STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055992	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Covina Healthcare Center	850 S. Sunkist Ave. West Covina, CA 91790

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40438 Based on observation, interview, and record review, the facility failed to provide reasonable accommodation of needs for two of two sampled residents (Residents 29 and 80) by failing to ensure the resident's call lights (an alerting device for nurses or other nursing personnel to assist a patient when in need) were within reach and appropriate to the resident's physical ability. These deficient practices had the potential for Residents 29 and 80 not to receive necessary care or delayed services to meet their needs. Findings: a. During a review of Resident's 29 Admission Records (AR), the AR indicated Resident 29 was admitted to the facility on [DATE] with diagnoses that included Peripheral Vascular Disease (PVD, a slow progressive narrowing of the blood flow to the arms and legs) and osteoarthritis (a progressive disorder of the joints, caused by gradual loss of cartilage). During a review of Resident 29's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 9/5/2024, the MDS indicated Resident 29 had moderately impaired cognition (ability to understand). Resident 29 required supervision or touching assistance (helper did verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with oral hygiene and partial/moderate assistance (helper did less than half the effort) with toileting hygiene, shower, upper and lower body dressing and personal hygiene. During a review of Resident 29's untitled Care Plan (CP), revised on 9/26/2024, the CP indicated Resident 29 was at risk for self-care deficit and unavoidable falls. The CP interventions included to place the resident's call light for assistance within reach and resident needed prompt response to all request for assistance. During a concurrent observation and interview on 9/30/2024 at 10:11 am with Licensed Vocational Nurse 5 (LVN 5) inside Resident 29's room, Resident 29 was sitting in a wheelchair at the rear part of the bed, holding the bed remote control mistaken as the call light. Resident 29's call light was on the upper part of the bed. Resident 29 stated, I could not reach my call light. LVN 5 stated, the resident's call light should be placed next and close to the resident so the resident could reach and use to call for help when needed for safety. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/2/2024 at 9:53 am with the facility's Director of Nursing (DON), the DON stated, resident's call light should be placed on the strong arm/hand of the resident to use for assistance and during emergency. During a review of the facility's Policy and Procedure (P&P) titled, Call Light, revised January 2024, the P&P indicated, Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor. Upon admission and as needed, resident call light shall be within reach. Answer the resident call system in a timely manner. 40037 b. During a review of Resident 80's AR, the AR indicated Resident 80 was admitted to the facility on [DATE] with diagnoses that including hypertension (HTN-high blood pressure) and lack of coordination. During a review of Resident 42's MDS dated [DATE], the MDS indicated Resident 80 had clear speech, usually understood others and made self-understood. The MDS indicated Resident 80 required substantial/maximal assistance (helper does more than half the effort, helper lifts or holds trunk or limbs and provides more than half the effort) for toilet hygiene and toilet transfer, and partial/moderate assistance (helper does less than half the effort) for sit to lying and chair/bed-to-chair transfer. During a concurrent observation and interview on 9/30/2024 at 10:45 am, in Resident 80's room, Resident 80 was lying in bed. Resident 80's call light was coiled on the wall at the back of Resident 80's head of bed. Resident 80 stated, Resident 80 looked around and did not know where the call light was. Resident 80 saw the call light after being pointed out and stated Resident 80 could not reach the call light. Resident 80 stated, Resident 80 needed to use the call light to ask for help. Treatment Nurse (TN) stated, Resident 80 could not reach the call light while lying in bed. TN stated, the resident's call light should be within reach of the resident to use to call staff for help when needed. TN stated, residents could get hurt trying to get out of bed by themselves if the call light was not within reach. During a review of the facility's Policy and Procedure (P&P) titled, Call Light, revised 1/2024, the P&P indicated Residents are provided with a means to call staff for assistance throught a communication system that directly calls a staff member or a centralized workstation. Upon admission and as needed, resident call light shall be within reach.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40438 Based on interview and record review, the facility failed to ensure the resident's Advance Directive (AD, a legal document indicating resident preference on end-of-life treatment decisions) was discussed, written information was provided to the residents and/or responsible parties and current copy was in the medical chart for three of three sampled residents (Residents 12, 54 and 78) consistent with the facility's policy and procedure on advance directives. These failures had the potential for facility staff to provide medical treatment and services against the resident's will. Findings: a. During a review of Resident 12's Admission Records (AR), the AR indicated Resident 12 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD, a chronic lung disease causing difficulty in breathing) and asthma (a condition in which a person's airways become inflamed, narrow and swollen, which makes it difficult to breathe). During a review of Resident 12's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 8/6/2024, the MDS indicated Resident 12 had intact cognition (ability to understand) and required substantial/maximal assistance (helper did more than half the effort) with oral and toileting hygiene, shower, upper and lower body dressing and personal hygiene. During a concurrent interview and record review on 10/1/2024 at 9:42 AM with the admission coordinator (AC), Resident 12's Physician Orders for Life-Sustaining Treatment (POLST, a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done to the resident at the end-of-life) dated 8/19/2017 and AD were reviewed. AC stated, Resident 12's POLST indicated Resident 12 did not have an AD. AC stated Resident 12 had no documented evidence that assistance was offered or declined to formulate an AD. AC stated an AD needed to be done every time a resident was admitted to the facility to determine the resident's desires and wishes on how to care for the resident and which representative to make decision on the resident's behalf. b. During a review of Resident 54's AR, the AR indicated Resident 54 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing) and dementia (a progressive state of decline in mental abilities). During a review of review of Resident 54's History and Physical (H&P) dated 7/10/2024, the H &P indicated Resident 54 did not have the capacity to understand and make decisions. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 54's MDS dated [DATE], the MDS indicated Resident 54 had severely impaired cognition and required substantial/maximal assistance with eating, oral hygiene, upper and lower body dressing, and personal hygiene. The MDS indicated Resident 54 was dependent (helper did all of the effort, resident did none of the effort to complete the activity) with shower and putting on/taking off footwear. During a concurrent interview and record review on 10/1/2024 at 9:50 am with the AC, Resident 54's POLST dated 7/11/2024 and AD were reviewed. The POLST indicated Resident 54 did not have an AD. AC stated Resident 54 had an AD acknowledgement form which was not signed by the resident's conservator (appointed by a judge to act or make decisions for the person who needs help) since admission. AC stated the AD should be filled out completely and signed every time the resident was admitted to the facility. During an interview on 10/2/2024 at 10:01 am with the facility's Director of Nursing (DON), the DON stated, AD should be filled out with every admission and as needed for the staff to determine the kind of care and treatment the resident preferred and wished while in the facility. During a review of the facility's Policy and Procedure (P&P) titled, Advance Directives, revised September 2023, the P&P indicated, If the resident or representative indicates that he or she has not established advance directives, the facility staff will offer assistance in establishing advance directives. The resident or representative is given the option to accept or decline assistance, and care will not be contingent on either decision. 40037 c. During a review of Resident 78's AR, the AR indicated Resident 78 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included dysphagia (difficult swallowing) and chronic congestive heart failure (CHF-a heart disorder which causes the heart to not pump blood efficiently). During a review of Resident 78's MDS dated [DATE], the MDS indicated Resident 78 had clear speech, usually able to understand others and made self-understood. The MDS indicated Resident 8 had impaired cognition (ability thinking, learning, and understanding). The MDS indicated Resident 78 was dependent (helper does all of the effort; resident does none of the effort to complete the activity) for toilet hygiene and sit to lying. During a review of Resident 78's POLST dated 9/24/2024, the POLST did not indicate whether or not Resident 78 had executed an AD. During an interview on 9/30/2024 at 3:02 pm, Social Service Director (SSD) stated, the POLST form was the only form the facility used to identify if a resident had executed an AD. The SSD stated, there was no documentation for Resident 78 indicating if Resident 78 had an AD. The SSD stated, it was important to identify if Resident 78 had an AD for staff to determine the treatment options for the resident. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled Advance Directives, revised 9/2023, the P&P indicated, the social services director of designee inquires of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives during the initial assessment.

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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** 40438 Based on observation, interview and record review, the facility failed to develop a specific and individualized person-centered care plan to meet the resident's needs for two of two sampled residents (Residents 45 and 55). a. A care plan was not developed for Resident 45 with dementia (a progressive state of decline in mental abilities). b. A care plan was not developed for Resident 55 for the use of black box medications - Furosemide (water pill that treats fluid retention) and Tylenol #3 with Codeine 3 (a combination narcotic drug that is used to relieve mild to moderate pain). These failures had the potential to result in inconsistent implementation of the care to Residents 45 and 55. Findings: a. During a review of Resident 45's Admission Records (AR), the AR indicated Resident 45 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included dementia (a progressive state of decline in mental abilities), anxiety (intense, excessive, and persistent worry and fear about everyday situations) and depression (loss of pleasure or interest in activities for long period of time). During a review of Resident 45's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 7/23/2024, the MDS indicated Resident 45 had severely impaired cognition (ability to understand) and required substantial/maximal assistance (helper did more than half of the effort to complete the activity) with oral and toileting hygiene, shower, upper and lower body dressing, and personal hygiene. During a concurrent interview and record review on 10/1/2024 at 4:13 pm with Registered Nurse Supervisor 1 (RN Sup 1), the care plans for Resident 45 were reviewed. RN Sup 1 stated, there was no care plan developed for dementia for Resident 45. RN Sup 1 stated care plan to address dementia should be developed for Resident 45 to address the problems and monitor if interventions were effective. During an interview on 10/2/2024 at 10:04 am with the Director of Nursing (DON), the DON stated a care plan should be developed for Resident 45 with dementia upon admission, and update during changes of condition, based on diagnosis, medications, assessment, treatment, and diet. The DON stated care plans were updated quarterly and as needed for the staff to determine the interventions and treatment necessary for the care of the resident. During the review of the facility's Policy and Procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, revised March 2023, the P&P indicated, The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	49252 b. During a review of Resident 55's AR, the AR indicated the resident was admitted to the facility on [DATE] with diagnoses that included End Stage Renal Disease (ESRD -irreversible kidney failure). During a review of Resident 55's History and Physical (H&P) dated 7/3/2024, the H&P indicated Resident 55 had ESRD and was on dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed to function) and Congestive Heart Failure (CHF - a heart disorder which causes the heart to not pump the blood efficiently). During a review of Resident 55's MDS dated [DATE], the MDS indicated Resident 55 had moderately impaired cognition. During an observation on 9/30/24 at 10:29 am in Resident 55's room, Resident 55 was sitting in bed with swelling to both legs. During a review of Resident 55's Order Summary Report (OSR) dated 7/11/2024, the Order Summary Report indicated orders for the following medications with black box warnings (a black box warning indicates that the drug carries a significant risk of serious or even life-threatening adverse effects and was the strongest warning that the U.S. Food and Drug Administration): 1. Furosemide Oral Tablet 40 milligrams (mg- metric unit of measurement), give two tablets by mouth two times a day for edema (swelling from fluid trapped in the tissues). The order was written on 7/1/2024. 2. Tylenol with Codeine #3 Oral Tablet 300-30 mg (Acetaminophen with Codeine); give one tablet by mouth every six hours as needed for pain management. The order was written on 7/2/2024. During a review of Resident 55's Medication Administration Records (MAR) dated 10/1/2024 through 10/31/2024, the MAR indicated Resident 55 was last administered Furosemide 40 mg oral tablets for edema on 10/2/2024 at 9:00 am and Tylenol with Codeine #3 oral tablet 300-30 mg for pain management on 10/2/2024 at 12:45pm. During a concurrent interview and record review on 10/2/2024 at 3:18 pm with Registered Nurse Supervisor 1 (RN Sup 1), Resident 55's care plan was reviewed. The care plan did not indicate/address the regularly scheduled and as needed black-box medications of Furosemide and Tylenol with Codeine #3 for Resident 55. RN Sup 1 stated, Furosemide and Tylenol with Codeine #3 were high risk drugs that could have contraindications or side effects that would affect Resident 55 and necessitated a care plan. RN 1 further stated, without a care plan, nursing staff were unable to closely monitor for side effects, implement proper interventions, set goals, and monitor the resident's progress on these medicines (Furosemide and Tylenol with Codeine #3). During an interview on 10/3/2024 at 9:50 am with the Director of Staff Development (DSD), the DSD stated care plans were needed for medications with black box warnings and were significant because they set goals and timelines for a resident's care. The DSD stated, without care plans for Furosemide and Tylenol with Codeine #3 staff would not know the needed care for the resident, preventing staff from providing the best care possible. The DSD further stated, each resident should have a comprehensive person-centered care plan individualized to their needs. (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 the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, last revised 3/2023, the P&P indicated, a comprehensive, person-centered care plan included measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs and was developed and implemented for each resident. The comprehensive, person-centered care plan also described the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, and would reflect currently recognized standards of practice for problem areas and conditions.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 14330 Based on observation, interview and record review, the facility failed to coordinate care with hospice (compassionate care for people near the end of life) provider for one of two sampled residents (Resident 34) by failing to ensure the Hospice Registered Nurse (HRN) visited Resident 34 on 9/19/24, 9/23/24 and 9/30/24, as scheduled. This deficient practice placed Resident 34 at risk of not receiving appropriate care in a timely manner. Findings: During a review of Resident 34's Admission Record (AR), the AR indicated the facility readmitted the resident on 6/28/24, with diagnoses that included Alzheimer's disease (a disease characterized by a progressive decline in mental abilities) and heart failure (also known as congestive heart failure [CHF], is a condition that develops when the heart doesn't pump enough blood for body needs). During a review of Resident 34's Physician Order Sheet (POS) dated 6/28/24, the POS indicated an order for Hospice 1 for diagnosis of CHF. During an observation on 9/30/24 at 10:46 a.m., Resident 34 was sitting in the wheelchair watching television in her room, alert and coherent. Resident 34 had an ongoing oxygen inhalation at four liters (unit of measurement) per minute of oxygen through nasal cannula (a flexible soft tube that delivers extra oxygen through a tube and into the nose). During a concurrent interview and record review on 10/1/24 at 3:38 p.m., the Director of Nursing (DON) stated there was no documented evidence of HRN visit notes for Resident 34 on 9/19/24, 9/23/24 and 9/30/24. The Hospice Sign-In Sheet indicated HRN came to see Resident 34 in the facility on those dates (9/19/24, 9/23/24 and 9/30/24). The DON stated the DON was responsible for monitoring/auditing the scheduled visits of Hospice staff to ensure visit notes for the Hospice resident was done the DON failed to do so. According to the DON, it was important for HRN to document the assessed care needs of Resident 34 and to collaborate with the facility staff regarding Hospice services provided to Resident 34. During a review of the facility's Policy and Procedures (P&P) titled, Hospice Program dated 7/2023, the P&P indicated the facility's DON was designated to coordinate the care provided by the Hospice staff to the Hospice resident in the facility.

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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. 14330 Based on observation, interview, and record review, the facility failed to promote healing and prevent development of pressure ulcer/injury (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) for one of one sampled resident (Resident 14) by failing to ensure Resident 14 was not lying on the site of the pressure ulcer and was repositioned every two hours while in bed. This deficient practice placed Resident 14 at risk for further skin breakdown, prevent healing of the wound and/or worsen the pressure ulcer. Findings: During a review of Resident 14's Admission Record (AR), the AR indicated the facility readmitted the resident on 2/22/23, with diagnoses that included diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and heart failure (also known as congestive heart failure [CHF], is a condition that develops when the heart doesn't pump enough blood for body needs). During a review of Resident 14's Wound Management Assessment (WMA) dated 2/22/23, the WMA indicated Resident 14 was readmitted to the facility without a pressure ulcer. During a review of Resident 14's WMA dated 3/15/23, the WMA indicated Resident 14 had Stage 2 pressure ulcer of the left buttock and was healed on 3/31/23. During a review of Resident 14's Change in Condition Evaluation (CCE) dated 9/26/24, the CCA indicated Resident 14 had a reopened Stage 2 pressure ulcers of the left and right buttocks. The left buttock pressure ulcer measured 1.5 centimeter (cm-unit of measurement) in length (L) x 0.8 cm in width (W), and the right buttock pressure ulcer measured 2.5 cm (L) x 2 cm (W). During a review of Resident 14's Care Plan (CP) titled, Pressure Ulcer Stage 2 on left buttock and right buttock dated 9/26/24, the CP indicated Resident 14 needed to be turned and repositioned at least every two hours in bed and whenever necessary. During a concurrent observation and interview on 9/30/24 at 10:51 a.m., Resident 14 was lying on his back in bed. Certified Nursing Assistant 1 (CNA1) was present in Resident 14's room. CNA1 stated Resident 14 should be turned and repositioned in bed on right side lying position, back and left side lying position every two hours to heal the pressure ulcer by relieving the pressure off the wound. During an observation on 9/30/24 at 11:52 a.m., 12:55 p.m., and 1:30 p.m., Resident 14 was lying on his back in bed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 9/30/24 at 2:30 p.m., Resident 14 was lying on his back in bed. CNA1 stated CNA 1 was unable to turn and reposition Resident 14 in bed every two hours because CNA 1 was busy providing care to other residents. CNA1 stated CNA 1 repositioned Resident 14 on his back after cleaning Resident 14 at 10 a.m., today (9/30/24). CNA1 further stated Resident 14's pressure ulcer would get bigger if the resident was lying on his back for a long period of time due to poor circulation in the wound. During observations on 10/1/24 at 8:02 a.m., 9:17 a.m., and 10:15 a.m., Resident 14 was lying on his back in bed. During a concurrent observation and interview on 10/1/24 at 11 a.m., Resident 14 was lying on his back in bed. CNA 6 stated Resident 14 should not be repositioned on the site of the pressure ulcer because the pressure ulcer would get worse due to pressure in the wound. During the treatment observation on 10/2/24 at 9:10 a.m., Resident 14 was observed with a Stage 2 pressure ulcer of the right and left buttocks. The right buttock pressure ulcer measured 5 cm (L) x 2.5 cm (W), and the left buttock measured 4.5 cm (L) x 3.5 cm (W). The wound bed (base of the wound) of both buttocks were red in color, no depth.

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40438 Based on observation, interview, and record review, the facility failed to provide necessary care and services for gastrostomy tube (GT, a tube inserted through the abdomen that delivers nutrition directly to the stomach) site as ordered by the physician and as indicated in the plan of care for two of two sampled residents (Residents 45 and 54). These failures had the potential for complications related to tube feedings for Residents 45 and 54. Findings: a. During a review of Resident 45's Admission Records (AR), the AR indicated Resident 45 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included dementia (a progressive state of decline in mental abilities), anxiety (intense, excessive, and persistent worry and fear about everyday situations), depression (low mood or loss of pleasure or interest in activities for long period of time) and gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach). During a review of Resident 45's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 7/23/2024, the MDS indicated Resident 45 had severely impaired cognition (ability to understand) and required substantial/maximal assistance (helper did more than half of the effort to complete the activity) with oral and toileting hygiene, shower, upper and lower body dressing and personal hygiene). The MDS indicated Resident 45 required feeding tube for nutrition. During a review of Resident 45's Order Summary Report (OSR) dated 9/28/2024, the OSR indicated Resident 45 had a physician's order for licensed staff to cleanse the peg-tube site with normal saline (NS), pat to dry and cover with T-drain sponge and secure with tape every day. During a review of Resident 45's Treatment Administration Record (TAR) for September 2024, the TAR indicated Resident 45's peg-tube site dressing was changed on 9/29/2024 and 9/30/2024. During a review of Resident 45's Care Plan (CP) dated 9/30/2024, the CP indicated Resident 45 was at risk for irritation and/or infection related to the GT site. The CP interventions included to provide treatment as ordered and call the medical doctor (MD) if ineffective. During a concurrent observation and interview on 9/30/2024 at 11:27 am with the Infection Preventionist Nurse (IPN- a nurse who helps prevent and identify the spread of infectious disease in the healthcare environment) Resident 45 had a GT site with T-drain dressing dated 9/28/2024. The IPN stated GT site dressing should be changed daily to prevent infection around the site and the stoma (opening). b. During a review of Resident 54's AR, the AR indicated Resident 54 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing) and dementia. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 54's History and Physical (H&P) dated 7/10/2024, the H &P indicated Resident 54 did not have the capacity to understand and make decisions. During a review of Resident 54's MDS dated [DATE], the MDS indicated Resident 54 had severely impaired cognition and required substantial/maximal assistance with eating, oral hygiene, upper and lower body dressing, and personal hygiene. The MDS indicated Resident 54 was dependent (helper did all of the effort, resident did none of the effort to complete the activity) with shower and putting on/taking off footwear. During a review of Resident 54's OSR dated 7/10/2024, the OSR indicated Resident 54 had a physician's order for licensed staff to cleanse peg-tube site with normal saline and apply dry dressing daily. During a review of Resident 54's TAR for September 2024, the TAR indicated Resident 54's GT dressing was changed on 9/29/2024 and 9/30/2024. During a concurrent observation and interview on 9/30/2024 at 10:21 am with Certified Nurse Assistant 2 (CNA 2) and CNA 3 inside Resident 54's room, Resident 54 had a GT site with T-drain dressing dated 9/28/2024. Both CNAs stated, Resident 54's GT site dressing was not clean and was falling off/coming out. During an interview on 9/30/2024 at 11:34 am with the facility's Treatment Nurse (TN), TN stated GT site dressing should be changed daily including the weekends to keep away growth of bacteria on the GT site. During the interview on 10/2/2024 at 9:58 am with the facility's Director of Nursing (DON), the DON stated GT site should be checked every day for any signs and symptoms of infection and GT dressing should be changed as ordered by the physician to prevent infection. During a review of the facility's undated Policy and Procedure (P&P) titled, Gastrostomy/Jejunostomy Site Care, the P&P indicated, Perform dressing changes as per physician orders and as needed.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40037 Based on observation, interview, and record review, the facility failed to assure one of one sampled resident (Resident 185) received care and service for parenteral antibiotic (a drug used to treat infections caused by bacteria and other microorganisms) consistent with professional standards of practice. The PICC line dressing was not labeled with date indicating when the dressing was applied. This failure had the potential to result in infection to the resident and worsen the resident's health condition. Findings: During a review of Resident 185's Admission Record (AR), the AR indicated Resident 185 was admitted to the facility on [DATE], with diagnoses that included sepsis (a life-threatening blood infection) and hypertension (high blood pressure). During a review of Resident 185's Physician Order Summary Report (POSR) dated 9/20/2024, the POSR indicated the physician ordered for licensed staff to change Resident 185's PICC line dressing on day shift every Friday. During a review of Resident 185's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 9/24/2024, the MDS indicated Resident 185 had clear speech, usually understood others, and sometimes made self-understood. The MDS indicated Resident 185 was dependent (helper does all of the effort) for personal hygiene and chair/bed-to-chair transfer. During an observation on 9/30/2024 at 10:07 am, in Resident 185's room, Resident 185 was sitting up in a wheelchair next to the bed. There was a PICC line at Resident 185's right upper arm with dressing gauze covering the insertion site. The PICC line dressing was not labeled with date indicating when the dressing was applied. During a concurrent interview with Registered Nurse Supervisor 1 (RN Sup 1), RN Sup 1 stated, Resident 185 was on Cefazolin Sodium (antibiotic) intravenously daily because Resident 185 had sepsis. RN Sup 1 stated, Resident 185's PICC dressing should be changed and labeled with date so that staff know when the next time to change the dressing. RN Sup 1 stated, PICC line dressing should be changed every seven days or as needed when soiled for infection control purposes. RN Sup 1 stated this measure was for resident's health and safety. RN Sup 1 stated, staff should document in the resident's medical record after each time PICC line dressing was changed. During a review of the facility's Policy and Procedure titled PICC Dressing Change, dated 3/2023, the P&P indicated Change catheter securement device every 7 days and PRN (as needed). Label dressing with date, time, and nurse's initials.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 14330 Based on observation, interview, and record review, the facility failed to provide necessary care and services for one of one sampled resident (Resident 34) on oxygen therapy (treatment that provides supplemental, or extra oxygen) consistent with professional standards of practice, by failing to follow the physician's order to provide two liters of oxygen through nasal cannula (a flexible soft tube that delivers extra oxygen through a tube and into the nose) to Resident 34. This deficient practice placed Resident 34 at risk for difficulty of breathing and respiratory complications. Findings: During a review of Resident 34's Admission Record (AR), the AR indicated the facility readmitted the resident on 6/28/24, with diagnoses that included Alzheimer's disease (a disease characterized by a progressive decline in mental abilities) and heart failure (also known as congestive heart failure [CHF], is a condition that develops when the heart doesn't pump enough blood for body needs). During a review of Resident 34's Physician Order Sheet (POS) dated 6/28/24, the POS indicated an order for licensed staff to provide Resident 34 two liters (unit of measurement) per minute of oxygen through nasal cannula continuously every shift for shortness of breath. During a review of Resident 34's Care Plan (CP) for oxygen therapy dated 8/21/24, the CP indicated Resident 34 will be free of symptoms of respiratory distress by providing continuous oxygen at two liters per During observations on 9/30/24 at 10:46 a.m., 11:45 a.m. and at 2:20 p.m., Resident 34 had ongoing oxygen inhalation at four liters per minute through nasal cannula. During an interview on 10/1/24 at 10:15 a.m., Licensed Vocational Nurse 4 (LVN 4) stated LVN 4 forgot to check if Resident 34's oxygen flow rate was at two liters per minute through nasal cannula when LVN 4 made rounds on 9/30/24 at around 7:25 a.m. LVN 4 stated excessive oxygen inhalation could damage the lungs that would cause difficulty of breathing due to oxygen toxicity (breathing in too much supplemental oxygen). During a review of the facility's Policy and Procedure (P&P) titled, Oxygen Administration dated 2/2024, the P&P indicated oxygen therapy needed to be administered as ordered by the physician to provide safe oxygen administration.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40037 Based on interview and record review, the facility failed to perform post (after) hemodialysis (HD, a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed to function) assessment for one of two sampled residents on HD (Resident 186). This failure had the potential to placed Resident 186 at risk for complications from the hemodialysis site. Findings: During a review of Resident 186's Admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE] with diagnoses that included End Stage Renal Disease (ESRD, irreversible kidney failure), dependence on renal dialysis (HD) and hypotension (low blood pressure). During a review of Resident 24's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 9/25/2024, the MDS indicated Resident 186 had clear speech, usually understood others, and made self-understood. Resident 186 required substantial/maximal (helper does more than half the effort) assistance for toileting hygiene, roll left and right, and chair/bed-to-chair transfer. During a review of Resident 186's Dialysis Communication Record (DCR, a medical record used to document a patient's status between the facility and dialysis center including patient information, treatment information, vital signs before, during and after HD) dated 9/30/2024, there was no documentation for post dialysis assessment on 9/30/2024. The post dialysis assessment for 9/30/2024 was left blank. During an interview on 10/1/2024 at 1:56 pm, the Director of Nursing (DON) stated, Resident 186's DCR should be completed right after the resident returned to the facility to ensure the HD access site was free from bleeding and the resident's vital signs were within the resident's baseline. The DON stated all residents on HD should be assessed before and after HD session to ensure the access site dressing was intact without bleeding and there no change of resident's vital signs/condition. During a review of the facility's undated Policy and Procedure (P&P) titled End-Stage Renal Disease, Care of a Resident with, the P&P indicated, Residents with End-Stage Renal Disease (ESRD) will be cared for according to currently recognized standards of care. Staff caring for residents with ESRD, including residents receiving dialysis care outside the facility, shall be trained in the care and special needs of these residents, including the type of assessment data that is to be gathered about the resident's condition on a daily or per shift basis.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40438 Based on observation, interview, and record review, the facility failed to attempt the use of appropriate alternatives to grab bars before its installation for two of two sampled residents (Residents 35 and 14). These deficient practices placed Residents 35 and 14 at risk for entrapment and injury from the use of bedrails. Findings: a. During a review of Resident 35's Admission Records (AR), the AR indicated Resident 35 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included hemiplegia (total paralysis of the arm, leg and trunk on the same side of the body), hemiparesis (weakness on one side of the body), and depression (loss of pleasure or interest in activities for long period of time). During a review of Resident 35's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 7/30/24, the MDS indicated Resident 35 had intact cognition (ability to understand). The MDS indicated Resident 35 was dependent (helper did all of the effort, resident did none of the effort to complete the activity) with oral and toileting hygiene, shower and lower body dressing and required substantial/maximal assistance (helper did more than half the effort) with upper body dressing and personal hygiene. During an observation on 9/30/24 at 10:40 am inside Resident 35's room, Resident 35 was lying in bed on her back with grab bars up on both sides of the bed. Resident 35 was alert and coherent. During a concurrent interview and record review on 10/2/24 at 11:28 am with the Director of Nursing (DON), Resident 35's medical records (chart) and PointClickCare (PCC, a cloud-based software used in long-term and post-acute care facilities) were reviewed. The DON stated, there was no documented evidence that appropriate alternatives were attempted and did not meet the needs of Resident 35 before grab bars were installed. The DON stated all less restrictive and appropriate alternatives should be exhausted and failed prior to the use of bedrails or grab bars to prevent potential entrapment and injury to the resident. 14330 b. During a review of Resident 14's AR, the AR indicated the facility readmitted the resident on 2/22/23, with diagnoses that included diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and heart failure (also known as congestive heart failure [CHF], a condition that develops when the heart doesn't pump enough blood for body needs). (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and concurrent interview on 9/30/24 at 10:51 a.m., and 10/1/24 at 8:02 a.m., Resident 14 was lying on his back in bed with grab bars up on both middle sides of the bed frame. The grab bars measured approximately one foot in length with an open gap between the end of the grab bar approximately one foot in width. Resident 14 stated he was not using the grab bars because he cannot turn and reposition in bed by himself. Resident 14 did not know why the grab bars were always up. During a concurrent interview and record review on 10/3/24 at 11:26 a.m., the Director of Nursing (DON) stated grab bars were made of metal material and are accident hazard when used for Resident 14. The DON stated, the grab bars could cause injury and/or death when Resident 14's limb or head was entrapped in between the open space of the grab bar. The DON stated, Resident 14 could have fractured limb, skin bruises or laceration from bumping on the grab bars. The DON stated, Resident 14's medical record did not contain information that appropriate alternatives to grab bars were attempted and evaluated if it did not meet the needs of Resident 14 before the grab bars were applied. During a review of the facility's policy and procedure (P&P) titled, Bed safety and Bed Rails, revised August 2023, the P&P indicated, Bed rails include side rails, safety rails and grab/assist bars. The use of bedrails or side rails (including temporarily raising the side rails for episodic use during care) is prohibited unless the criteria for use of bed rails have been met, including attempts to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent. Prior to the installation or use of a side or bed rail, alternatives to the use of side or bed rails are attempted.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. 40037 Based on observation, interview, and record review, the facility failed to ensure 13 out of 38 rooms (Rooms 14, 15, 16, 17, 18, 19, 27, 28, 29, 36, 37, 38 and 39) met the square footage requirement of 80 square feet (sq. ft.) per resident in multiple resident rooms. This deficient practice had the potential to adversely affect the residents' health, safety, and quality of life. Findings: During an observation on 10/2/2024, from 11:28 am to 1 pm, Rooms 14, 15, 16, 17, 18, 19, 27, 28, 29, 36, 37, 38 and 39 did not meet the minimum requirement of 80 sq. ft. per resident in multiple resident rooms. The residents in these rooms were able to ambulate freely and/or maneuver in their wheelchairs freely. Nursing staff had enough space to provide care to these residents with dignity and privacy. There was space for beds, side tables, dressers, and other medical equipment. During an interview with the Administrator (ADM) on 10/2/2024, at 1:03pm, regarding Rooms 14, 15, 16, 17, 18, 19, 27, 28, 29, 36, 37, 38 and 39 that did not meet the minimum requirement of 80 sq. ft. per resident in multiple resident rooms, the ADM stated the ADM would submit a room wavier for these resident rooms. During a review of the facility's room waiver request dated 10/1/2024, the room waiver request indicated there was ample room to accommodates wheelchairs and other medical equipment, as well as space for mobility and movement of ambulatory residents. There was adequate space for nursing care, and the health and safety of residents occupying these rooms are not in jeopardy. These rooms are in accordance with the special needs of the residents, and do not have an adverse effect on the residents' health and safety or impedes the ability of any resident in the rooms to attain his or her highest practicable well-being. The room waiver showed the following: Room Sq. Ft. Beds 14 234.03 3 15 234.03 3 16 232.23 3 17 234.40 3 18 233.19 3 19 234.89 3 27 233.65 3 (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	28 232.73 3 29 225.50 3 36 232.23 3 37 233.07 3 38 233.93 3 39 233.60 3 The minimum square footage for 3-bed rooms is 240 sq. ft. During interviews with residents both individually and collectively, the residents did not express any concerns regarding the size of their rooms.

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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** 40438 Based on observation, interview, and record review, the facility failed to keep an electric fan (a powered machine used to create a flow of air to cool and ventilate rooms and control humidity) in a safe and sanitary condition for one of one sampled resident (Resident 12). This failure had the potential to affect the resident's quality of life. Findings: During a review of Resident 12's Admission Records (AR), the AR indicated Resident 12 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD, a chronic lung disease causing difficulty in breathing) and asthma (a condition in which a person's airways become inflamed, narrow and swollen). During a review of Resident 12's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 8/6/2024, the MDS indicated, Resident 12 had intact cognition (ability to understand) and required substantial/maximal assistance (helper did more than half the effort) with oral and toileting hygiene, shower, upper and lower body dressing and personal hygiene. During a concurrent observation and interview on 9/30/2024 at 11:12 am with Resident 12 inside the resident's room, Resident 12 had a white electric fan at bedside. The blades of the electric fan were full of dust. Resident 12 stated the fan blades were dusty and Resident 12 could not remember the last time the fan was cleaned. During an interview on 9/30/2024 at 11:14 am with Housekeeping (HK) staff , HK stated electric fan or any equipment inside the resident's room should be kept clean for infection control. During an interview on 10/1/2024 at 10:56 am with the Maintenance Supervisor (MS), MS stated, any equipment inside the resident's room needed to be clean. MS stated housekeeping staff (in general) should check and clean any equipment inside the residents' room daily to prevent infection, to keep the residents safe and maintain a good and comfortable environment for the residents. During a review of the facility's Policy and Procedure (P&P) titled, Homelike Environment, revised February 2021, the P&P indicated, The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting including a clean, sanitary and orderly environment.