STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055989	A. Building B. Wing	03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Manor	610 North Garfield Avenue Monterey Park, CA 91754

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 46779 Based on observation, interview and record review, the facility failed to treat resident with dignity and respect by ensuring one of five sampled residents (Resident 78) by receive meal at the same time as other residents who were dining in the dining room during lunch time on 3/25/2025. The deficient practice resulted in Resident 78 reported feeling disrespected and frustrated when watching other residents eating and completing their meals in front of him. Findings: During a review of Resident 78's Admission Record (AR), the AR indicated the facility originally admitted Resident 78 on 11/18/2024 and readmitted him on 1/2/2025 with diagnoses that included chronic obstructive pulmonary disease (a group of lung [an organ located in the chest and provide gas exchange for the body] diseases that cause ongoing damage to the airway and lungs, leading to difficulty breathing) and pulmonary edema (a condition where fluid accumulates in the lungs, making it difficult to breathe). During a review of Resident 78's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 2/21/2025, indicated Resident 78 had moderately impaired memory and cognition (ability to think and reason). The MDS indicated Resident 78 required supervision or touching assistance with eating, oral hygiene and personal hygiene, partial/moderate assistance with chair/bed-to-chair transfer, and substantial/maximal assistance with toileting hygiene and shower/bathe self. During an observation on 3/25/2025 at 12:06 PM, there were five tables in the dining room and 14 residents were sitting in the dining room to eat. The staffs served meal trays to 11 residents and were eating. Resident 78, who was sitting at a table at the corner of the dining room, did not received his meal tray and was watching other residents eating. During an observation on 3/35/2025 at 12:15 PM, one resident completed her meal and left the dining room. During an observation on 3/25/2025 at 12:19 PM, Resident 78 still did not receive his meal tray yet and took out a white bread bun from his pocket and ate bread bun in the dining room. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/25/2025 at 12:21 PM, Resident 78 stated he felt disrespected and was frustrated with waiting for a long time for his meal tray while watching other eating. During an interview on 3/25/2025 at 12:23 PM, Resident 78 received his meal tray. During an interview on 3/25/2025 at 12:29 PM with the Treatment Nurse (TXN), the TXN stated he was assisting and monitoring the residents in the dining room. The TXN stated he saw Resident 78 did not receive his meal tray at the same time the other residents, and the resident received his meal tray 17-minutes late. TXN stated he saw Resident 78 was eating his own white bread bun during his wait for the meal tray. The TXN stated Resident 78 usually does not eat lunch in the dining room, so the dietary staff probably did not prepare his meal tray first with other residents who usually dined in the dining room. The TXN stated Resident 78 was sitting at the corner of the dining room, so the staff might have noticed his presence there. The TXN stated the staff should have notified the dietary staff about the residents who were brought in the dining room to ensure all the residents would receive meal trays at the same time as the other residents to preserve their dignity. During an interview on 3/28/2025 at 4:30 PM with the Director of Nursing (DON), the DON stated the staff should be aware the residents in the communal dining room provide meal trays in a timely manner, so the residents would not wait for a long time and watch other residents eat to preserve their dignity. During a review of the facility ' s policy and procedure (P&P), titled Promoting/Maintaining Resident Dignity, dated 12/19/2022, the P&P indicated all staff members are to protect and promote and maintain resident dignity and respect resident rights.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47467 Based on interview, and record review, the facility failed to follow its policy and procedure (P&P) titled, Notification of Changes, revised [DATE], its professional standards of practice and the physician ' s order for one of one sampled resident (Resident 98), who had a diagnosis of acute respiratory failure with hypoxia (a life-threatening condition where the lungs fail to deliver enough oxygen to the blood, leading to dangerously low oxygen levels in the body), chronic obstructive pulmonary disease exacerbation (COPD, sudden severe symptoms of a lung disease characterized by poor airflow to the lungs that results in shortness of breath, difficulty breathing and respiratory distress) and pulmonary hypertension [a condition that affects the blood vessels (the network of tubes through which blood is pumped around the body) in the lungs] by failing to ensure LVN 1 immediately notified the physician when CNA 1 reported to LVN 1 that Resident 98 was experiencing labored breathing with his oxygen saturation decreased to 88% on [DATE] at 5:30 AM, and when LVN 1 assessed Resident 98 with findings of weakness and oxygen saturation continued to decrease to 70% on [DATE] at 5:50 AM. This deficient practice resulted in the delay in diagnosis, care, and services of Resident 98 ' s condition. Resident 98 expired on [DATE] at 5:59 AM, after CNA 1 reported to LVN 1 that Resident 98 was weak, and his oxygen level decreased to 88% on [DATE] at around 5:30 AM. Cross Referemce to F695 Findings: During a review of Resident 98's Admission Record (AR), the AR indicated the facility admitted Resident 98 on [DATE] with diagnoses that included acute respiratory failure with hypoxia, COPD with exacerbation (worsened symptoms), pulmonary hypertension, type 2 diabetes mellitus with hyperglycemia (DM, a chronic condition that happens when the body has persistently high blood sugar levels), and Atrial Fibrillation (Afib, a common type of irregular heartbeat). During a review of Resident 98 ' s Order Summary Report (OSR), indicated on [DATE], Resident 98 had a physician order to monitor temperature and oxygen saturation every shift for suspected/confirmed Covid-19, and to call the physician if oxygen saturation is newly below 91%, or if the resident ' s usual oxygen saturation is lower or is 3% or more lower than their baseline. During a review of Resident 98 ' s Care plan (CP), dated [DATE], indicated Resident 98 had COPD exacerbation. The goal was that the resident would display optimal breathing patterns daily and the interventions included monitoring for signs and symptoms of acute respiratory insufficiency such as shortness of breath at rest, cyanosis (a bluish or purplish discoloration of the skin, typically caused by a lack of oxygen in the blood), and somnolence (lethargy, weakness, and difficulty thinking), and to administer oxygen via NC at ,d+[DATE] LPM continuously, may titrate oxygen to ,d+[DATE] LPM via mask to maintain oxygen saturation greater or equal to 94%. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 98 ' s CP, dated [DATE], indicated Resident 98 was at risk for Covid-19 related to diagnosis of COPD exacerbation, DM, and Afib. The interventions included to follow POLST form, monitor temperature and pulse oximetry per physician ' s order and report abnormal findings to the physician. During a review of Resident 98's CP, dated [DATE], indicated Resident 98 had altered cardiovascular status related to Afib, hypertension (high blood pressure), and hyperlipidemia (high level of fats in the bloodstream). The interventions included to monitor the resident ' s vital signs and notify the physician of significant abnormalities, monitor/document/report to the physician for changes in cap refill (a quick test to assess blood flow to tissues by observing how quickly color returns to the nail bed after pressure is applied) and color/warmth of extremities. During a review of Resident 98's History and Physical, dated [DATE], indicated Resident 98 had the capacity to understand and make decision. During a review of Resident 98's OSR, indicated on [DATE], Resident 98 had a physician order for oxygen via NC at ,d+[DATE] LPM continuously, may titrate oxygen to ,d+[DATE] LPM via mask to maintain oxygen saturation greater or equal to 94%. During a review of Resident 98's OSR, indicated on [DATE], Resident 98 had a physician order to follow POLST as per instructions. During a review of Resident 98's POLST, dated [DATE], indicated if the resident was found with a pulse and/or is breathing, in addition to provide oxygen treatment, the healthcare provider may use non-invasive positive airway pressure(a method of breathing support that delivers pressurized air or oxygen through a mask without inserting a tube into the windpipe) which included continuous positive airway pressure (CPAP, a machine that uses mild air pressure to keep breathing airways open), bi-level positive airway pressure (BiPAP, a type of device that helps with breathing), and bag valve mask (a handheld device used to provide emergency breaths to someone who is not breathing or not breathing adequately) assisted respirations. During a review of Resident 98 ' s Minimal Data Set (MDS-a federally mandated resident assessment), dated [DATE], indicated Resident 98 ' s cognition (ability to think, remember, and reason with no difficulty) was moderately impaired and needed moderate assistance (helper does less than half the effort) in eating and oral hygiene. During a review of Resident 98 ' s Progress Notes, dated [DATE], indicated at 5:50 AM during CNA morning care, Resident 98 responded only by opening his eyes, breathing slowing down with oxygen saturation at 70% via NC until the resident passed away. During a review of Resident 98 ' s Weights and Vitals Summary, indicated Resident 98 ' s last vital signs was taken on [DATE] 1:09 AM with the resident ' s blood pressure at ,d+[DATE] mmHg, oxygen saturation of 93% while the resident was on room air, heart rate at 100 beats per minute, and temperature of 98.7 F. There was no documented evidence that Resident 98 was monitored for vital signs on [DATE] at 5:50 AM when Resident 98 was found responded only by opening his eyes with slow breathing. During a review of Resident 98 ' s SBAR Communication Form, indicated there was no physician notification related to Resident 98 ' s decreased in oxygen saturation on [DATE] at 5:50 AM. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 98 ' s Record of Death, dated [DATE], indicated Resident 98 passed away on [DATE] at 5:59 AM. During a review of Resident 98 ' s Physician ' s Discharge Summary, dated [DATE], indicated Resident 98 was admitted on [DATE] and was discharged from the facility due to resident expired on [DATE] at 5:59 AM. During an interview on [DATE] at 6:38 AM with CNA 1, CNA 1 stated, he took care of Resident 98 from 11 PM on [DATE] until the resident passed away on [DATE]. CNA 1 stated, when he received Resident 98 at the beginning of his shift, the resident was alert and oriented, and the resident ' s vital signs including BP and oxygen saturation was within normal limit though he could not recall the exact number for the vitals. CNA 1 stated, around ,d+[DATE]:30 AM when he last round on his residents, he noticed that Resident 98 responded when he called the resident's name, and the resident was still warm to touch but the resident was very weak with his oxygen level was around 88%. CNA 1 stated, he immediately reported his findings to LVN 1 and recalled that LVN 1 came to assess Resident 98. CNA 1 stated, LVN 1 and CNA 1 went to check Resident 98 almost every ,d+[DATE] mins in about 1 hour before the resident passed away. CNA 1 stated, they (LVN 1 and CNA 1) checked Resident 98's vital signs about 4 times but could not recall or document the results. CNA 1 stated, he could only recall that Resident 98 ' s oxygen level was at 88% when he first found the resident around ,d+[DATE]:30 AM and notified LVN 1. Stated, resident slowing died in about 1 hour while receiving oxygen via NC. During an interview on [DATE] at 7 AM with LVN 1, LVN 1 stated, he was the charge nurse that took care of Resident 98 from 11 PM on [DATE] until the resident passed away on [DATE]. LVN 1 stated, the resident was alert, oriented and responsive at the beginning of his shift, and recalled that Resident 98 ' s oxygen saturation was above 90%. LVN 1 stated, Resident 98 was able to make his needs known and used the urinal by himself. LVN 1 stated, when LVN 1 provided Resident 98 with his scheduled breathing treatment at 4 AM, Resident 98 ' s oxygen saturation was about 93%. LVN 1 stated, he put the resident back on , d+[DATE] LPM oxygen via NC after the breathing treatment. LVN 1 stated around 5:30 AM, CNA 1 came and told him that there was a change in condition for Resident 98 that the resident was breathing very slow and was very weak. LVN 1 then came in Resident 98 ' s room, the resident opened his eyes but was very weak and was receiving oxygen continuously at 3 LPM via NC. LVN 1 stated, LVN 1 checked the resident's vital signs a few times but could not recall the results. LVN 1 stated, he did not document the resident's vital signs in the medical record. LVN 1 stated, there was a Registered Nurse (RN) during his shift, but he did not let the RN know. LVN 1 stated, he did not increase the oxygen level per physician ' s order because the resident had diagnosis of COPD. LVN 1 stated, he called Resident 98 ' s physician after the resident passed away. LVN 1 stated, he supposed to notify Resident 98 ' s physician, call for help or call 911 when CNA 1 reported to him that Resident 98 was weak with slow breathing and a decrease in the resident ' s oxygen saturation. LVN 1 stated, Resident 98 passed away in about less than one hour after he was notified by CNA 1. During a review of LVN 1 ' s statement provided by the facility, dated [DATE], indicated on [DATE] at 5:50 AM, CNA 1 called his attention that Resident 98 was only responding by opening his eyes, LVN 1 checked the oxygen saturation with the reading indicated 70% while Resident 98 was receiving oxygen at 3 LPM. The statement indicated, LVN 1 elevated head of the bed at high flower ' s position, then suddenly the resident became weak and unresponsive, like the resident ' s last breath. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of CNA 1 ' s statement provided by the facility, dated [DATE], indicated on [DATE] at 5:30 AM, CNA 1 came to change Resident 98 ' s diaper and noticed a change in his condition and immediately reported his findings to LVN 1. The statement indicated, Resident 98 ' s oxygen saturation was at 89%, then went down to 88%, and suddenly dropped down to 70%. LVN 1 and CNA 1 checked Resident 98 ' s blood pressure which was lower than the limit, then CNA 1 and LVN 1 elevated Resident 98 ' s head of the bed higher and the resident became unresponsive. The statement indicated, Resident 98 ' s breathing was slowing down until his last breath. During an interview on [DATE] at 9:40 AM with the DON, the DON stated when CNA 1 reported to LVN 1 that Resident 98 was weak with oxygen saturation was trending down, LVN 1 was expected to immediately assess the resident, monitor and document Resident 98 ' s vital signs. The DON stated, when LVN 1 found that Resident 98 ' s oxygen saturation of 70%, LVN 1 was expected to immediately call for help or Code Blue, follow the physician order to titrate Resident 98 ' s oxygen therapy, follow Resident 98 ' s POLST, call 911 and notify the physician to prevent a delay in treatments and interventions. During an interview on [DATE] at 1:02 PM with Resident 98 ' s Primary Physician (PP) 1, PP 1 stated, he did not expect Resident 98 to pass away within a week of admission to the nursing facility. PP 1 stated, when Resident 98 ' s oxygen saturation went from ,d+[DATE]% to 88%, it meant that there was a sudden drop of oxygen saturation or a sudden change in condition, LVN 1 was expected to follow the physician's orders, and notify him right away. PP 1 stated, when Resident 98 ' s oxygen saturation dropped to 70%, LVN 1 supposed to follow the resident ' s POLST, call 911 and notify the physician again. PP 1 stated, he was notified after Resident 98 already passed away on [DATE]. During a review of the facility ' s Policy and Procedure (P&P) tiled, Notification of Changes, revised [DATE], indicated the facility consult with the resident ' s physician when there is a change requiring such notification. Circumstances requiring notification include significant change in the resident ' s physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status, which may include life-threatening conditions. During a review of the facility ' s P&P titled, Medical Emergency Response, revised [DATE], indicated the following: - The employee who first witnesses or is first on the site of a medical emergency will initiate immediate action, basic first aid and summon for assistance. - A nurse will assess the situation and determine the severity of the emergency, designate a staff member to announce a Code Blue if necessary, notify the physician and call 911 as needed. During a review of the facility ' s P&P titled, Oxygen Administration, revised [DATE], indicated staff shall notify the physician of any changes in the resident ' s condition, including changes in vital signs, oxygen concentrations, or evidence of complications associated with the use of oxygen.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47467 Based on observation, interview, and record review, the facility failed to ensure four of four sampled residents (Resident 47, 85, 94, and 14), was provided with privacy by failing to: 1. Ensure Certified Nurse Assistant (CNA) 1 closed the curtain while changing Resident 47's brief. 2. Ensure CNA 5 closed the curtain while cleaning and changing Resident 85 ' s gown. 3. Ensure Resident 94 and Resident 14 in room [ROOM NUMBER] were provided with visual privacy in a shared resident room during the temporary removal of privacy curtains. This failure resulted in the violation of residents right for privacy and dignity that had a potential to result in the residents ' negative affect in their self-esteem. This deficient practice also had the potential to compromise the dignity and privacy of both residents in the room, possibly resulting in exposure during care, embarrassment, psychosocial harm, and reduced trust in caregiver affecting their comfort, safety, and willingness to participate in care. Findings: 1. During a review of Resident 47's Admission Record (AR), the AR indicated the facility admitted Resident 47 on 10/3/2019 and readmitted on [DATE] with diagnoses that included dysphagia (difficulty in swallowing) following cerebral infarction (or ischemic stroke, occurs when the blood supply to part of the brain is blocked or reduced), pneumonia (a severe lung infection), and dementia [the loss of cognitive functioning (thinking, remembering, and reasoning) to such an extent that it interferes with a person's daily life and activities]. During a review of Resident 47's History and Physical (H&P), dated 7/24/2024, indicated Resident 47 did not have the capacity to understand and make decision. During a review of Resident 47's Minimal Data Set (MDS-a federally mandated resident assessment), dated 10/10/2024, indicated Resident 47 ' s cognition (ability to think, remember, and reason with no difficulty) was severely impaired and needed moderate assistance (helper does less than half the effort) in eating and oral hygiene. During a concurrent observation on 3/25/2025 at 9:30 AM in Resident 47 ' s room, Resident 47 was lying in bed and CNA 1 was changing Resident 47's brief with the privacy curtain opened and exposed Resident 47 from the waist down. During an interview on 3/25/2025 at 9:35 AM with CNA 1 in Resident 47 ' s room, CNA 1 stated, he left the curtain open because the resident ' s room was hot. CNA 1 stated, he should have turned on the resident's fan for air instead of leaving the curtain open due to privacy issue. During an interview on 3/25/2025 at 12:30 AM with Resident 47's Family Member (FM) 1 in the resident ' s room, FM 1 stated, Resident 47 was non-verbal (unable to communicate verbally). FM 1 stated, if Resident 47 was exposed to strangers, the resident would feel upset. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/27/2025 at 10:33 AM with the Director of Staff Development (DSD), the DSD stated CNA 1 should always provide Resident 47 with privacy by pulling the curtain closed before changing Resident 47's brief. The DSD stated, there should be no excuses to not pulling the curtain closed. The DSD stated, Resident 47 could be negatively affected with the resident ' s right, dignity and self-esteem. 2. During a review of Resident 85's AR, the AR indicated the facility admitted Resident 85 on 10/4/2024 and readmitted on [DATE] with diagnoses that included chronic gout [a disease that causes redness and swelling of the joints (the part of the body where two or more bones meet to allow movement)], osteoarthritis (a joint disease, in which the tissues in the joint break down over time), pulmonary edema (a condition where excess fluid accumulates in the lungs, making it difficult to breathe), and type 2 diabetes mellitus (DM2 - condition that results in too much sugar circulating in the blood). During a review of Resident 85's H&P, dated 10/8/2024, indicated Resident 85 had the capacity to understand and make decision. During a review of Resident 85 ' s MDS, dated [DATE], indicated Resident 85 ' s cognition (ability to think, remember, and reason with no difficulty) was intact and was dependent (helper does all of the effort) in personal hygiene, upper and lower body dressing. During a concurrent observation on 3/25/2025 at 9:45 AM in Resident 85's room, Resident 85 was lying in bed and CNA 5 was cleaning and changing Resident 85's gown. Resident 85's curtain not drawn closed and exposed Resident 85 from the waist down. During an interview on 3/25/2025 at 9:55 AM with CNA 5, CNA 5 stated, he left the curtain opened so Resident 85 could watch TV. During an interview on 3/25/2025 at 10:07 AM with Resident 85, Resident 85 stated, he did not request to have the curtain opened to watch TV. Resident 85 stated, he was upset being exposed to strangers. During an interview on 3/27/2025 at 10:33 AM with the DSD, the DSD stated CNA 5 should always provide Resident 85 with privacy by pulling the curtain before cleaning and changing Resident 85 ' s gown. The DSD stated, there should be no excuses to not pulling the curtain. The DSD stated, Resident 85 could be negatively affected with the resident ' s right, dignity and self-esteem. During a review of the facility ' s policy and procedure (P&P) titled, Resident Rights, revised 12/19/2022, the P&P indicated, the resident has a right to personal privacy. Personal privacy includes accommodations, and personal care. During a review of the facility ' s P&P titled, Promoting/Maintaining Resident Dignity, revised 12/19/2022, the P&P indicated all staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights, maintain resident privacy. 50012 (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During a review of Resident 94 ' s AR, the AR indicated the facility admitted Resident 94 on 1/31/2025, with diagnoses including hypertension (a long-term medical condition in which the blood pressure in the arteries is persistently elevated), and dysphagia (difficulty or discomfort in swallowing). During a review of Resident 94 ' s H&P, dated 2/2/2025 indicated, Resident 94 had the mental capacity to make medical decisions. During a review of Resident 94's MDS, dated [DATE], indicated the cognitive (the ability to think and process information) skills for daily decisions making was moderately impaired, and dependent on staff for the activities of daily living. During a review of Resident 14's AR, the AR indicated the facility admitted Resident 14 on 10/21/2021, with diagnoses including hypertension (a long-term medical condition in which the blood pressure in the arteries is persistently elevated), and dementia (decline in mental ability severe enough to interfere with daily life) During a review of Resident 14's H&P, dated 8/28/2024 indicated, Resident 14 does not have the mental capacity to make medical decisions. During a review of Resident 14's MDS, dated [DATE], indicated the cognitive (the ability to think and process information) skills for daily decisions making was severely impaired, and dependent on staff for the activities of daily living. During an observation on 3/25/2025 at 10:52 AM, in room [ROOM NUMBER]. It was noted that there was no privacy curtains installed around the beds of Resident 94 and Resident 14. Both residents were observed present in the room at the time of observation. During an interview on 3/25/2025 at 10:30 AM with the Maintenance Supervisor (MS), stated that the privacy curtains had been removed at approximately 8AM to be washed and would be returned and reinstalled at approximately 11AM. During a concurrent observation and interview on 3/25/2025 at 10:55 AM, with Certified Nurse Assistant 7 (CNA) 7 in room [ROOM NUMBER] stated, We either close the door or wait until the curtains are back to provide care. The door was open during the observation, and no care was observed being provided at that time. During an interview on 3/28/2025 at 1:20 PM with the Director of Nursing (DON), the DON stated, It is not acceptable to leave a room without privacy curtains while residents are present. Temporary privacy curtains or partitions should be put in place immediately when permanent curtains are removed. Residents must always have visual privacy. During a review of the facility's policy and procedure (P&P) titled, Promoting/Maintaining Resident Dignity , revised 2022, indicated the facility will maintain resident privacy.

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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** 46779 Based on observation, interview and record review, the facility failed to provide a homelike environment to two of three residents (Resident 52, and 27) by failing to: 1. Ensure the sliding screen door in Resident 52's room was not out of track on the bottom and did not have multiple holes and tears on the screen for over a month. 2. Ensure Resident 27 had a safe and functional floor with repaired broken tiles due to a water leak. These deficient practices had result in unclean and unsafe environment that affected Resident 52's comfort and promoted a non homelike environment in the resident's living area resulted that impacted Resident 27's quality of life. Findings: 1. During a review of Resident 52's Admission Record (AR), the AR indicated the facility originally admitted Resident 52 on 9/5/2022 and readmitted him on 1/13/2025 with diagnoses that included dementia (a term for a range of conditions that affect the brain's ability to think, remember, and function normally) and hypertension (high blood pressure). During a review of Resident 52's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 1/16/2025, indicated Resident 52 had moderately impaired memory and cognition (ability to think and reason). The MDS indicated Resident 52 required partial/moderate assistance with eating, oral hygiene and chair/bed-to-chair transfer, and dependent with toileting hygiene and shower/bathe self. During an observation on 3/25/2025 at 10:09 AM, the screen door in Resident 52's room was out of track on the bottom and had multiple holes and tears. During an interview on 3/25/2025 at 10:09 AM, Resident 52 stated the screen door had been broken for over one month. Resident 52 stated he liked to have some fresh air by opening the sliding glass door, but the broken screen door created gaps and holes for the dirty, leaves, and bugs coming into the room, which making him feel very uncomfortable. Resident 52 stated he reported it to the maintenance staff multiple times, but no one fixed the screen door yet. (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 3/25/2025 at 10:15 AM with the Maintenance Supervisor (MS), the MS stated the tears and holes on the screen holes was caused by the wear and tear. The MS stated he did not conduct the routine check on the condition of the screen doors in the residents' rooms. The MS stated he did not know the bottom of the sliding screen door and was off the track and had tears and holes on the screen door which he does not know how long sliding door had been in its current condition. The MS stated he would rely on other staff to report to him about the repair needed in the residents' rooms, but he did not receive any report about this screen door from other staff. The MS stated the screen door should had been fixed and repaired as soon as possible to provide a homelike environment for the resident and his comfort. During a review of the facility's policy and procedure (P&P), titled Preventative Maintenance Program, dated 12/19/2022, the P&P indicated A preventative Maintenance Program shall be developed and implemented to ensure the provision of a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. 47467 2. During a review of Resident 27's AR, the AR indicated the facility admitted Resident 27 on 2/25/2016 and readmitted on [DATE] with diagnoses that included aphasia (a language disorder that affects a person's ability to communicate) following cerebral infarction (or ischemic stroke, occurs when the blood supply to part of the brain is blocked or reduced), and type 2 diabetes mellitus (DM2 - condition that results in too much sugar circulating in the blood). During a review of Resident 27's History and Physical, dated 11/20/2024, indicated Resident 27 did not have the capacity to understand and make decision. During a review of Resident 27's MDS, dated [DATE], indicated Resident 27's cognition (ability to think, remember, and reason with no difficulty) was severely impaired and was dependent (helper does all of the effort) in the ability to walk at least 10 feet in the room. During a concurrent observation and interview on 3/28/2025 at 9:50 AM with Certified Nurse Assistant (CNA) 6 in Resident 27's room, Resident 27 was sleeping in bed. Resident 27's floor was unrepaired with missing tiles right below the resident's bed. CNA 6 stated, the floor has been unrepaired due to water leak about a month ago. During a concurrent observation and interview on 3/28/2025 at 10:04 AM with the Maintenance Supervisor (MS), Resident 27's floor was unrepaired with missing tiles right below the resident's bed. The MS stated their water pipe which was just right outside Resident 27's room broke in January 2025 and was repaired. The MS stated, after the pipe was repaired, they have not repaired Resident 27's floor. The MS stated, Resident 27 should always be provided with homelike environment and a functional floor. During a review of the facility's policy and procedure (P&P) titled, Safe and Homelike Environment, revised 12/19/2022, the P&P indicated, in accordance with the residents' rights, the facility will provide a safe, clean, comfortable and homelike environment. This includes ensuring that the resident van receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. Environment refers to any environment in the facility that is frequented by the residents, including but not limited to the resident's room. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Preventative Maintenance Program, revised 12/19/2022, the P&P indicated, the Maintenance Director is responsible for developing and maintaining a schedule of maintenance services to ensure that the buildings, grounds, and equipment are maintained in a safe and operable manner.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50012 Based on observation, interview, and record review, the facility failed to ensure Minimum Data Set (MDS-a federally mandated resident assessment tool) entries were accurate and reflects resident's status for one of three sampled residents (Resident 99) who was discharged home with home health services. The MDS was incorrectly coded as a transfer to a hospital, which does not reflect the actual discharge disposition of the resident who was discharged to home. This failure resulted in inaccurate documentation in the resident's medical record could impact continuity of care, facility reporting accuracy, and regulatory compliance. Incorrect discharge coding may also affect quality measures, reimbursement, and tracking of resident outcomes. Findings: During a review of Resident 99's Admission Record indicated the facility admitted Resident 99 on 1/27/2025 with diagnoses that included hypertension (a long-term medical condition in which the blood pressure in the arteries is persistently elevated) and hyperlipidemia (a condition where there are high levels of fat in the blood). During a review of Resident 99's MDS dated [DATE], Section A indicated the resident had been discharge to an acute hospital. During a review of Resident 99's physician orders, dated 2/21/2025, indicated an order to discharge Resident 99 home on 2/25/2025 with home health services. During a concurrent interview and record review on 3/27/2025 at 4:53 PM with the MDS Nurse (MDSN), Resident 99's MDS was reviewed, she acknowledged the discrepancy, and stated, I will make a correction to the MDS immediately. MDSN stated the MDS should indicate resident was discharge home under care of organized home health services organization. During a review of the Center for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Manual, it indicated that facilities must ensure MDS discharge assessments accurately reflect the resident's discharge location and care needs.

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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** 48481 Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for one of four sampled residents (Resident 10) who had an impaired vision and needed eyeglasses to improve his vision and to meet the residents ' needs, resident ' s goals, and preferences. The deficient practices have the potential to delay necessary care and services to assist with the Resident 10 ' s vision that and affect resident ' s quality of life. Findings: During an observation on 3/25/25 at 12:11pm, Resident 10 was awake watching Television in the room with a pair of eyeglasses was on the table. Resident 10 stated he ' s waiting for the new pair of eyeglasses to be sent to him because the old pair doesn ' t work well for him anymore, which he held for about a year. Resident 10 stated the optometrist (a healthcare professional for routine eye and vision care) came to facility about a month ago and checked his vision. Resident 10 stated everything has become blurry, affecting his quality of life, and even adequate lighting will not make it better. Resident 10 stated he used to read newspaper everyday but he ' s not able to do so because of the old eyeglasses and he still waiting for the new pair of prescription. Resident 10 stated when he asked about the new pair of eyeglasses this morning, the Social Service told him to continue to wait because the estimated delivery is about six (6) to eight (8) weeks. During a review of Resident 19's Admission Record, indicated Resident 10 was admitted on [DATE] with diagnoses including intervertebral disc degeneration, thoracic region (loss of cushioning in the spine between the neck and lower back), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and acquired absence of right leg below knee (loss of the right leg below the knee, typically due to medical intervention such as surgery following severe injury or disease.) During a review of Resident 10's Minimum Data Set (MDS- a resident assessment tool) dated 2/2/25 indicated Resident 10 ' s vision was adequate (sees fine details, such as regular print in newspapers/books) in adequate light. No corrective lenses (contacts, glasses, or magnifying glass) used. The MDS also indicated Resident 10 ' s cognition was moderately impaired (short-term memory is more affected, significant difficulty with memory, reasoning, problem-solving, and daily tasks, including confusion, trouble following conversations, and challenges managing complex situations.) The MDS also indicated that Resident 10 required partial/ moderate assistance (Helper does less than half the effort. Helper lifts, holds, or support trunk or limbs, but provides less than half the effort) on personal hygiene. During a review of Resident 10's Physician Order Summary, dated 1/29/25, indicated May see optometrist annually and as needed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 10's Optometry Note, dated 2/24/25, indicated Resident 10 ' s has history of dry eye and cataract (a cloudy area in the lens) in OD and OS (both eyes.) The notes also indicated recommendation: new glasses with new lenses prescription. During a review Resident 10 ' s Care Plans from 1/30/25 to 3/26/25, indicated Resident 10 did not have a care plan related to the resident ' s impairment of vision. During a review of Resident10 ' s Clinical records that included Nursing or Social Service Progress Note between 2/24/25 and 3/24/25, the records did not have documented evidence related to resident ' s impaired vision and optometry visit. During an interview on 3/27/25 at 2:10 pm with LVN 2, LVN 2 stated she was not aware of Resident 10 ' s vision concern until Resident 10 told her about his waiting for new eyeglasses this morning. LVN 2 stated she has not referred to Social Service to talk to the resident at this time. During an interview on 3/27/25 at 2:20 pm with the Social Service Director (SSD), the SSD stated on 2/24/25 during the optometry visit, the optometrist verbally told her and Resident 10 that it takes six to eight weeks to process order and have the prescription shipped. SSD stated she did not have any documentation about the visit or order tracking for Resident 10 ' s optometry visit. During an interview on 3/27/25 at 3:05pm with Director of Nursing (DON), the DON stated nursing staff should have been aware when residents had optometry visit and should have evaluated resident's sensory change, and a care plan for his vision should have been developed. The DON stated the responsibility to identify problems is accountable of all nursing staff, the residents with unidentified care concerns are affected with their quality of life and delay delivery of care and services. During a review of the facility ' s Policy and Procedure (P&P) titled Comprehensive Care Plan, revised on 12/19/22, the P&P indicated that the care planning process will include an assessment of the resident ' s strengths and needs and will incorporate the resident ' s personal and cultural preferences in developing goals of care. The comprehensive care plan will describe the services are to be furnished to attain or maintain the resident ' s highest practicable physical, mental, and psychosocial well-being; the resident ' s goals for admission, desired outcomes, and preferences for future discharge. The comprehensive care plan will be prepared by an interdisciplinary team (IDT) that includes but not limited to a registered nurse, social service director/ social worker, and administration.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48481 Based on observation, interview, and record review, the facility failed to ensure one of three sampled resident (Resident 11) was provided care and services to prevent skin pressure injury (PI-pressure injury skin damage due to unrelieved pressure or sheer or friction to the skin). Resident 11 developed Stage 2 PI (partial-thickness loss of skin, presenting as a shallow open sore or wound) on left first metatarsal (big toe) that developed in the facility and on 12/31/24 that progressed to Stage 3 P1 (Full-thickness loss of skin. Dead and black tissue may be visible) on 3/4/25. Resident 11 ' s new footwear was not assessed and evaluated to determine if the shoes was effective to prevent worsening or development of new or old pressure injury. This deficiency had the potential for Resident 11's left first metatarsal pressure injury to worsen and experience pain and infection. Findings: During a review of Resident 11's Admission record (AR) indicated that Resident 11 was originally admitted on [DATE] and readmitted on [DATE] with diagnoses that included chronic atrial fibrillation (an irregular and often very rapid heart rhythm), dementia (a progressive state of decline in mental abilities), and spinal stenosis (The spaces inside the bones of the spine get too small). During a review of Resident 11's Minimum Data Set (MDS - a resident assessment tool) dated 2/21/25, indicated that Resident 11 ' s cognition (ability to think, make decisions, understand, learn, and make needs known) was severely impaired. The MDS also indicated Resident 11 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently [occasionally]) on rolling left and right, sitting to lying, lying to sitting on side of bed, sitting to standing, chair/bed-to-chair transfer, toilet transfer, walking 10 feet, walking 50 feet with two turns, and walking 150 feet. During a review of Resident 11's Resident Admission Assessment (RAA) dated 5/14/21, the RAA indicated that Resident 11's skin was warm and dry to touch, brownish discoloration noted on dorsal left foot. No PI was documented in RAA. During a review of Resident 11's Change in Condition (CIC) dated 12/24/24, the CIC indicated a redness was noted on left plantar 1st metatarsal phalangeal join (the connections between the bones in the foot and the toe bones.) No Staging or wound description documented in the CIC. No CIC was created on 12/31/24 for Resident 11 ' s change of skin condition. During a review of Resident 11's Wound Progress Notes (WPN) indicated the following for left lateral first metatarsal (left toe, big): 1. WPN dated 12/31/24: Epithelialization (the process of becoming covered with or converted to layers of cells that line hollow organs and glands): Partial thickness tissue loss. Exudate (fluid that leaks out of blood vessels into nearby tissues) amount: None. Apply betadine daily. Recommend new footwear/shoe. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The WPN dated 2/18/25: Epithelialization: Partial thickness tissue loss. Exudate amount: None. Apply Betadine (povidone-iodine, a topical antiseptic used to clean wounds and skin, and to help prevent infections) used to daily. Recommend new footwear/shoe. 3. The WPN dated 3/4/25: Stage 3 PI with full thickness tissue loss, scant exudate volume, wound is moist. Quality of tissue status, wound drainage status, and length and width status: Assessed during an initial visit, no comparison was made at this visit. 4. The WPN dated 3/25/25 indicated Resident 11 had a Stage 3 PI with full thickness tissue loss with scant exudate, wound is moist. Quality of tissue status deteriorated compared to the previous visit ' s conclusion. During a review of Resident 11 ' s Treatment Administration Record (TAR) dated 12/1/24~12/31/24, the TAR indicated that Resident 11 started treatment on left first metatarsal with applying Betadine and leave open to air on 12/24/25. The TAR indicated the same treatment was provided to Resident 11 between 1/1/25~1/31/25 and 2/1/25~ 2/28/25. During a review of Resident 11 ' s Care Plan revised 12/21/24 indicated Problem: Left first metatarsal PI, with the predisposing factors included improper footwear, the Care Plan did not include any interventions related to footwear. During an observation and concurrent interview on 3/27/25 at 11:45 am with Resident 11, there were two pairs of shoes (with Resident 11 ' s name written) in the closet for Resident 11, one is white while the other pair is black. Resident 11 stated she wore shoes when she got up to activity or to use bedside commode. Resident 11 stated she liked to wear the white sneakers, although the white sneakers were a little tight and it hurts her because she has a wound. During an observation and concurrent interview on 3/27/25 at 11:55 am with Treatment Nurse (TXN) and CNA 4, CNA 4 stated the white sneakers in the resident ' s room were older and the black pair was brought by the resident ' s family recently, however Resident 11 always asked for the white pair. TXN stated he was not very familiar with Resident 11 ' s PI and had no idea about the issue of footwear. TXN stated he assessed the wound and provided treatment daily but had not checked Resident 11 ' s footwears to determine if the footwear caused the PI. During an interview on 3/27/25 at 3:40 pm with the Director of Nursing (DON), the DON stated the TXN should have assessed predisposing factors of PI of each resident, and Resident 11 ' s new footwear should have been assessed and evaluated to determine if the shoes was effective to prevent worsening or development of new or old pressure injury. During a review of the facility ' s Policy and Procedure (P&P) titled Pressure Injury Prevention Guidelines revised on 11/27/23, the P&P indicated the following: -Individualized interventions will address specific factors identified in the resident ' s risk assessment, skin assessment, and any pressure injury assessment. -Interventions will be implemented in accordance with physician orders, including the type of prevention devices to be used and, for tasks, the frequency for performing them. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Interventions will be documented in the care plan and communicated to all relevant staff.

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47467 Based on interview, and record review, the facility failed to provide the necessary respiratory care and interventions in accordance with the resident's respiratory care needs, care plan, facility policy and professional standards of practice, the physician's order and facility's policy and procedure for one of three closed record sampled residents (Resident 98) diagnosed of acute respiratory failure with hypoxia (a life-threatening condition where the lungs fail to deliver enough oxygen to the blood, leading to dangerously low oxygen levels in the body), chronic obstructive pulmonary disease exacerbation (worsened COPD, sudden severe symptoms of a lung disease characterized by poor airflow to the lungs that results in shortness of breath, difficulty breathing and respiratory distress) and pulmonary hypertension [a condition characterized by high blood pressure (BP, the measurement of the pressure or force of blood inside the blood vessels) in the arteries of the lungs which makes the heart work harder to pump blood through the narrowed or damaged blood vessels in the lungs that causes shortness of breath and difficulty breathing] by failing to: 1. Monitor Resident 98 for respiratory distress (life-threatening condition that causes severe difficulty breathing. It occurs when the lungs become inflamed and damaged, making it difficult for oxygen to reach the bloodstream) and change in respiratory condition, in accordance with the resident's care plan for COPD and physician orders, when Certified Nurse Assistant (CNA) 1 found Resident 98 with weakness, labored breathing, and an oxygen saturation (blood oxygen level) of 88% (normal range ,d+[DATE]%) while receiving oxygen via nasal cannula (NC- a plastic flexible tubing used to deliver oxygen into the nose) at 2 LPM [Liters (unit of volume) Per Minute (unit of time)] and reported his findings to Licensed Vocational Nurse (LVN) 1. 2. Follow physician orders to titrate (adjust) Resident 98's oxygen therapy to ,d+[DATE] LPM via mask to maintain oxygen blood levels of 94% and above, when Resident 98's oxygen saturation decreased to 70% on [DATE] at 5:50 AM, while receiving 2 LPM of oxygen via NC. 3. Ensure LVN 1 monitored and documented Resident 98's vital signs (measurements of the body's most basic functions, including temperature, pulse rate, breathing rate, and BP, used to assess a person's overall health), treatments rendered, and reported to the physician, in accordance with the physician orders. 4. Ensure LVN 1 immediately notified the physician and called 911 (an emergency number) emergency services, when CNA 1 reported to LVN 1 that Resident 98 was experiencing labored breathing with his oxygen saturation decreased to 88% on [DATE] at around 5:30 AM, and when LVN 1 assessed Resident 98 with findings of weakness and oxygen saturation continued to decrease to 70% on [DATE] at 5:50 AM. 5. Ensure LVN 1 implemented Resident 98's Physician Orders for Life-Sustaining Treatment (POLST, a portable medical order that communicates a patient's wishes for end-of-life care and treatment interventions) according to the resident's preferences. These deficient practices resulted in the delay in diagnosis, care, and respiratory services for Resident 98's change in respiratory condition. Resident 98 expired at the facility on [DATE] with the cause of death as cardiac dysrhythmia (abnormal or irregular heartbeat), acute respiratory distress and pulmonary hypertension. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On [DATE] at 3:09 PM, while onsite at the facility, the California Department of Public Health (CDPH) an Immediate Jeopardy situation (IJ, a situation in which the provider's noncompliance with one or more requirements of participation has caused or is likely to cause serious injury, harm, impairment, or death of a resident) was identified and called regarding the facility's failure to notify the physician regarding significant changes in Resident 98's respiratory conditions and provide the necessary respiratory care and monitoring. On [DATE] at 7:52 PM, the IJ was removed in the presence of the Administrator (ADM) and the Director of Nurses (DON) after the facility submitted an acceptable IJ Removal Plan (a plan that identifies all actions the facility will take to immediately address the noncompliance that has resulted in the IJ situation) and while onsite at the facility, the surveyors verified/confirmed the facility's implementation of the IJ Removal Plan and the IJ situation was no longer present. The IJ Removal Plan dated [DATE], included the following: 1. On [DATE], the Director of Nursing (DON) and Registered Nurse (RN) supervisor evaluated current residents with oxygen order (12 residents) and/or with diagnosis of COPD (32 residents) for appropriate assessment and interventions. 2. On [DATE], the Regional Nurse Consultant (RNC) provided one on one education to DON and Director Staffing Development (DSD) related to respiratory care, assessment and documentation, monitoring for any change of condition, oxygen administration as ordered by the physician, notification of the physician, escalation of emergent medical services (911) if needed, and implementation of POLST per resident preference. 3. On [DATE], the Regional Nurse Consultant (RNC) conducted an interview with LVN 1 and CNA 1 regarding the death incident of Resident 98. The RNC investigated for the licensed nurse documentation, monitoring of change of condition and the reason for not calling 911 and for the possible root cause. 4. On [DATE], the RNC provided one on one education to LVN 1 related to respiratory care, assessment and documentation, monitoring for any change of condition, oxygen administration as ordered by the physician including skills competency, notification of the physician, escalation of emergent medical services (911) if needed, and implementation of POLST per resident preference. 5. On [DATE], the DON or designee conducted re-education for licensed nursing staff on the following topics: documentation, oxygen administration, compliance with individualized interventions in each resident's care plan, implementation of POLST and notification of the physician and following physician orders. 6. On [DATE], the DON or designee started auditing residents with COPD and or Oxygen order 3 times weekly (Monday - Wednesday- Friday) for 4 weeks to ensure physician's orders were carried out, resident specific care plans were implemented, and necessary respiratory equipment/supplies were in place, and monitor if change of condition occurred. Upon identification, the DON or designee would immediately address concerns and remedy any audit deficiencies with the licensed nursing staff immediately. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055989	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Manor	610 North Garfield Avenue Monterey Park, CA 91754

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

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	7. On [DATE], A Quality Assurance and Performance Improvement (QAPI, a data-driven approach to improve the quality of care and services in healthcare settings) Plan was implemented to track and report on above audit findings. The findings will be presented on the last Wednesday of the month for the monthly Quality Assessment and Assurance (QAA, an integrated system of management activities involving planning, implementation, assessment, reporting, and quality improvement to ensure that a process, or service is of the type and quality needed and expected) meeting for a minimum of three months. After the initial three months, the QAA Committee will decide regarding the continued frequency of audits and subsequent reporting, with audits continuing at least monthly to sustain compliance. 8. On [DATE] the RNC discussed regarding Chronic Obstructive Pulmonary Disease (COPD) and pulmonary hypertension with post-test to LVN 1 to ensure understanding of the medical condition. 9. On [DATE], the DON or designee provided education to licensed nurses regarding COPD and pulmonary hypertension with post-test to ensure understanding of the medical condition. Cross reference to F580 and F867. Findings: During a review of Resident 98's Admission Record (AR), the AR indicated the facility admitted Resident 98 on [DATE] with diagnoses that included acute respiratory failure with hypoxia, COPD with exacerbation (worsened symptoms), pulmonary hypertension, type 2 diabetes mellitus with hyperglycemia (DM, a chronic condition that happens when the body has persistently high blood sugar levels), and atrial fibrillation (afib a common type of irregular heartbeat). During a review of Resident 98's Order Summary Report (OSR), indicated on [DATE], Resident 98 had a physician order to monitor temperature and oxygen saturation every shift for suspected/confirmed Covid-19 (Coronavirus disease, an infectious disease caused by the SARS-CoV-2 virus), and to call the physician if oxygen saturation is newly below 91%, or if the resident's usual oxygen saturation is lower or is 3% or more lower than their baseline. During a review of Resident 98's Care plan (CP), dated [DATE], indicated Resident 98 had COPD exacerbation. The goal was that the Resident 98 would display optimal breathing patterns (a respiratory rate of 12 to 20 breaths per minute with regular, rhythmic inhalations and exhalations) daily with the interventions that included monitoring for signs and symptoms of acute respiratory insufficiency such as shortness of breath at rest, cyanosis (a bluish or purplish discoloration of the skin, typically caused by a lack of oxygen in the blood), and somnolence (lethargy, weakness, and difficulty thinking), and to administer oxygen via NC at , d+[DATE] LPM continuously, may titrate oxygen to ,d+[DATE] LPM via mask to maintain oxygen saturation greater or equal to 94%. During a review of Resident 98's CP, dated [DATE], indicated Resident 98 was at risk for Covid-19 related to diagnosis of COPD exacerbation, DM, and afib. The interventions included to follow Resident 98's POLST, monitor temperature and pulse oximetry (a test used to measure oxygen levels of the blood) per physician's order and report abnormal findings to the physician. (continued on next page)

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	055989	A. Building B. Wing	03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During a review of Resident 98's CP, dated [DATE], indicated Resident 98 had altered cardiovascular (related to heart and blood vessels) status related to afib, hypertension (high BP), and hyperlipidemia (high level of fats in the bloodstream). The interventions included to monitor Resident 98's vital signs and notify the physician of significant abnormalities, monitor/document/report to the physician for changes in capillary refill (a quick test to assess blood flow to tissues by observing how quickly color returns to the nail bed after pressure is applied) and color/warmth of extremities. During a review of Resident 98's History and Physical, dated [DATE], indicated Resident 98 had the capacity to understand and make decision. During a review of Resident 98's OSR, indicated on [DATE], for Resident 98 to receive oxygen via NC at , d+[DATE] LPM continuously, may titrate oxygen to ,d+[DATE] LPM via mask to maintain oxygen saturation greater or equal to 94%. During a review of Resident 98's OSR, indicated on [DATE], the physician ordered to follow the instructions in Resident 98's POLST. During a review of Resident 98's POLST, dated [DATE], indicated if Resident 98 was found with a pulse and/or is breathing, the healthcare provider may, in addition oxygen treatment, use a non-invasive positive airway pressure (a method of breathing support that delivers pressurized air or oxygen through a mask without inserting a tube into the windpipe) which included continuous positive airway pressure (CPAP, a machine that uses mild air pressure to keep breathing airways open), bi-level positive airway pressure (BiPAP, a type of device that helps with breathing), and bag valve mask (a handheld device used to provide emergency breaths to someone who is not breathing or not breathing adequately) assisted respirations. During a review of Resident 98's Minimal Data Set (MDS-a federally mandated resident assessment), dated [DATE], indicated Resident 98's cognition (ability to think, remember, and reason) was moderately impaired and needed moderate assistance (helper does less than half the effort) in eating and oral hygiene. During a review of Resident 98's Weights and Vitals Summary, indicated Resident 98's last vital signs was taken on [DATE] at 1:09 AM with the resident's BP at ,d+[DATE] mmHg (millimeters of mercury, a unit of measurement for pressure), oxygen saturation of 93% while the resident was on room air, heart rate at 100 beats per minute, and temperature of 98.7 degrees Fahrenheit (a scale for measuring temperature). There was also no documented evidence that Resident 98 was monitored for vital signs on [DATE] at 5:50 AM when Resident 98 responded to touch only by opening his eyes, and had slow breathing. During a review of Resident 98's Progress Notes, dated [DATE], indicated at 5:50 AM during CNA morning care, Resident 98 responded only by opening his eyes, breathing slowing down with oxygen saturation at 70% via NC until the resident passed away. There was no documented evidence in the report that Resident 98 was provided with increased oxygen level to increase oxygen saturation to 94% as ordered by the physician. There was also no documented evidence that Resident 98 was monitored for vital signs, provided with ,d+[DATE] LPM oxygen via mask per physician's order on [DATE] at 5:50 AM when Resident 98 responded to touch only by opening his eyes, had slow breathing, and oxygen saturation at 70 % while on 3 LPM oxygen via NC. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During a review of Resident 98's SBAR Communication Form (a structured approach to healthcare communication, standing for Situation, Background, Assessment, and Recommendation to ensure clear and concise information exchange, especially in critical situations) and clinical records on [DATE], indicated that there was no documented evidence that the physician was notified when Resident 98's condition changed by responding only by opening his eyes, breathing slowing down with oxygen saturation at 70% via NC on [DATE] at 5:50 AM until the resident expired on [DATE] at 5:59 AM. During a review of Resident 98's Record of Death, dated [DATE], indicated Resident 98 expired on [DATE] at 5:59 AM with the final diagnosis that included COPD, hypoxia and respiratory failure. During a review of Resident 98's Physician's Discharge Summary, dated [DATE], indicated Resident 98 was admitted on [DATE] and was discharged from the facility due to resident expired on [DATE] at 5:59 AM. During a review of Resident 98's Death Certificate dated [DATE], indicated Resident 98 expired on [DATE] with the primary cause of death as cardiac dysrhythmia and secondary cause of death that included acute respiratory distress and pulmonary hypertension. During an interview on [DATE] at 6:38 AM with CNA 1, CNA 1 stated, he took care of Resident 98 from 11 PM on [DATE] until the resident expired on the morning of [DATE]. CNA 1 stated, when he was caring for Resident 98 at the beginning of his shift, Resident 98 was alert and oriented, with the vital signs including BP and oxygen saturation was within normal limits, though he could not recall the results of the vital signs and time they were taken. CNA 1 stated, around ,d+[DATE]:30 AM during his rounds in the facility, he noticed that Resident 98 did not respond when he called Resident 98's name, and breathing very slow but his skin was warm when touched and the resident was very weak with his oxygen level at around 88%. CNA 1 stated, he immediately reported to LVN 1 that Resident 98's oxygen blood level was low and then LVN 1 went to assess Resident 98. CNA 1 stated, they (LVN 1 and CNA 1) checked Resident 98's vital signs about four times, but he could not recall the results and time the vital signs were taken. CNA 1 stated, he could only recall that Resident 98's oxygen level was at 88% when he first found the resident around ,d+[DATE]:30 AM and notified LVN 1. CNA 1 then stated Resident 98 slowly died in about 1 hour while receiving oxygen via NC. During a concurrent record review and interview on [DATE] at 6:52 AM with LVN 1, Resident 98's Weights and Vitals Summary, SBAR Communication Form, and clinical records on [DATE] and [DATE] were reviewed. LVN 1 stated, there was no records indicating Resident 98 was assessed and monitored for vital signs, Resident 98's physician was notified, or interventions were provided related to Resident 98's slow breathing with oxygen saturation at 70% on [DATE] at 5:50 AM. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on [DATE] at 7 AM with LVN 1, LVN 1 stated, he was the charge nurse that took care of Resident 98 from 11 PM on [DATE] until the resident expired on [DATE] at 5:59 AM. LVN 1 stated, Resident 98 was alert, oriented and responsive at the beginning of his shift on [DATE], with oxygen saturation above 90% while receiving oxygen supplement at 3 LPM. LVN 1 stated, Resident 98 was able to make his needs known. LVN 1 stated, when LVN 1 provided Resident 98 with his scheduled breathing treatment (treatment to prevent difficulty breathing and shortness of breath) at 4 AM, Resident 98's oxygen saturation was about 93% and Resident 98 was placed back on ,d+[DATE] LPM oxygen via NC after the breathing treatment. LVN 1 stated around 5:30 AM, CNA 1 told him Resident 98 had a change in condition and breathing very slow and was very weak. LVN 1 stated he went to Resident 98's room, and Resident 98 opened his eyes but was very weak. LVN 1 stated he checked Resident 98's vital signs a few times but could not recall the results of the VS and he did not document the vital signs in Resident 98's clinical record. LVN 1 stated, he did not report Resident 98's change of condition to the Registered Nurse (RN) who was working during his shift on [DATE]. LVN 1 stated, he did not increase Resident 98's oxygen level as per physician's order because the resident had diagnosis of COPD. LVN 1 stated, he did not inform the physician when Resident 98's condition changed with oxygen saturation down to 88% and 70%. LVN 1 stated he informed Resident 98's physician after the resident passed away on [DATE]. LVN 1 stated, he supposed to notify Resident 98's physician, call for help or call 911 when CNA 1 reported to him that Resident 98 was weak with slow breathing and a decrease in the resident's oxygen saturation. LVN 1 stated, Resident 98 expired less than one hour after he was notified by CNA 1 for Resident 98's weakness and slow breathing. During a review of LVN 1's statement provided by the facility, dated [DATE] not timed, indicated on [DATE] at 11 PM, Resident 98 was laying comfortably in bed with oxygen via delivered via NC at 3 LPM with no sign and symptoms of respiratory distress. The statement indicated on [DATE] at 4 AM, LVN 1 administered the routine breathing treatment, Resident 98 was sleepy in bed, then at 5:50 AM, CNA 1 called LVN 1's attention and informed him that Resident 98 was only responding by opening his eyes. The statement indicated LVN 1 checked Resident 98's oxygen saturation that was 70 %. While Resident 98 was receiving oxygen supplement at 3 LPM. The statement indicated, LVN 1 elevated the Resident 98's head of the bed then suddenly Resident 98 became weak and unresponsive, like the resident last breath. During a review of CNA 1's statement provided by the facility, dated [DATE] not timed, indicated on [DATE] at 5:30 AM, CNA 1 came to change Resident 98's diaper and noticed a change in his condition and immediately reported his findings to LVN 1. The statement indicated, Resident 98's oxygen saturation was at 89%, then went down to 88%, and suddenly dropped down to 70%. LVN 1 and CNA 1 checked Resident 98's BP which was lower than the limit, then CNA 1 and LVN 1 elevated Resident 98's head of the bed higher and the resident became unresponsive. The statement indicated, Resident 98's breathing was slowing down until his last breath. During an interview on [DATE] at 9:40 AM with the DON, the DON stated when CNA 1 reported to LVN 1 that Resident 98's oxygen saturation was trending down and the resident was weak, LVN 1 should have immediately assessed, monitored and documented Resident 98's vital signs in the resident's clinical record. The DON stated, when LVN 1 found Resident 98's oxygen saturation of 70%, LVN 1 should have immediately called for help or Code Blue (an emergency code indicating a patient is experiencing a life-threatening medical emergency, typically a cardiac or respiratory arrest, requiring immediate medical attention and resuscitation efforts). followed the physician order to titrate Resident 98's oxygen therapy, followed Resident 98's POLST, called 911, and notified the physician to prevent a delay in treatments and interventions. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on [DATE] at 1:02 PM with Resident 98's Primary Physician (PP) 1, PP 1 stated when Resident 98's oxygen saturation of ,d+[DATE]% went down to 88%, it was a sudden drop of oxygen saturation or a sudden change in condition, PP 1 stated LVN 1 was supposed to follow the physician's orders and notified him (PP1) right away, followed Resident 98's POLST, called 911 and notified the physician again. PP 1 stated, he was not notified of Resident 98's significant change in respiratory status on [DATE]. PP 1 stated, he was notified only after Resident 98 already expired on [DATE]. During a review of the facility's Policy and Procedure (P&P) titled, Oxygen Administration, revised [DATE], indicated the following: - Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences. - The equipment needed for oxygen administration will depend on the type of delivery system ordered. Type of delivery systems include nasal cannula, non-rebreather mask, CPAP mask, BiPAP mask. - Staff shall notify the physician of any changes in the resident's condition, including changes in vital signs, oxygen concentrations, or evidence of complications associated with the use of oxygen. During a review of the facility's P&P tiled, Notification of Changes, revised [DATE], indicated the facility consult with the resident's physician when there is a change requiring such notification. Circumstances requiring notification include significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status, which may include life-threatening conditions. During a review of the facility's P&P titled, Medical Emergency Response, revised [DATE], indicated the following: - The employee who first witnesses or is first on the site of a medical emergency will initiate immediate action, basic first aid and summon for assistance. - A nurse will assess the situation and determine the severity of the emergency, designate a staff member to announce a Code Blue (a medical emergency alert, usually indicating a person has experienced cardiac or respiratory arrest requiring immediate resuscitation efforts) if necessary, notify the physician and call 911 as needed. - All available staff will respond to the emergency accordingly. - The RN Supervisor or Charge Nurse of the unit will take the Emergency Cart to the code site, ensure accurate documentation of the event and delegate any other duties or tasks needed.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50012 Based on observation, interview, and record review, the facility failed to maintain a medication error rate of five percent or (5%) or less during medication pass for one of four observed residents (Residents 52) in which three (3) medication errors were identified out of 29 opportunities that yielded a cumulative error rate of 10.34 %. The facility failed to ensure: 1. Licensed Vocational Nurse 2 (LVN 2) checked the heart rate of Resident 52 prior to the administration of Metoprolol tartrate (medication that lowers blood sugar level) and Amlodipine (medication ordered to manage hypertension [HTN - elevated blood pressure]). 2. Licensed Vocational Nurse 2 (LVN 2) provided food during medication administration of Metoprolol and Metformin HCL (medication given to lower blood sugar level) ordered by the physician. These deficient practices had the potential to result in ineffective managed hypertension and diabetes and may cause a harmful significant drop in the heart rate, blood pressure, hypoglycemia (low blood sugar) and upset stomach for Resident 52. Cross reference with F760. Findings: During a review of Resident 52's Admission Record (Face Sheet), indicated the facility admitted the resident on 9/5/2022 and readmitted on [DATE] with diagnoses including diabetes mellitus (DM: long-term metabolic disorder that is characterized by high blood sugar, insulin resistance, and relative lack of insulin) and HTN. During a review of Resident 52 ' s History and Physical (H&P), dated 12/24/2024 indicated, Resident 52 does not have the mental capacity to make medical decisions. During a review of Resident 52's Minimum Data Set (MDS-a federally mandated resident assessment tool), dated 1/16/2025, indicated the resident ' s cognitive (the ability to think and process information) skills for daily decisions making was severely impaired, and was dependent on staff for the activities of daily living. During a review of Resident 52's Order Summary, dated 3/27/2025, the Order Summary Report indicated to administer the following medications to the resident: a. Amlodipine Besytate Oral tablet 10mg (milligram) give one table by mouth in the morning for HTN hold for systolic blood pressure (SBP - the amount of pressure in the arteries during contraction of the heart muscle) <110 or HR (hear rate) <60 with a Start date 1/13/2025 (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Metoprolol Tartrate Oral Tablet 50 mg (Metoprolol Tartrate) Give 1 tablet by mouth three times a day for Hypertension (Hold if SBP <110 or HR <60 / Administered with food) with a Start date 2/1/2025 c. Metformin HCl Oral Tablet 500 MG (Metformin HCl) Give 1 tablet by mouth two times a day for DM (diabetes) administer with food. During a medication pass observation and concurrent interview with the LVN 2 on 3/27/2025 at 9:26AM, LVN 2 prepared the medications Amlodipine and Metoprolol and checked the Resident 52 ' s blood pressure but she did not check the resident ' s heart rate as indicated by the physician ' s order. As the LVN 2 was about to administer the Amlodipine and Metoprolol, the surveyor asked, What is the resident ' s heart rate? LVN 2 paused and stated that she forgot to check Resident 52's HR. LVN 2 then checked the resident ' s heart rate, which was 65 bpm (beats per minute), before proceeding with administration. During an interview on 3/27/2025 at 9:26AM, LVN 2 stated she forgot to check Resident 52's heart rate. LVN 2 checked the resident's heart rate, then proceeded to administer metoprolol tartrate since Resident 26's heart rate was 65 beats per minute. LVN 2 she acknowledged the error of not providing food during medication administration. During an interview on 3/28/2025 at 1:50 PM, with the Director of Nurses (DON stated, Heart rate must be checked before administering medications like Metoprolol and Amlodipine because it can lower the heart rate. If a resident ' s heart rate is already low, giving the medication can be harmful and may cause serious complications, including dizziness, falls, or even more severe cardiac issues. DON stated nurse need to provide food to residents if there is an ordered to give. During a review of the facility's policy and procedure (P&P) titled, Medications Administration, revised 2022, indicated to: Obtain and record vital signs when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician ' s prescribed parameters. Administered medication as ordered in accordance with manufacture specification. Provide appropriate amount of food and fluid.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50012 Based on interview and record review the facility failed to ensure one out of four residents (Resident 52) was free from significant medication errors as indicated in the physician ' s order, pharmacy recommendation and facility's policy and procedures by failing to ensure Licensed Vocational Nurse (LVN) 2 failed to check the heart rate of Resident 52 prior to the administration of Metoprolol tartrate (medication given to lower the blood pressure) and Amlodipine (medication ordered to manage Resident 52's hypertension [HTN - elevated blood pressure]). This failure places the resident at risk for adverse effects, including bradycardia (low heart rate), hypotension (low blood pressure), dizziness, increasing the risk of falls, and cause the heart to stop that could lead to hospitalization or death. Findings: During a review of Resident 52's Admission Record (Face Sheet), indicated the facility admitted the resident on 9/5/2022 and readmitted on [DATE] with diagnoses including diabetes mellitus (DM: long-term metabolic disorder that is characterized by high blood sugar, insulin resistance, and relative lack of insulin) and hypertension (HTN-a long-term medical condition in which the blood pressure in the arteries is persistently elevated). During a review of Resident 52's History and Physical (H&P), dated 12/24/2024 indicated, Resident 52 does not have the mental capacity to make medical decisions. During a review of Resident 52's Minimum Data Set (MDS-a federally mandated resident assessment tool), dated 1/16/2025, indicated the resident ' s cognitive (the ability to think and process information) skills for daily decisions making was severely impaired, and was dependent on staff for the activities of daily living. During a review of Resident 52's Order Summary, dated 3/27/2025, the Order Summary Report indicated to administer the following medications to the resident: a. Amlodipine Besytate Oral tablet 10mg (milligram) Give one table by mouth in the morning for HTN hold for systolic blood pressure (SBP - the amount of pressure in the arteries during contraction of the heart muscle) < (less than)110 or HR (hear rate) <60 with a start date 1/13/2025. b. Metoprolol Tartrate Oral Tablet 50 mg (Metoprolol Tartrate) Give 1 tablet by mouth three times a day for Hypertension (Hold if SBP <110 or HR <60 / administered with food) with a start date 2/1/2025 (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a medication pass observation and concurrent interview with the LVN 2 on 3/27/2025 at 9:26AM, LVN 2 prepared the medications Amlodipine and Metoprolol and checked the Resident 52 ' s blood pressure but she did not check the resident ' s heart rate as required by the physician ' s order. As the LVN 2 was about to administer the Amlodipine and Metoprolol, the surveyor asked, What is the resident ' s heart rate? The LVN 2 paused and stated that she forgot to check Resident 52's HR. LVN 2 then checked the resident ' s heart rate, which was 65 bpm (beats per minute), before proceeding with administration. During an interview on 3/27/2025 at 9:26AM, LVN 2 stated she forgot to check Resident 52's heart rate. LVN 2 checked the resident's heart rate, then proceeded to administer metoprolol tartrate since Resident 52s heart rate was 65 beats per minute. During an interview on 3/27/2025 at 1:50 PM, with the Director of Nurses (DON stated, Heart rate must be checked before administering medications like Metoprolol and Amlodipine because the medication can lower the heart rate. If a resident ' s heart rate is already low, giving the medication can be harmful and may cause serious complications, including dizziness, falls, or even more severe cardiac (heart) issues. During a review of the facility's policy and procedure (P&P) titled, Medications Administration, revised 2022, indicated to obtain and record vital signs when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician ' s prescribed parameters.

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	055989	A. Building B. Wing	03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Manor	610 North Garfield Avenue Monterey Park, CA 91754

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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 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. 46779 Based on observation, interview and record review, the facility failed to ensure the two of two dietary staff (Dietary Manager and Facility Cook) had appropriate competencies and skills sets to carry out the functions of the food and nutrition service based on resident assessments, individual plans of care of the 30 residents who were prescribed with pureed diet (diet with food that has been blended, mashed, or strained until it's smooth and free of lumps, like applesauce or mashed potatoes, often used for those with difficulty chewing or swallowing) and were served pureed food that was pasty and thick in texture by failing to: 1. Ensure the Facility [NAME] reviewed and followed the recipe to ensure adequate measurement of thickener powder (powder like starch used to thicken the texture of food) were mixed when preparing the pureed food on 3/26/2025. 2. Ensure the Dietary Manager follow the pureed recipe and oversee the Facility [NAME] when preparing puree food for the residents on 3/26/2025. The deficient practices had put the residents at risk poor nutrition to weigh loss or gain, and risk of chocking and aspiration (food enters the airway and affecting air exchange in the body) that could result in aspiration pneumonia (severe infection of the lungs) and/or death. Findings: During an observation on 3/26/2025 at 10:46 AM in the kitchen, to prepare for puree chicken, the Facility [NAME] mixed unmeasured amount of chopped chicken, chicken flavor gravy powder, and water into a blender, then grinded the mixture. During an observation on 3/26/2025 at 10:49 AM in the kitchen, the Facility [NAME] poured the grinded chicken into a stainless-steel steam pan and scooped the thickener power that was less than a full scoop and mixed the thickener power in the grinded chicken. Next, the Facility [NAME] put grinded chicken inside the oven to keep it warm. The recipe for the pureed chicken was not present and the Facility [NAME] did not review and follow the recipe for pureed chicken to ensure adequate measurement of thickened powder were mixed during the cooking process. During an observation on 3/26/2025 at 11:10 AM in the kitchen, to prepare for puree noodle, the Facility [NAME] filled the unmeasured amount of cooked noodle and water into the blender and grinded the mixture. During an observation on 3/26/2025 at 11:12 AM in the kitchen, the Facility [NAME] poured the grinded noodle into a stainless-steel steam pan then used a cooking spoon to scoop the thickener powder four times without checking the recipe and added with the grinded noodle. The recipe for the pureed noodle was not present and the cook did not review and follow the recipe for pureed noodle during the cooking process. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 3/26/2025 at 11:24 AM in the kitchen, the Facility [NAME] poured the unmeasured amount of grinded vegetable into a stainless-steel steam pan. Then, the Facility [NAME] scooped the thickener powder three times without checking the recipe and added to the grinded vegetable. The recipe for the pureed vegetable was not present and the cook did not check and follow the recipe for pureed vegetable during the cooking process. During an observation and interview on 3/26/2025 at 11:28 AM with the Dietary Manager (DM) in the kitchen, the DM filled the blender and grinded unmeasured amount of regular rice porridge. The DM did not add any thickener power into the grinded porridge. The DM stated the grinded porridge was for the facility's residents on pureed diet. During an observation on 3/26/2025 at 11:34 AM in the kitchen, the Dietary Aid (DA) grinded some chocolate cookies in the blender, then, she lifted the thickener container and poured an unmeasured amount of the thickener powder into the blender two times. Next, the DA grinded the cookies with thickener power again. During a concurrent observation and interview on 3/26/2025 at 1:10 PM with the DM, the consistency of the test tray's pureed chicken and noodle was pasty. The DM performed the spoon tilt test (a test used to a spoon to test the texture of food to ensure it is safe and easy to swallow) on the test tray's pureed chicken and noodle to determine if the texture of the pureed food was appropriate. The DM stated the pureed chicken and noodle were too sticky and did not slide off the spoon when tilted, so the textures of the pureed chicken and noodle were not consistent with pureed texture. The DM stated the dietary staff supposed to measure how much the thickener power was put into the pureed food when preparing them. The DM stated someone was supposed to check the final products to make sure texture of the food was correct, but she was not sure which dietary staff was the one in charge of checking the final product before the tray line and they did not have log of checking the textures of the food. During an interview on 3/26/2025 at 2:11 PM with the Facility [NAME] stated, she did not follow the pureed recipes and did not know if they had the pureed recipes available. The [NAME] stated she added the thickener powder by eyeballing the amount of thickener needed, instead of measure it, when preparing pureed food. The [NAME] stated she would taste the pureed food and based on her experience to determine if the texture of the pureed food was right. During an interview on 3/26/2025 at 4:18 PM with the Registered Dietitian (RD), the RD stated the dietary staff should follow the pureed recipes when preparing pureed food because following the recipe could ensure the food provides necessary nutrition for the resident ' s needs and ensure the food had right texture to prevent choking. During a review of the facility's Recipe for Pureed Fish/Meat/Poultry, dated 3/27/2025, the recipe indicated for 35 servings, the ingredients included cooked meat product six and half pounds (lb, a measurement unit for weight) and one ounce (oz, a measurement unit), reserved cooking liquid or broth one quarter (qt, a measurement unit) and food thickener three tablespoons (tbsp, a measurement unit) and one and half teaspoon (tsp, a measurement unit). The recipe also indicated add thickener with one and half tsp and add more gradually until desired texture is achieved. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's Recipe for Pureed Vegetables, dated 3/27/2025, the recipe indicated for 35 servings, the ingredient included cooked, drained and seasoned vegetables one gallon (gal, a measurement unit) and one and half cup and food thickener three tbsp and one and half tsp. The recipe also indicated add thickener with one and half tsp and add more gradually until desired texture is achieved. During a review of the facility's Recipe for Pureed Desserts, dated 3/27/2025, the recipe indicated for 35 servings, the ingredients included 35 regular portion of desserts, apple juice or two percent milk three and half cups, and food thickener three tbsp and one and half tsp. The recipe also indicated add thickener with one and half tsp and add more gradually until desired texture is achieved. The recipe also indicated add thickener with one and half tsp and add more gradually until desired texture is achieved. During a review of the facility's Recipe for Pureed Potatoes, Pasta, [NAME] and other Grains, dated 3/27/2025, indicated for 35 servings, the ingredients included cooked and drained potatoes, pasta or rice one gal and one and half cups, broth or two percent milk two qt and third of fourth cup, margarine one third of a cup and one and two third of a tbsp, and food thickener three tbsp and one and half tsp. During a review of the facility's policy and procedure (P&P), titled Pureed Food Preparation, dated 12/19/2022, the P&P indicated to Follow the recipes and spreadsheets for pureed food items. During a review of the facility's P&P, titled Therapeutic Diet Orders, dated 12/19/2022, the P&P indicated Dietary and nursing staff are responsible for providing therapeutic diets in the appropriate form and/or the appropriate nutritive contents as prescribed.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47467 Based on observation, interview, and record review, the facility failed to provide food prepared in a form designed to meet individual needs for one of two sampled residents (Resident 47) who had difficulty swallowing was served pureed diet (a food item that has been blended, mixed, or processed into a smooth and uniform texture) that was too thick in texture. This deficient practice resulted in Resident 47 and other residents with difficulty swallowing to be at increased risk for choking (happens when something blocks the airway, preventing a person from breathing properly, often due to food or other objects getting stuck in the throat) and aspiration (accidentally inhaling food, liquid, or other material into the lungs instead of the stomach, which can lead to complications like pneumonia [a severe lung infection]) that could lead to death. Finings: During a review of Resident 47's Admission Record (AR), the AR indicated the facility admitted Resident 47 on 10/3/2019 and readmitted on [DATE] with diagnoses that included dysphagia (difficulty in swallowing) following cerebral infarction (or ischemic stroke, occurs when the blood supply to part of the brain is blocked or reduced), pneumonia, and dementia [the loss of cognitive functioning (thinking, remembering, and reasoning) to such an extent that it interferes with a person's daily life and activities]. During a review of Resident 47's History and Physical (H&P), dated 7/24/2024, indicated Resident 47 did not have the capacity to understand and make decision. The H&P indicated, Resident 47 had diagnosis that included Covid pneumonia, dementia, and was a potential for rehabilitation due to aspiration prevention. During a review of Resident 47's Minimal Data Set (MDS-a federally mandated resident assessment), dated 10/10/2024, indicated Resident 47 ' s cognition (ability to think, remember, and reason with no difficulty) was severely impaired and needed moderate assistance (helper does less than half the effort) in eating and oral hygiene. During a review of Resident 47's Order Summary Report, indicated Resident 47 had a physician order on 2/2/2025 for regular diet with puree texture and thin consistency (flows easily and is not thick). (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 47's Speech Therapy - SLP Evaluation (Speech-Language Pathologist comprehensive assessment to determine if a person has swallowing disorders, or feeding disorders) and Plan of Treatment, for the period of 1/26/2025 - 2/22/2025, indicated Resident 47 needed maximal assistance in feeding and had difficulty in initiating oral stage (a preparatory phase which includes suckling, chewing, breaking down food, mixing the food with saliva; and the formation of a bolus [chewed food] of suitable size and consistency), oral residue (food or liquid remaining in the mouth after swallowing) and residue were on palate (the roof of the mouth) and/or tongue with clearance attempts. The evaluation indicated Resident 47 had impaired pharyngeal phase [the rapid stage where the food bolus is propelled from the back of the mouth into the esophagus (a tube that connects the mouth to the stomach)] as evidenced by reflexive throat clearing (involuntary action, like a cough, to clear the throat, often triggered by a sensation of something stuck or irritating in the throat) after intake. The evaluation indicated Resident 47 was at risk for aspiration and the recommendation was aspiration precautions with close supervision during oral feeding, and regular diet with moist puree consistencies. During a review of Resident 47's Nutritional Assessment, dated 3/11/2025, indicated Resident 47 had diet order for regular diet with pureed texture and thin liquid consistency. The assessment indicated Resident 47's risk factors were difficulty in swallowing, coughing or choking during meals, and complaints of difficulty or pain when swallowing. During a review of Resident 47's care plan, dated 3/19/2025, indicated Resident 47 had a potential for choking, aspiration, weight loss, poor intake related dysphagia manifested by impaired chewing/swallowing. The care plan indicated the goal was that Resident 47 would be able to chew food and tolerate oral intake without difficulty and the interventions included to provide alter diet consistency to accommodate the resident ' s chewing ability, assist during meals times, and provide diet as ordered. During a concurrent observation and interview on 3/25/2025 at 12:30 PM with Resident 47's Family Member (FM) 1 in the resident's room, FM 1 assisting Resident 47 to eat food brought from home with no facility staff present, a facility's lunch tray was observed at Resident 47's bedside. FM 1 stated, she had been preparing food for Resident 47 and fed him every day for a year because the facility's puree food was too thick, and Resident 47 would gag and cough out if she tried to feed him the facility's food because the food would get stuck in his mouth. During a concurrent observation and interview on 3/25/2025 at 12:45 PM with Resident 47's FM 1 in the resident's room, FM 1 showed the surveyor Resident 47's lunch tray which was brought in by the facility. FM 1 stated, she did not know what was prepared by the facility. FM 1 stated, there was a portion of white puree food that looked like puree rice to her. FM 1 the food was sticking to the spoon without able to slide down and there were still lumps in the remaining white food. FM 1 then fed Resident 47. Resident 47 was observed chewing and constantly coughed out the spoonful of food when trying to swallow it. During an interview on 3/25/2025 at 12:55 PM with Certified Nurse Assistant (CNA) 2, CNA 2 stated, he had been working in the past 9 months and had been seeing Resident 47's family members brought in food to feed Resident 47 during breakfast, lunch and dinner every day. During an observation on 3/26/2025 at 12:55 PM with Resident 47's FM 1 in the resident's room, FM 1 was feeding Resident 47 with homemade food, no staffs was present in the resident's room. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 3/26/2025 at 1:05 PM with the Dietary Manager (DM) in Resident 47's room, Resident 47's lunch tray was observed while FM 1 was feeding Resident 47 with homemade food. The DM stated, based on their menu, Resident 47's lunch tray should have puree chicken, puree noodles and puree blended vegetables. The DM demonstrated a spoon test for puree consistency on Resident 47's lunch tray brought by the facility and stated that the consistency did not pass the test because the food should be thinner. The DM stated, Resident 47's food was too thick and was not in the correct consistency, which could create a potential that food could get stuck in the resident's mouth and potentially increase risk of choking. During an interview on 3/26/2025 at 2:43 PM with the facility's cook (Cook) in the kitchen, the [NAME] stated, she did not review and follow the facility's recipe when preparing for puree food. The [NAME] stated, she was trained by the previous DM and remembered how to make puree food. The [NAME] stated, after she completed making puree food, she would taste it and based on her experience, if the taste seemed like the right texture for her, the food was ready to be served. During an interview on 3/26/2025 at 4:32 PM with the facility's Registered Dietician (RD), the RD stated, it was very important that the [NAME] must always follow the facility's recipe when making puree food for the correct texture and consistency. The RD stated, due to risk of aspiration and choking, Resident 47 should always be provided with the correct diet texture and consistency. During a review of the facility's policy and procedure (P&P) titled, Therapeutic Diet Orders, dated 12/19/2022, indicated the facility provides all residents with foods in the appropriate form as prescribed by a physician, and/or assessed by the interdisciplinary team to support the resident's treatment/plan of care, in accordance with his/her goals and preferences. Therapeutic diets will be based on the resident's individual needs as determined by the resident's assessment. Therapeutic diets may be considered in certain situations but not limited to: swallowing difficulty.

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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. 46779 Based on observation, interview, and record review the facility failed to follow proper sanitation and safe food handling in accordance with the facility ' s policy and procedures by failing to ensure: 1. The scoop used for scooping flour was not on the top of the flour container and was stored in a plastic bag when not in use to limit exposure to potential contamination. 2. The dietary staff correctly conduct the calibration (correlating the readings of an instrument with those of a standard to check the instrument's accuracy) of the food thermometer used to readily identify the proper temperatures of the food being served. These deficient practices had the potential to result in cross contamination and food-borne illnesses (food poisoning) of the residents with symptoms including upset stomach, stomach cramps, nausea, vomiting, diarrhea and fever and can lead to other serious medical complications and hospitalization . and put residents at risk for foodborne illnesses (illness caused by food contaminated with bacteria, viruses, parasites, or toxins). Findings: 1. During a concurrent observation and interview on 3/25/2025 at 8:32 AM with the Dietary Manager (DM), in the kitchen dry storage room, a scoop with the white powdery residue was on the top of the flour container that was not placed in a plastic bag. The DM stated the scoop should be placed in a plastic bag to prevent potential contamination to the scoop and the flour that would be used for cooking for the residents. The DM stated the dietary staff who used last probably forgot to put the scoop back into the plastic bag this morning. 2. During a concurrent observation and interview on 3/26/2025 at 9:30 AM with the DM, the DM prepared a cup of ice water and submerged a digital thermometer ' s sensing area in the ice water. The DM removed the digital thermometer out of the ice water after the display screen read 39-degree Fahrenheit (a measurement unit for temperature). The DM stated the thermometer was calibrated as long as the thermometer reading was below 40-degree Fahrenheit. The DM stated this thermometer was used for checking the hot and cold food that were served to the residents. During an interview on 3/26/2025 at 9:35 AM with the DMA, the DMA stated the digital thermometer which was used to check the temperature of hot and cold food should be calibrated in the ice water and the reading should read 32-degrees Fahrenheit. The DMA stated the DM did not calibrate the thermometer correctly and could lead to inaccurate temperature measurement for the food that were served to the residents, and cause food poisoning. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility ' s policy and procedure (P&P), titled Food Safety and Food Storage, revised on 11/4/2024, the P&P indicated Foods and beverages shall be distributed and served to residents in a manner to prevent contamination and maintain food at the proper temperature and out of the Danger Zone, and All equipment used in the handling of food shall be cleaned and sanitized, and handled in a manner to prevent contamination. During a review of the facility ' s P&P, titled Calibrating Thermometers, dated 12/19/2022, the P&P indicated Dietary employees will use either the ice-point method . calibrate and verify the accuracy of food thermometers and To use the ice-point method: a. Prepare a 50/50 ice and water mixture. b. Submerge the sensor/probe of the thermometer a minimum of 2 inches into the solution until the needle stops moving and temperature has stabilized, about 30 seconds. c. Temperature measurement should be 32 Fahrenheit.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46779 Based on interview and record review, the QAPI committee (Quality Assurance and Performance Improvement committed are group of facility staff uses data-driven approach to improve the quality of care and services in healthcare settings) facility failed to systematically identify investigate, analyze and use data and information relating to monitoring and preventing adverse events (an untoward, undesirable and usually unanticipated event that causes death or serious injury, or the risk thereof) in the facility by collecting data and input from direct staffs, residents and responsible parties in accordance with the facility ' s policy and procedure by failing ensure: 1. A system in place to Identify, address and develop a written plan to ensure the dietary staff following the pureed food (food that has been blended, mashed, or strained until it's smooth and free of lumps, like applesauce or mashed potatoes, often used for those with difficulty chewing or swallowing) recipes when preparing pureed food for 30 residents of 30 residents who were prescribed with pureed diet. 2. A system in place to identify and investigate any possible adverse event of the possible or actual cause of one of one sampled resident (Resident 98) who expired from respiratory distress related to COPD, pulmonary hypertension. 3. A system in place to ensure determine that Resident 98 ' s POLST was implemented according to the resident ' s preference of end-of-life treatments. These deficient practices placed the residents at risk for adverse events including deaths that could have been prevented. In addition, the deficient practice had put the residents at risk poor nutrition to weigh loss or gain, and risk of chocking and aspiration (food enters the airway and affecting air exchange in the body) that could result in pneumonia (severe infection of the lungs) and/or death. Cross Reference to F802, F580 and F695. Findings: 1. During a kitchen observation on [DATE] at 10:46 AM, the dietary staff did not review and follow the recipe to ensure adequate measurement of thickener powder (powder like starch used to thicken the texture of food) were mixed when preparing the pureed food who were prescribed with pureed diet and were served pureed food that was pasty and thick in texture. During a concurrent observation and interview on [DATE] at 1:10 PM with the Dietary Manager (DM), the DM stated the dietary staff did not measure how much the thickener power was put into the pureed food when they were preparing them. The DM stated someone was supposed to check the final products to make sure texture of the food was correct, but she was not sure which dietary staff was the one in charge of checking the final product before the tray line and they did not have log of checking the textures of the food. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 2:11 PM with the Cook, the [NAME] stated she did not follow the pureed recipes and did not know if they had the pureed recipes available. The [NAME] stated she added the thickener powder by eyeballing the amount of thickener needed, instead of measure it, when preparing pureed food. The [NAME] stated she and the dietary manager would taste the pureed food and based on her experience to determine if the texture of the pureed food was right. During an interview on [DATE] at 4:18 PM with the Registered Dietitian (RD), the RD stated the dietary staff should follow the pureed recipes when preparing pureed food because following the recipe could ensure the food provides necessary nutrition for the resident ' s needs and ensure the food had right texture to prevent choking. During an interview on [DATE] at 2:40 PM with the Administrator (ADM), the ADM stated the dietary supervisor, and Registered Dietitian had mentioned the issue of the inappropriate texture of the pureed food to him more than three times in the past, but this issue had not been discussed in the QAPI and there was no written QAPI plan to address it. The ADM stated they should have discussed this issue during the QAPI and should have done something more effectively for it. 47467 2. On [DATE] at 3:09 PM, while onsite at the facility, the California Department of Public Health (CDPH) an Immediate Jeopardy situation (IJ, a situation in which the provider ' s noncompliance with one or more requirements of participation has caused or is likely to cause serious injury, harm, impairment, or death of a resident) was identified and called regarding the facility ' s failure to notify the physician regarding significant changes in Resident 98 ' s respiratory conditions and provide the necessary respiratory care and monitoring. 3. LVN 1 who was in charge of Resident 98 on [DATE] to [DATE] did not implemented Resident 98 ' s Physician Orders for Life-Sustaining Treatment (POLST, a portable medical order that communicates a patient's wishes for end-of-life care and treatment interventions) according to the resident ' s preferences. During an interview on [DATE] at 7 AM with LVN 1, LVN 1 stated, he was the charge nurse that took care of Resident 98 from 11 PM on [DATE] until the resident expired on [DATE] at 5:59 AM. LVN 1 stated, Resident 98 was alert, oriented and responsive at the beginning of his shift on [DATE], with oxygen saturation above 90% while receiving oxygen supplement at 3 LPM. LVN 1 stated around 5:30 AM, CNA 1 told him Resident 98 had a change in condition and breathing very slow and was very weak. LVN 1 stated he went to Resident 98's room, and Resident 98 opened his eyes but was very weak. LVN 1 stated he checked Resident 98's vital signs a few times but could not recall the results of the VS and he did not document the vital signs in Resident 98's clinical record. LVN 1 stated, he did not report Resident 98's change of condition to the Registered Nurse (RN) who was working during his shift on [DATE]. LVN 1 stated, he did not increase Resident 98's oxygen level as per physician's order because the resident had diagnosis of COPD. LVN 1 stated, he did not inform the physician when Resident 98's condition changed with oxygen saturation down to 88% and 70%. LVN 1 stated he informed Resident 98's physician after the resident passed away on [DATE]. LVN 1 stated, he did not know why he did not notify Resident 98's physician, call for help or call 911 when CNA 1 reported to him that Resident 98 was weak with slow breathing and a decrease in the resident's oxygen saturation. LVN 1 stated, Resident 98 expired less than one hour after he was notified by CNA 1 for Resident 98's weakness and slow breathing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055989	A. Building B. Wing	03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Manor	610 North Garfield Avenue Monterey Park, CA 91754

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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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the death certificate of Resident 98 indicated Resident 98 expired at the facility on [DATE] with the cause of death as cardiac dysrhythmia (abnormal or irregular heartbeat), acute respiratory distress and pulmonary hypertension. During an interview on [DATE] at 9:40 AM with the Director of Nursing (DON) stated, she did not investigate the possible cause of death of Resident 98 on [DATE]. The DON stated, after she was made aware of the incident by the surveyor, she then proceeded to investigate and interviewed Licensed Vocation Nurse (LVN) 1 and Certified Nurse Assistant (CNA) 1, who took care of Resident 98 on [DATE] from 11 PM until the resident expired on [DATE] at 5:59 AM, to identify possible cause of death and determine if the staffs implemented preventive actions per facility ' s policy and procedures. During an interview on [DATE] at 3:10 PM with the Administrator (ADM), the ADM stated, he should be made aware of any type of adverse event in the facility. The ADM stated, he was not informed about Resident 98 ' s death. The ADM stated, the DON was supposed to be in charge of the daily census and the number of residents that expired or transferred to the hospital daily. The ADM stated, due to the lack of oversight from the DON, the incident was not identified as an adverse event and was not brought to his attention. The ADM stated, Resident 98 ' s death should had been identified with possible causes and determine if there was a written plan that should have been created and implemented when Resident 98 expired on [DATE]. During a review of the facility ' s policy and procedure (P&P) titled, Quality Assurance and Performance Improvement (QAPI, a data-driven approach to improve the quality of care and services in healthcare settings), revised [DATE], the P&P indicated the following: -It is the policy of the facility to develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life and address all the care and unique services the facility provides. -The facility will maintain documentation and demonstrate evidence of its ongoing QAPI program. Documentation may include but is not limited to: systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events. -The facility maintains procedures for feedback, data collection systems, and monitoring, including adverse event monitoring. The facility draws data from multiple sources, which may include but not limited to: incident/accident reports, including reports of adverse events, paper and electric medical records, medical record audits. -Department heads are responsible for ensuring data is collected appropriately and performance metrics are monitored in accordance with facility policy. Sample data collection forms are maintained with the written QAPI plan. -Facility staff monitor residents for medical errors and adverse events in accordance with established procedures for the type of adverse event. An investigation will be conducted on each identified medical error or adverse event to analyze cause. Preventive actions and mechanisms will be implemented to prevent medical errors and adverse events, including feedback and educations. Monitoring will be conducted to ensure desired outcomes are achieved and sustained.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055989	A. Building B. Wing	03/28/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47467 Based on observation, interview, and record review, the facility failed to ensure a clean and sanitary environment for six out of 20 sampled residents(Residents in room [ROOM NUMBER] and 5) when a rusty and dirty commode was found in shared bathroom of room [ROOM NUMBER] and 5. This failure resulted in unsanitary environment and potential to lower the residents' quality of life. Findings: During an observation on 3/25/2025 at 9:52 AM in the shared the restroom between room [ROOM NUMBER] and 5, a dirty and rusty commode was observed. During an interview on 3/25/2025 at 10 AM with Housekeeper (HK) 1, HK 1 stated, she was not aware and did not receive any report that the commode was dirty and rusty. HK 1 stated, HK 1 supposed to check all equipment and report to the Maintenance Supervisor (MS) to replace dirty and rusty commode. HK 1 stated, she could not recall if she checked shared restrooms between room [ROOM NUMBER] and 5 to make sure all equipment was clean and functional. During a concurrent observation and interview on 3/25/2025 at 10:10 AM with the MS in the shared restroom between room [ROOM NUMBER] and 5, a dirty and rusty commode was observed. The MS stated, the commode was shared by all six residents residing in room [ROOM NUMBER] and 5. The MS stated, by the appearance of the commode, it should have been dirty and rusty for at least a few days. The MS stated, he was responsible to make sure all the facility ' s equipment were sanitary, clean, and functional. The MS stated, he would replace a new commode right away. During a review of the facility ' s policy and procedure (P&P) titled, Safe and Homelike Environment, revised 12/19/2022, the P&P indicated, sanitary includes, but is not limited to, preventing the spread of disease-causing organisms by keeping resident care equipment clean and properly stored. Resident care equipment includes, but is not limited to, equipment used in the completion of the activities of daily living. During a review of the facility ' s P&P titled, Preventative Maintenance Program, revised 12/19/2022, the P&P indicated, a preventative maintenance program shall be developed and implemented to ensure the provision of safe, sanitary, and comfortable environment for residents, staff, and the public. The Maintenance Director is responsible for developing and maintaining a schedule of maintenance services to ensure that the buildings, grounds, and equipment are maintained in a safe and operable manner.