the residents and staff if insects and pest gets inside the facility. A review of the facility ' s policies and procedures (P&P) titled Pest Control, (undated), indicated, keep facility grounds free of trash and brush and keep the dumpster area clean and lid closed. A review of the facility ' s policies and procedures (P&P) titled Sanitation and Infection control, dated 2018, indicated, food infested by insects or pests should be dispose of immediately, and keep lids of outside trash dumpster closed.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47882 Based on observation, interview, record review, the facility failed to ensure a call light (a device that allows residents to signal caregivers when they are in need of help and allows caregivers to communicate with each other at a distance) was accessible while in bed for one of five sampled residents (Resident 39) who was observed with call light stuck between the left side bedrail and the bed, hanging below the bottom of the mattress. Resident 39 stated she needed assistance from the staffs because she was having difficulty putting her sweater and she was feeling cold and unable to reach the call light to call for assistance. This failure had the potential for Resident 39 not to receive assistance timely or not receive assistance with her needs or in an event of an emergency that could result in a decline in performing ADLs (activities of daily living) residents well being. Findings: A review of Resident 39 ' s admission record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included displaced bicondylar fracture (involved two areas) of right tibia (shinbone), osteoporosis (disease that weakens your bones), and type 1 diabetes mellitus (inadequate control of blood levels of glucose/sugar) with chronic kidney disease (kidneys are damaged and cannot filter blood as well as they should). A review of Resident 39 ' s History and Physical (H&P), dated 3/5/2024, the H&P indicated Resident 39 had the capacity to understand and make healthcare decision. A review of Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 2/10/2024, indicated Resident 39 ' s was usually able to make self-understood (difficulty communicating some words or finishing thoughts but is able if prompted or given time) and usually understands others (misses some part/intent of message but comprehends most conversation). The MDS indicated Resident 39 was independent with eating, supervision or touching assistance (helper provides verbal cues and/or touching/steadying and or contact guar assistance as resident completes activity) with oral hygiene, substantial/maximal assist (helper does more than half the effort) with upper and lower body dressing, and dependent (helper does all the effort) bathing and personal hygiene. A review of Resident 39 ' s Care Plan (CP) initiated on 10/2/2023, indicated Resident 39 had self-care deficit with ADLs related to physical limitation/disability. The CP goal is to provide Resident 39 with needed assistance in ADL to maintain comfort and dignity. Interventions included provide assistance needed to the Resident including incontinent care. A review of Resident 39 ' s Care Plan (CP) initiated on 10/2/2023, indicated Resident 39 had a history of falls, and was at high risk for falls, with goals that included to decrease resident ' s risk of fall and injury with interventions that included to keep call light within reach. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 4/22/2024 at 11:15 AM with Social Service Director (SSD) in Resident 39 ' s room, Resident 39 was having difficulty putting on her sweater, while the call light was stuck between the left side bedrail and the bed, hanging below the bottom of the mattress unreachable for the Resident 39. SSD validated the observation and stated, Resident 39 can use the call light for assistance and should be within reach. During an interview with Marketing Director/ Interpreter (MDI) on 4/22/2024 at 11:20 AM in Resident 39 ' s room, MDI stated Resident 39 reported to her she was cold, needed assistance with her sweater and could not reach the call light. During an interview with Licensed Vocational Nurse (LVN) 4 on 4/22/2024 at 11:30 AM, LVN 4 stated Resident 39 was alert enough to use the call light for assistance, but the call light should always be within reach. During an interview with Registered Nurse (RN) 1 on 4/23/2024 at 10:45 AM, RN 1 stated, call light should be within reach so residents could call for assistance with ADLs needs and for safety. During an interview with the Director of Nurses (DON) on 4/24/2024 at 8:04 AM, DON stated, her expectation was to ensure the call light would be answered immediately and within the residents reach at all times for ADLs assistance and safety. A review of the facility ' s policy and procedure (P&P) titled, Morning Care, (undated), indicated; facilitate residents ' overall comfort, cleanliness, grooming, well-being, and place the call button where the resident can use it. A review of the facility ' s policy and procedure (P&P) titled, Call Lights-Answering Of, (undated), indicated; facility staff will provide an environment that helps meet the residents needs, respond to resident ' s call light in a timely manner, and when leaving the room, ensure that the call light is placed within the resident ' s reach.