STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055995	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Convalescent Center of North Long Beach	260 E Market St Long Beach, CA 90805

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41699 Based on observation, interview and record review, the facility failed to: 1.Eensure one of three sampled residents (Resident 3) provided privacy while sitting on a wheelchair wearing an incontinent brief (diaper). This deficient practice had the potential to affect Resident 3's self-worth and dignity. 2.Ensure one of eight sampled residents (Resident 61) who had limited range of motion [(ROM) full movement potential of a joint (where two bones meet)] and mobility (ability to move) was dressed in their own clothes and not in a hospital- type gowns. This failure had the potential to negatively impact Resident 61's psychosocial (social conditions related to mental health) well-being and prevented Resident 61 from receiving movement to the left arm during activities of daily living (ADLs, tasks related to personal care including bathing, dressing, hygiene, eating, and mobility). Findings: 1.During a review of Resident 3's Admission Order, the Admission Record indicated Resident 3 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including type 2 diabetes mellitus (a condition in which the body fails to metabolize (process) glucose (sugar) correctly), hemiplegia (paralysis of one side of the body) and hemiparesis (weakness of one side of the body) following cerebral infarction (lack of adequate blood supply to the brain), and dysphagia (difficulty of swallowing). During a review of Resident 3's Minimum Data Sheet (MDS- a standardized assessment and care screening tool) dated 04/01/2024 indicated Resident 3 had moderate cognitive impairment (ability to learn, understand, and make decisions) and requires maximal assistance for oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, putting on/taking off footwear and personal hygiene. During an observation on 06/25/2024 at 8:41 a.m., 10:07 a.m. and 11:04: a.m. observed Resident 3 sitting in a wheelchair wearing incontinence pad (diaper) and hospital; gown. Observed Resident 3's body exposed and can be seen from the hallway. Resident 3's privacy curtain was not drawn. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/26/2024 at 2:11 p.m., the Certified Nursing Assistant (CNA 6) stated if the resident body was exposed and can be seen by passerby, that was a dignity issue and very demeaning to Resident 3. During an interview on 06/26/2024 at 2:18 p.m., the Director of Staff Development (DSD) stated it was important to always cover the resident's body and should not be expose to the public because it was a dignity issue and will affect resident psychosocial wellbeing. During an interview on 06/26/2024 at 3:08 p.m., CNA 7 stated that no resident's body should be exposed to the public because it affects the resident psychosocial being, self-worth and that was a dignity issue that can lead to depression (feeling of sadness) and social isolation. During the review of facility's policy and procedure (P&P) titled Dignity revised on 02/2021, indicated Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. Staff promote, maintain, and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures. 2.During a review of Resident 61's Admission Record, Resident 61 was admitted to the facility on [DATE] with diagnoses including cerebral infarction (brain damage due to a loss of oxygen to the area) due to embolism (blood vessel blockage) of the right middle cerebral artery (largest of the major blood vessels in the brain), hemiplegia (paralysis of one side of the body) and hemiparesis (weakness of one side of the body), hypertensive (abnormally high blood pressure) heart disease, type 2 diabetes mellitus (high blood sugar), and major depressive disorder (depression, a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with daily functioning). During a review of Resident 61's care plan titled Episodes of refusing care, initiated on 4/16/2021, the care plan interventions including to encourage Resident 61 to make decisions concerning timing of care, clothes to wear, and what activities to attend. During a review of Resident 61's physician orders, dated 1/23/2024, the physician orders indicated for the Restorative Nursing Aide (RNA, certified nursing aide program that helps residents to maintain their function and joint mobility) to perform passive range of motion (PROM, movement of joint through the ROM with no effort from the person) to both legs, five times per week as tolerated. The physician orders, dated 1/23/2024, also indicated for the RNA to provide Resident 61 with PROM to the left arm, seven times per week as tolerated. During a review of Resident 61's Minimum Data Set (MDS, a comprehensive assessment and care screening tool), dated 4/8/2024, the MDS indicated Resident 61 had clear speech, expressed ideas and wants, understood verbal content, and had intact cognition (ability to think, understand, learn, and remember). The MDS indicated Resident 61 had ROM limitations in one arm and one leg and was dependent for showering/bathing, upper body dressing, lower body dressing, rolling to either side in bed, and tub/shower transfers. The MDS indicated chair/bed-to-chair transfers were not attempted with Resident 61 due to medical condition or safety concerns. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 6/24/2024 at 1:34 p.m. in Resident 61's bedroom, Resident 61 was lying awake in bed wearing a hospital gown with conversational speech. Resident 61 stated he was unable to move the left arm and left leg since admission to the facility and did not receive exercises every day. During a concurrent observation and interview on 6/25/2024 at 8:57 a.m. with Restorative Nursing Aide 1 (RNA 1) in Resident 61's bedroom, Resident 61 was lying awake in bed wearing a hospital type gown and requested to receive pain medication prior to the exercises. Resident 61 stated having 10 out of 10 pain (pain scale, 0 meaning no pain and 10 meaning the worst pain possible) deep inside the left arm and the left leg. During an observation on 6/25/2024 at 11:06 a.m. with RNA 1 in Resident 61's bedroom, Resident 61 was lying awake in bed wearing a hospital gown with the left arm positioned directly on the left side of Resident 61's body. Resident 61's left shoulder was rotated toward the body, the left elbow was in an extended position, the forearm was excessively rotated inward in a position that made the left-hand palm face away from Resident 61's body, the wrist was bent downward in a 90-degree position, and the left-hand middle, ring, and small fingers had a claw-like appearance. During an observation on 6/26/2024 at 8:35 a.m. in Resident 61's bedroom, Resident 61 was lying awake in bed wearing a hospital type gown and asked to be turned to the left side. The Director of Nursing (DON) and Central Supply (CS) came to Resident 61's bedside to assist Resident 61 with turning toward the left. Resident 61 asked the DON and CS to be careful with the left arm due to pain. During an interview on 6/26/2024 at 9:37 a.m. with CS, CS stated she was also a Certified Nursing Assistant (CNA). CS stated Resident 61 was repositioned to turn toward the left side. CS stated Resident 61 had pain in the left arm because of the left arm contracture (condition of shortening and hardening of muscles, tendons, or other tissue, often leading to joint stiffness), which CS stated was positioned abnormally. During an observation on 6/26/2024 at 1:37 p.m. with the Director of Rehabilitation (DOR) in Resident 61's room, Resident 61 was lying in bed wearing a hospital type gown with the left arm positioned on the side of the body. During a concurrent observation and interview on 6/27/2024 at 1:20 p.m. with Resident 61 in Resident 651's room, Resident 61 was lying awake in bed wearing a hospital type gown with the left arm positioned directly to the side of Resident 61's body. Resident 61 stated the left arm had some pain at rest that sharply increased when someone touched or moved the left arm for exercises. Resident 61 stated he would like to wear my own clothes, like sweatshirts and sweatpants, not hospital type clothes. Resident 61 provided permission to look in the closet directly across from Resident 61's bed. Resident 61's closet was full of clothes, including but not limited to 27 shirts, two pairs of pants, and one pair of shorts. During an interview on 6/27/2024 at 1:42 p.m. with Certified Nursing Assistant 5 (CNA 5) and Resident 61 in Resident 61's room, CNA 5 stated Resident 61 was dressed in a hospital type gown because Resident 61 had pain in the left arm, preventing Resident 61 from putting on a shirt. CNA 5 stated Resident 61 did not like to get out of bed because Resident 61 felt pain throughout the body. Resident 61 stated the left arm pain prevented Resident 61 from getting dressed and getting out of bed. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/28/2024 at 11:56 a.m. with the DON, the DON stated the facility was the resident's home and residents were dressed in regular clothes to promote dignity (state of being worthy of honor or respect). During a review of the facility's policy and procedure (P&P) titled, Dignity, the P&P indicated each resident Shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth. The P&P indicated the Residents were treated with dignity and respect at all times, including encouraging residents to dress in clothing that they prefer. Cross Reference F688

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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** 41699 Based on observation, interview, and record review the facility failed to ensure call light was within reach for two of seven sampled residents (Resident 20 and 57). This deficient practice had the potential for Resident 20 and 57 not able to find the call light to call for assistance when needed, and experienced loss of self-esteem. Findings: During a review of Resident 20's Admission Order, the Admission Record indicated Resident 20 was admitted to the facility on [DATE], with diagnoses including acute respiratory failure (a serious condition that makes it difficult to breathe on your own), vascular dementia (changes to memory, thinking, and behavior resulting from conditions that affect the blood vessels in the brain), dysphagia (difficulty of swallowing). During a review of Resident 20's Minimum Data Sheet (MDS- a standardized assessment and care screening tool) dated 04/02/2024 indicated Resident 20 had no cognitive impairment (ability to learn, understand, and make decisions) and requires assistance for all activities of daily living. During a review of Resident 20's care plan titled High risk for decreased ability to perform activities of daily living such as bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, and toileting (undated), interventions including to place the call light within reach. During a concurrent observation and interview on 06/24/2024 at 10:13 with Resident 20, observed Resident 20's call light hanging at the side of the bed and Resident 20 cannot reach it. Resident 20 stated sometimes it takes longer for the staff to answer the call light. Resident 20 stated it was hard to ask for help if you cannot reach the call light. During an observation on 06/24/2024 at 11:44 a.m., and 1:04 p.m., observed Resident 20's call light hanging at the side of the bed and resident cannot reach it. During a review of Resident 57's Admission Order, the Admission Record indicated Resident 57 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including congestive heart failure (heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen), dysphagia (difficulty of swallowing), and ischemic cardiomyopathy (refers to the heart's decreased ability to pump blood properly). During a review of Resident 57's MDS dated [DATE] indicated Resident 57 had moderate cognitive impairment and requires dependent assistance for oral hygiene, toileting hygiene, shower/bath self and putting on/taking off footwear and maximum assistance for upper/lower body dressing and personal hygiene. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 57's care plan titled High risk for falls related to impaired mobility, gait/balance problems, incontinence, poor communication/comprehension and unaware of safety needs revised on 04/05/2024, interventions including to place the call light within reach while in bed or proximity to the bed. During an observation on 06/24/2024 at 1:28 p.m., 2:35 p.m., and 3:41 p.m., observed Resident 57's call light was on the floor and Resident 57 cannot reach it. During an interview on 06/26/2024 at 2:09 p.m., Certified Nursing Assistant (CNA 6) stated call light must be within reach to be able to call for help so that needs can be provided, if resident will try to reach the call light, it makes the resident high risk for fall and injury. During an interview on 06/24/2024 at 2:13 p.m., the Director of Staff Development (DSD) stated if resident cannot reach the call light to call for help, resident can become restless and frustrated and will feel like less of a person and needs are not met. DSD stated if resident was unable to call for assistance there was potential for fall and injury if resident will try to reach the call light. During the review of facility's policy and procedure (P&P) titled Answering the Call Light revised on 09/2022, indicated The purpose of this procedure was to ensure timely responses to the resident's requests and needs. Ensure that the call light was accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 36943 Based on observation, interview, and record review, the facility failed to notify nursing and the primary physician of the change in condition (COC- major decline or improvement in a resident's status that will not resolve itself without intervention) for two of eight sampled residents (Resident 102 and 61) with limited range of motion ([ROM], full movement potential of a joint {where two bones meet}) and mobility (ability to move) concerns by failing to: a. Report Resident 61's increased pain and ROM impairments in the left leg indicated on the Rehab Screening (brief assessment of a resident's abilities), dated 11/5/2021. b. Report Resident 102's significant decline in mobility and activities of daily living (ADLs, tasks related to personal care including bathing, dressing, hygiene, eating, and mobility) indicated on the Rehab Screening, dated 4/5/2024. These deficient practices prevented Resident 102 and Resident 61 from receiving intervention to decrease pain and improve their ability to perform ADLs, mobility, and ROM to prevent contractures (condition of shortening and hardening of muscles, tendons, or other tissue, often leading to joint stiffness). Findings: a.During a review of Resident 61's Admission Record, Resident 61 was admitted to the facility on [DATE] with diagnoses including cerebral infarction (brain damage due to a loss of oxygen to the area) due to embolism (blood vessel blockage) of the right middle cerebral artery (largest of the major blood vessels in the brain), hemiplegia (paralysis of one side of the body) and hemiparesis (weakness of one side of the body), hypertensive (abnormally high blood pressure) heart disease, type 2 diabetes mellitus (high blood sugar), and major depressive disorder (depression, a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with daily functioning). During a review of Resident 61's Rehab Screening, dated 11/5/2021 by Physical Therapist (PT, professional aimed in the restoration, maintenance, and promotion of optimal physical function) 1 (PT 1), the Rehab Screening indicated Resident 61's physician orders for Restorative Nursing Aide (RNA, certified nursing aide program that helps residents to maintain their function and joint mobility) was for passive range of motion (PROM, movement of joint through the ROM with no effort from the person) of the left leg, five times per week as tolerated. The Rehab Screening indicated Resident 61's ROM in the right arm and right leg were within functional limits (WFL, sufficient movement without significant limitation). The Rehab Screening indicated Resident 61's ROM in the left arm and left leg were impaired (unspecified). The Rehab Screening indicated Resident 61 had increased stiffness, pain, and was at risk for contracture on the left leg. The Rehab Screening indicated Resident 61 would benefit from PT services to prevent and minimize contractures, improve pain, and improve ROM. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 61's MDS, dated [DATE], the MDS indicated Resident 61 had clear speech, expressed ideas, and wants, understood verbal content, and had intact cognition. The MDS indicated Resident 61 had ROM limitations in one arm and one leg and was dependent for showering/bathing, upper body dressing, lower body dressing, rolling to either side in bed, and tub/shower transfers. The MDS indicated chair/bed-to-chair transfers were not attempted with Resident 61 due to medical condition or safety concerns. During a concurrent observation and interview on 6/24/2024 at 1:34 p.m. in Resident 61's bedroom, Resident 61 was lying awake in bed wearing a hospital gown. Resident 61 stated he was unable to move the left arm and left leg since admission to the facility and did not receive exercises every day (unknown length of time). During a concurrent observation and interview on 6/25/2024 at 8:57 a.m. with Restorative Nursing Aide 1 (RNA 1) in Resident 61's bedroom, Resident 61 was lying awake in bed wearing a hospital gown and requested to receive pain medication prior to RNA exercises. Resident 61 stated having level 10 out of 10 on a pain scale rating from zero to ten (pain screening tool using numerical value to assess the level of pain ranging from 0 to 3-mild pain, from 4 to 6- moderate pain, and from 7 to 9-severe pain, and 10- the worse pain possible) on the left arm and the left leg. During an observation on 6/25/2024 at 11:06 a.m. in Resident 61's bedroom, Resident 61 was lying awake in bed with the left arm positioned directly on the left side of Resident 61's body. Resident 61's left shoulder was rotated toward the body, the left elbow was in an extended position, the forearm was excessively rotated inward in a position that made the left-hand palm face away from Resident 61's body, the wrist was bent downward in a 90-degree position, and the left-hand middle, ring, and small fingers had a claw-like appearance. Resident 61's left leg was observed straight on the bed and the left ankle was bent away from the body. During a concurrent interview and record review on 6/28/2024 at 9:21 a.m. with the DOR, Resident 61's Rehab Screening, dated 11/5/2021, was reviewed. The DOR reviewed the Rehab Screening, which indicated Resident 61 would benefit from skilled PT services to prevent contractures, improve pain, and improve ROM. The DOR stated Resident 61 did not receive a PT Evaluation after the Rehab Screening, dated 11/5/2021. The DOR stated PT 1 should have informed the nurses that Resident 61 had a change in condition and to obtain orders from the physician for physical therapy. During an interview on 6/28/2024 at 11:22 a.m. with the Director of Nursing (DON), the DON stated changes in condition need to be reported to nursing to assess the resident thoroughly and to notify the physician for intervention. During a review of the facility's policy and procedure (P&P) titled, Change in Condition: Notification of, dated effective on 8/25/2021, the P&P indicated the facility must immediately inform the resident and consult with the resident's physician where there was a significant change in the resident's physical status and a need to alter treatment. b. During a review of Resident 102's Admission Record, the Admission Record indicated Resident 102 was admitted to the facility on [DATE] with diagnoses including pain in the right elbow, psychosis (severe mental disorder in which thought, and emotions are so impaired that contact is lost with external reality), and depression. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 102's PT Evaluation and Plan of Treatment, dated 1/10/2024, the PT Evaluation indicated Resident 102's left hip was fixed (immovable) into 90-degrees of hip flexion (bending the leg at the hip joint toward the body, normal 0-120 degrees) and 140 degrees of knee flexion (bending the knee, normal 0-135 degrees). During a review of Resident 102's MDS, dated [DATE], the MDS indicated Resident 102 had intact cognition. The MDS indicated Resident 102 had ROM limitations in both arms and one leg. The MDS indicated Resident 102 required partial/moderate assistance (helper does less than half the effort) for eating, oral hygiene, substantial/maximal assistance (helper does more than half the effort) for upper body dressing, and dependent (helper does all of the effort or the assistance of two or more helpers is required for the resident to complete the activity) for lower body dressing, rolling to both sides in bed, and moving from lying to sitting on the side of the bed. During a review of Resident 102's PT Discharge Summary, dated 3/5/2024, the PT Discharge Summary indicated Resident 102 tolerated wearing the left knee extension (straightening out the knee) splint (material used to restrict, protect, or immobilize a part of the body to support function, assist and/or increase range of motion) for four hours. The PT Discharge Summary also indicated the RNA, provided a 100 percent (%) return demonstration for exercises to both legs, including right leg active range of motion (AROM, performance of ROM of a joint without any assistance or effort of another person) exercises and left leg PROM exercises with left knee splint application. The PT Discharge Summary recommendations indicated for the RNA to provide right leg AROM, left leg PROM, and application of the left knee extension splint for four hours as tolerated. During a review of Resident 102's Rehab Screening, dated 4/5/2024 written by PT 1, the Progress Note for Rehab Screening indicated Resident 102's ROM in the right leg was within functional limits (WFL, sufficient movement without significant limitation). The Rehab Screening indicated both of Resident 102's arms and the left leg was impaired (unspecified). The Rehab Screening indicated Resident 102 had a significant decline with mobility, ROM, and ADLs. During a review of Resident 102's MDS, dated [DATE], the MDS indicated Resident 102 had clear speech, expressed ideas and wants, clearly understood verbal content, and had intact cognition. The MDS indicated Resident 102 had ROM limitations in both arms and one leg. The MDS indicated Resident 102 required substantial/maximal assistance for oral hygiene and upper body dressing and dependent for lower body dressing, rolling to both sides in bed, and moving from lying to sitting on the side of the bed. During an interview on 6/26/2024 at 3:32 p.m. with the Director of Rehabilitation (DOR), Resident 102's Rehab Screening, dated 4/5/2024, was reviewed. The DOR stated PT 1 should have reported Resident 102's decline to nursing as a change in condition. The DOR stated Resident 102 did not receive any PT or OT services after the Rehab Screening, dated 4/5/2024. During an interview on 6/28/2024 at 11:22 a.m. with the Director of Nursing (DON), the DON stated changes in condition need to be reported to nursing to assess the resident thoroughly and to notify the physician for intervention. (continued on next page)

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F 0580 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, Change in Condition: Notification of, dated effective on 8/25/2021, the P&P indicated the facility must immediately inform the resident and consult with the resident's physician where there was a significant change in the resident's physical status and a need to alter treatment. Cross Reference F688

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45269 Based on interview and record review, the facility failed to ensure one of ten residents (Resident 105) during Resident Council Meeting (organized group of residents who meet regularly to discuss and address concerns about their rights, quality of care and life) know how to file a grievance. This deficient practice had the potential to violate resident's rights to have his grievance heard and addressed. Findings: During a review of Resident 105's Admission Record, the Admission Record indicated Resident 105 was admitted to the facility on [DATE] with diagnoses including acute pyelonephritis (a bacterial infection causing inflammation of kidneys), benign prostatic hyperplasia (non-cancerous enlargement of prostate gland), and hemiplegia (paralysis of one side of the body) following cerebral infarction (damage to the brain from interruption of its blood supply) During a review of Resident 105's Minimum Data Set ([MDS] standardized assessment and care screening tool) dated 5/28/2024, the MDS indicated Resident 105 had an intact cognition (ability to think, understand, learn, and remember) and required partial assistance with transfer to and from bed to chair, toilet transfer, toileting hygiene and dressing. During a Resident Council Meeting on 6/25/2024, at 11:15 a.m., Resident 105 stated he did not know how to file a grievance or who was the person to approach if he needed assistance or help to file a grievance or address a concern. During an interview on 5/27/2024, at 5:31 p.m. with the Social Service Director (SSD), SSD stated the resident filled up a form if they had grievance about their care or missing personal items, refer them to the appropriate department and present their findings to the residents once they had reached a conclusion and resolution. SSD stated it was important for residents to know how to file grievance so the facility can address their needs and concerns. During an interview on 6/28/2024, at 6:22 p.m., with the Director of Nursing (DON), the DON stated residents should know how to file a grievance so the facility can meet their needs and prevent frustration among residents who required assistance in filing a grievance. During a review of facility's policy and procedure (P&P) titled Grievance/ Concern dated 8/25/2021, the P&P indicated Information about grievance will be provided upon admission or upon request, the resident or resident representative are provided with the Grievance Policy which informs of their right to voice grievances or concerns and the process for doing so.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Convalescent Center of North Long Beach	260 E Market St Long Beach, CA 90805

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46415 Based on observation, interview, and record review, the facility failed to ensure two of two sampled residents (Resident 16 and 56) were free from unnecessary restraint (any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body) as evidenced by: 1. Resident 16 having a bolster mattress (mattress has a defined perimeter that helps to create a secure and stable edge around the bed) with no order, no assessment, and no consent (permission for something to happen). 2. Identify, and appropriately monitor the use of built-in bolster pads in Resident 56's bed. These deficient practices had the potential to place Resident 16 and Resident 56 at risk for unnecessary prolonged use of restraints, restricting movement and impaired circulation. Findings: 1. During a review of Resident 16's Face Sheet (Admission record), the Face Sheet indicated Resident 16 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnosis including chronic diastolic (congestive) heart failure (heart's main pumping chamber on the left becomes stiff and is unable to fill the heart with blood properly), gastrostomy (surgical opening into the stomach for nutritional support), unspecified dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), aphasia (difficulty speaking), abnormal posture, cardiomegaly (enlarged heart), and psychosis (condition of the mind that results in difficulty determining what is real and what is not). During a review of Resident 16's Minimum Data Set [(MDS) a standardized assessment and care screening tool], dated 6/7/2024, the MDS indicated Resident 16's cognitive skills (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) were moderately impaired. The MDS indicated Resident 16 is dependent on all aspects of actives of daily living (ADL: bathing, personal hygiene, transferring). The MDS indicated Resident 16 has impairment on both upper (arms/shoulders) extremities and utilizes a wheelchair. During a review of Resident 16's Order Summary Report (Physician Order), the order summary report indicated: a. On 6/20/2022, Resident 16 may have a mattress with built in bilateral upper and lower bolster while in bed to promote proper body alignment. b. On 7/18/2023, to discontinue the order for Resident 16 to have a mattress with built in bilateral upper and lower bolster while in bed to promote proper body alignment. During a review of Resident 16's consent forms, there was no consent for bolster mattress. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 6/25/2024 at 8:30 a.m. with the Assistant Minimum Data Set Coordinator (AMDSC), AMDSC stated the bed Resident 16 is not on a low air mattress (designed to prevent and treat pressure wounds) and is not sure if the matter is called a bolster mattress. AMDSC stated this is not a restraint if the resident is able out move and can get out of bed. AMDSC stated she is not sure how often restraints are checked, but prior to restraining a resident, the resident must be assessed, receive a consent for the use of restraints, and notify the family if they accept the use of restraints. AMDSC stated you cannot restraint anyone without a consent and assess if the resident really needs the restraints or not. During a concurrent observation and interview on 6/25/2024 at 8:59 a.m. with Registered Nurse Supervisor 1 (RNS 1), RNS 1 stated the mattress looks like a special mattress as it has a zipper and is thicker than a regular mattress. During a concurrent observation and interview on 6/25/2024 at 3:26 p.m., with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated Resident 16 has the bolster mattress due to being a fall risk, so the resident won't be able to get out of bed and fall. LVN 2 stated an order is required to place the bolster mattress. During a concurrent interview and record review of Resident 16's order on 6/25/2024 at 3:28p.m. with LVN 2, LVN 2 stated she does not see an order or consent for the bolster mattress and does not know why the resident has that bed. During an interview on 6/25/2024 at 4:10p.m. with Certified Nursing Assistant 4 (CNA 4), CNA 4 stated the bolster mattress is to protect the resident from falling and the wedge is in the bed and the resident cannot remove it. CNA 4 stated the bed keep the resident in the center. CNA 4 stated it restricts the resident's movements and is not comfortable for the resident. During a concurrent interview and record review of Resident 16's order on 6/26/2024 at 3:25p.m. with RNS 1, RNS 1 stated the order indicated the built in bilateral bolster mattress was to promote body alignment and agreed that the mattress did look as if it had wedges that were built in. RNS 1 stated the order was started on 6/20/2022 and ended on 7/18/2023. RNS 1 stated if the order was discontinued, the bed should have been removed. RNS 1 stated she is not sure if you need a consent, but if it were a special bed, you would most likely need a consent from the responsible party and require a doctor's order. RNS 1 stated if the bolster mattress was continued, they would need a new order or try and remove the mattress. RNS 1 stated Resident 16 would be monitored to see if he is trying to get out of bed, whether it is impeding him in any way, or whether it was helping his body alignment to determine if Resident 16 really needs this bolster mattress. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/28/2024 at 7:17p.m. with Assistant Director of Nursing (ADON), ADON stated ADON stated they do not use side rails (a barrier attached to the side of a bed) and had a discussion of whether these beds with bolsters qualify as a possible form of restraint. ADON stated a restraint prevents a resident from getting out of bed to prevent them from falling. ADON stated the low air mattress with bolster mattress are for residents who have already had a fall being on a low air mattress and would require an order for the bolster. ADON stated upon admission, there is a generalized form that indicates a consent for devices, and since a resident's condition can change anytime, the consent for devices should be signed so that in case something did happen in a case where a device is needed, it can already be placed. ADON stated the residents on the bolster mattress should be monitored and assessed frequently since they have a higher risk for falls. ADON stated if a resident is on restraints, they require monitoring to prevent complications such as skin breakdown, fractures, pain, and trauma. During an interview on 6/28/2024 at 9:11p.m. with DON, Director of Nursing (DON), DON stated a restraint is a device that limits the movement of resident. DON stated the bolster mattress beds were already utilized at the facility when she was hired in December 2023, and no one had questioned the bed. DON stated Resident 16 is not a regular bed and using a least restrictive device as they do not have a lot of bed rails or grab bars. DON stated independent residents can go in and out of the bed freely, however the residents in bed have very limited mobility, are dependent, and cannot move in and out of bed with the bolster mattress. DON stated residents using a bolster mattress require an order and should have a consent as well because it is a device, and all device utilization requires a consent. DON stated during the clinical meeting, it would be discussed whether the device is needed based on the residents' condition (if they are improving or declining) to ensure the changing condition of the resident's needs are met. DON stated the purpose for the bolster mattress is to reposition the resident and bed bound residents meet the requirements, but not all the residents require the bolster mattress. DON stated if a resident is having a behavioral episode, or is restless, or is trying to climb out and dangle their fee, they would get the bolster mattress to prevent them from getting out of bed. During a concurrent observation of Resident 16's bed and interview on 6/28/2024 at 9:29p.m. with DON, DON stated she has not seen Resident 16 move his lower extremities (legs and hips) but can move his upper (arms and shoulders) extremities and the bolster mattress is positioned lower at the head of the bed compared to the foot of the bed. DON stated Resident 16 cannot move in and out of bed on his own. DON reiterated any device utilized need a consent and residents who use the device needs to be assessed as needed and quarterly to see if they still need it or not. DON stated if the resident is not being monitored while using a device indicates they are a not attending to the resident's needs. 2.During a review of Resident 56's Admission Record, the Admission Record indicated Resident 56 was admitted to the facility on [DATE] and was readmitted to the facility on [DATE] with diagnoses including sepsis(life threatening emergency that happens when your body's response to an infection), Parkinson's disease without dyskinesia(progressive disorder that affects the nervous system without involuntary movements), unspecified dementia with other behavioral disturbance (loss of cognitive functioning such as thinking, remembering and reasoning which can affect and interfere with daily life and activities), and anxiety disorder. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Minimum Data Set ([MDS] standardized assessment and care screening tool) dated 5/10/2024, the MDS indicated the Resident 56 had severely impaired cognitive skills and was dependent on staff with bed mobility, oral hygiene, dressing, bathing, bathing, and toileting hygiene. During a review of Resident 56's Physician Order Summary Report, dated 4/25/2024 indicated a telephone order of built in bilateral upper and lower bolster while in bed to promote body alignment. During a review of Resident 56's Medication Administration Record (MAR) dated 6/6/2024, the MAR indicated from 6/6/2024 to 6/16/2024, the resident had a mattress with built in bilateral upper and lower while in bed to promote proper body alignment every shift for poor safety awareness and was discontinued on 6/17/2024. During a subsequent observation on 6/24/2024, at 9:20 a.m., and on 6/25/2024, at 3:56 p.m., in Resident 56's room, Resident 56's low air loss mattress (mattress designed to distribute the residents' body weight by using alternating pressure therapy) had upper and lower bolster pads under the sheets bilaterally. Resident 56 was lethargic (condition marked by drowsiness and unusual lack of energy and mental alertness) and unable to communicate. During an interview on 6/25/2024, at 4:14 p.m., with Certified Nursing Assistant (CNA 4), CNA 4 stated Resident 56's upper and lower wedges were to keep him in the center of bed because resident used to wiggle his arms and legs but not actively climbing out of bed. During a concurrent observation and interview on 6/25/2024, at 3:56 p.m., with Director of Staff Development (DSD), DSD entered the room and demonstrated the wedges were called bolters pads which were inside and built in the mattress lining and were not removed easily by the resident. DSD stated these bolster pads keep the resident from falling off the bed. During an interview and record review on 6/26/2024, at 1:49 p.m., with Assistant Minimum Data Set Coordinator (AMDSC), AMDSC stated the bolster pads were not a form of restraints but agreed the bolster pads could not be removed by the resident easily and both upper and lower pads were adjacent to the body. AMDSC stated the bolster pads restricted the resident's movement. Reviewed Resident 56's Physician Order Summary Report and the order indicated bolster pads were discontinued since 6/17/2024. AMDSC stated the bolster pads should have been discontinued and removed from resident's bed when it was ordered by the physician on 6/17/2024. AMDSC stated bolster pads restricted the resident's movements and could lead to isolation or depression. AMDSC stated the bolster pads was ordered due to resident's poor safety awareness and prevention of fall. During an interview on 6/26/2024, at 3:56 p.m. with Registered Nurse Supervisor (RNS 1), RNS 1 stated the resident had declined medically and hospice care was offered to the family. RNS 1 stated the bolster pads were used for body alignment and prevention of fall. RNS 1 stated the physician's order to discontinue was missed and the licensed nurses should have removed them and reassessed the use of the bolster pads. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 6/26/2024, at 3:42 p.m., with Licensed Vocational Nurse (LVN 3) in Resident 56's room, LVN 3 stated Resident 56 used to roll over out of bed that's why they placed the bolster pads. Observed Resident 56 had no upper and lower bolster pads bilaterally on the bed. LVN 3 stated the facility used bolster pads on all residents who are in low air loss mattress to help them in their position and to prevent them from sliding off the bed. LVN 3 stated Resident 56 was weak and unable to remove the bolster pads. During an interview on 6/28/2024, at 9:31 p.m. with Director of Nursing (DON), the DON stated the bolster pads were not a restraint but were considered restrictive measures to prevent them from falling. DON stated residents who had behavioral problems or restless would need bolster pads. During a review of the facility's policy and procedure (P&P) titled, Use of Restraints, revised April 2017, the P&P indicated physical restraints are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body .if the resident cannot remove a device in the same manner in which the staff applied it given that resident's physical condition (i.e., side rails are put back down, rather than climbed over), and this restricts his/her typical ability to change position or place is considered a restraint. Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative (sponsor). The order shall include the following: the specific reason for the restraint (as it relates to the resident's medical symptom), how the restraint will be used to benefit the resident's medical symptoms, and the type of restraints, and period for the use of the restraint. Reorders are issued only after a review of the resident's condition by his or her physician. Restrained individuals shall be reviewed regularly (at least quarterly) to determine whether they are candidates for restraint reduction, less restrictive methods of restraints, or total restraint elimination. Documentation regarding the use of restraints shall include full documentation of the episode leading to the use of the physical restraints. How the restraint use benefits the resident by addressing the medical symptoms, length of effectiveness of the restraint time, and observation, range of motion and repositioning flow sheets. 45269

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F 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. 45269 Based on interview and record review, the facility failed to ensure thoroughly investigate the background of Registered Nurse Supervisor (RNS 1) who had history of disciplinary actions on her nursing license during hiring process. This failure had the potential to place residents at risk for abuse and gross negligence (repeated failure to provide required nursing care or exercise precaution in a situation which the nurse knew or should have known could result in patient harm). Findings: During a record review of RNS 1 's 2023 Facility's' Application for Employment, the Application for Employment indicated RNS1 had disclosed in her application form that she was asked to resign or was involuntarily discharged . During a review of RNS 1's California Board of Registered Nursing (BRN, state governmental agency established by law to protect the public by regulating the practice of registered nurses) Licensing details, indicated four administrative disciplinary actions(legal document formally charging a licensee with violation of the practice act and notifying the public that a disciplinary action is pending). During a review of RNS 1 BRN file titled Board Decision and Order dated 8/10/2015 indicated RNS 1 had two causes discipline on her RN License. The first cause of discipline was for gross negligence which involved RNS 1 screaming at the patient and slapping patient's hands. The second cause of discipline was about professional misconduct (actions that violate professional ethics or standards of practice) which involved co-workers. During an interview on 6/27/2024, at 5:06 p.m. with Director of Staff Development (DSD), DSD stated licensed nurses were interviewed by Director of Nursing (DON) and verified their nursing license. DSD stated if the DON accepted the applicant, she would process the application which involved background checking and if the nursing license was active the facility hires them. DSD stated RNS 1 was safe to practice because otherwise her license would be taken away by California Board of Registered Nursing and RNS 1 had grown into a better person. During a subsequent interview on 6/28/2024, at 5:31 p.m., with the DON, the DON stated they interview RN in person, check their background for criminal records, check their references from previous employment and verify their license during hiring process. The DON stated she was not the DON who hired RNS 1 and was not aware about the prior history of disciplinary actions on her license. The DON stated RNS 1 was clear, and the facility made an informed decision to hire her as a RN Supervisor. The DON stated if the facility failed to do a thorough check on an applicant's background and license during hiring the facility will place residents at risk for harm and will not be safe. DON stated hired employees should be trustworthy, competent, and capable of doing their job. (continued on next page)

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F 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/28/2024, at 6:10 p.m., with the Administrator (ADM), the ADM stated if she would have a talk with RNS 1 and had found something about RNS 1 background and license and would still hire her because the facility does not single her out. The ADM stated she was not aware RNS 1 had prior disciplinary actions on her license. The ADM stated RNS 1 was suspended for two days when she was involved in a recent allegation of abuse against a resident in the facility. During a record review of the employee corrective action notice dated 5/24/2024 RNS 1 was suspended for two(2) days due to investigation for alleged abuse. During an interview on 6/28/2024, at 5:58 p.m., with DSD, DSD stated former DON knew RNS 1 had priors' disciplinary actions on her nursing license and DSD pointed them out to former DON. DSD stated the former administrator during that time approved the hiring despite the presence of prior disciplinary actions on RNS 1 license. During an interview and record review of facility's Policy and Procedure about Background Screening Investigations with DON and ADM on 6/28/2024, at 9:59 p.m. DON read and validated the policy if background investigation discloses any misrepresentation on the application or former information indicating the individual has been convicted of abuse, neglect, mistreatment of individuals should not be employed. ADM and DON stated they did not read the letter or documents from California Board of Nursing regarding RNS 1's prior administrative disciplinary actions. ADM stated the background check of RNS 1 was clear and the facility was an equal opportunity and they do not discriminate and give everyone a chance to be hired in the facility. During a review of facility's policy and procedure (P&P) titled Background Screening Investigation revised 2008, the P&P indicated the facility conducts employment background screening checks, reference checks, and criminal conviction checks on all applicants for positions with direct access to residents. The P&P indicated licensed professional applying for a position that involve direct contact with residents their respective licensing board should be contacted to determine if any sanctions(a threatened penalty for disobeying a law or rule) have been assessed against the applicant's license. The P&P indicated should the background investigation disclose any misrepresentation on the application form or information indicating the individual has been convicted of abuse, neglect, mistreatment of individuals the applicant should not be employed or contracted.

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36943 Based on observation, interview, and record review, the facility failed to accurately assess functional limitation (limited ability to move a joint that interferes with daily functioning) in range of motion ([ROM] full movement potential of a joint [where two bones meet]) for two of eight sampled residents (Resident 15 and 57) with limited ROM and mobility (ability to move). This deficient practice provided inaccurate information sent to the federal database and had the potential to result in delayed or missed identification of joint range of motion changes, inaccurate care planning, and inadequate provision of services and treatments for Resident 15 and 57. Findings: a. During a review of Resident 15's Admission Record, indicated Resident 15 was admitted to the facility on [DATE] with diagnoses including dementia (decline in mental ability severe enough to interfere with daily life), dysphagia (difficulty swallowing), gastrostomy (G-tube, tube placed directly into the stomach for long-term feeding), and type 2 diabetes mellitus (high blood sugar). During a review of Resident 15's Rehab Screening (brief assessment of a resident's abilities), dated 11/8/2023 and 11/28/2023, the Rehab Screenings indicated Resident 15's ROM in both arms were impaired at both shoulders, elbows, wrists, and hands. During a review of Resident 15's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 11/28/2023, the MDS indicated Resident 15 had severely impaired cognition (ability to think, understand, learn, and remember) and was dependent (helper does all of the effort or the assistance of two or more helpers was required for the resident to complete the activity) for oral hygiene, upper body dressing, lower body dressing, showering/bathing, rolling to both sides in bed, and chair/bed-to-chair transfers. The MDS indicated Resident 15 had ROM impairments in one arm. During an observation on 6/24/2024 at 10:57 a.m. in Resident 15's bedroom, Resident 15 was lying in bed wearing arm splints (material used to restrict, protect, or immobilize a part of the body to support function, assist and/or increase range of motion) on both arms that extended from Resident 15's hands to the upper arms. During a concurrent interview and record review on 6/26/2024 at 5:07 p.m. with the MDS Coordinator (MDSC), Resident 15's Rehab Screening, dated 11/28/2023, and MDS, dated [DATE], were reviewed. The MDSC stated Resident 15 Rehab Screening indicated Resident 15 had ROM impairments in both arms. The MDSC stated Resident 15's MDS, dated [DATE], was inaccurate and should have indicated Resident 15 had ROM limitations in both arms. The MDSC stated the MDS was a representation of the resident's abilities and the information on the MDS was sent to the federal database. The MDSC stated inaccurate information was sent to the federal database for Resident 15's MDS, dated [DATE]. (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	b. During a review of Resident 57's Admission Record, indicated Resident 57 was admitted on [DATE] with diagnoses including dementia (decline in mental ability severe enough to interfere with daily life), dysphagia (difficulty swallowing), left hand contracture (condition of shortening and hardening of muscles, tendons, or other tissue, often leading to joint stiffness), and embolism (blood vessel blockage) and thrombosis (blood vessel blockage) of the aorta (large blood vessel of the heart that delivers oxygen to the body). During a review of Resident 57's Rehab Screening (brief assessment of a resident's abilities), dated 3/21/2024, the Rehab Screening indicated Resident 57 wore a left wrist, hand, finger orthosis (WHFO, material secured with straps that extends from the fingers to the forearm to properly position the fingers and wrist and prevent contractures). The Rehab Screening indicated Resident 57's ROM was impaired on the left shoulder, elbow, and hand. The Rehab Screening indicated Resident 57's ROM in the right arm and both legs were within functional limits (WFL, sufficient movement without significant limitation). The Rehab Screening indicated Resident 57 had a Restorative Nursing Aide (RNA, certified nursing aide program that helps residents to maintain their function and joint mobility) program to apply the left WHFO and to assist Resident 57 with walking using a front-wheeled walker (FWW, an assistive device with two front wheels used for stability when walking). During a review of Resident 57's MDS, dated [DATE], the MDS indicated Resident 57 had moderately impaired cognition and required substantial/maximal assistance for upper body dressing, lower body dressing, rolling from side to side in bed, chair/bed-to-chair transfers, and walking 10 feet. The MDS indicated Resident 57 did not have any ROM impairment to both arms and had ROM impairments in one leg. During an observation on 6/24/2024 at 1:25 p.m. in the hallway, Resident 57 was sitting in the wheelchair wearing a left-hand WHFO. During a concurrent interview and record review on 6/26/2024 at 5:23 p.m. with the MDS Coordinator (MDSC), Resident 57's Rehab Screening, dated 3/21/2024, and MDS, dated [DATE], were reviewed. The MDSC stated Resident 57's Rehab Screen indicated Resident 57 had ROM impairments in the left arm. The MDSC stated Resident 57's MDS, dated [DATE], was inaccurate and should have indicated Resident 57 had a ROM impairment in one arm and did not have any ROM impairments in both legs. The MDSC stated the MDS was a representation of the resident's abilities and the information on the MDS was sent to the federal database. The MDSC stated inaccurate information was sent to the federal database for Resident 57's MDS, dated [DATE].

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Windsor Convalescent Center of North Long Beach	260 E Market St Long Beach, CA 90805

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46415 Based on interview and record review, the facility failed to: 1. Ensure a Preadmission Screening and Resident Review (PASARR: required screening for individuals with serious mental illness to ensure needs are met and are placed in an appropriate environment) assessment was resubmitted for a resident who was newly diagnosed with a mental illness for one of one sample residents (Resident 89). 2.Follow up and PASARR recommendation to obtain Level II evaluation for three of three sampled residents (Resident 11, 15 and 57). These deficient practices had the potential for Resident 89,11,15, and 57 not receiving the necessary and appropriate psychiatric (diagnosis, treatment, and prevention of mental, emotional, and behavioral disorders) level of treatment and evaluation in the facility. Findings: 1. During a review of Resident 89's Admission record, the Admission Record indicated Resident 89 was initially admitted to the facility on [DATE] and was readmitted [DATE] with diagnoses schizoaffective disorder (mental health condition that combines symptoms of hallucinations and delusions with mood disorders such as depression or mania), unspecified psychosis (condition of the mind that results in difficulties in determining what is or is not real), and unspecified dementia (a group of symptoms that affects memory and thinking) without behavioral disturbance (aggression, anxiety). During a review of Resident 89's Minimum Data Set ([MDS] a standardized assessment and care screening tool), dated 4/12/2024, the MDS indicated Resident 89's cognitive skills (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) were mildly impaired. The MDS indicated Resident 89 had an active diagnosis of schizophrenia and dementia. During a review of the PASRR dated 7/27/2023, the PASARR indicated Resident 89 had a negative Level I am screening and did not require a level II mental health evaluation. During a review of the Physician Order Summary Report indicated there was an active order on 4/4/2024 for Seroquel (generic name Quetiapine Fumarate: used to treat certain mental or mood disorders such as sudden episodes of mania or depression) oral tablet 100 milligram (mg: unit of mass) one tablet by mouth every 12 hours related to schizoaffective disorder. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 6/26/2024 at 2:10 p.m., with Minimum Data Set Coordinator (MDSC), MDSC stated Resident 89 was admitted on [DATE] per admission record. MDSC stated a PASARR was done to provide extra services to ensure the residents were getting the necessary services to help manage their mental disorder or intellectual disability. MDSC stated Resident 89's PASARR dated 7/27/2023 indicated Resident 89 did not require a level II screening. MDSC stated Resident 89 had a diagnosis of schizoaffective on 12/29/2023, after the PASARR was completed. MDSC stated Resident 89 was receiving Seroquel 100 mg every 12 hours ordered on 5/4/2024. MDSC stated she did not do any of the PASARR and the last one was done in July 2023. MDSC stated if there was a new diagnosis, a PASARR should be done to check if there was a need for a level II assessment. MDSC stated the PASARR was not done due to an oversight on their part. 2.During a review of Resident 11's Admission Order, the Admission Record indicated Resident 11 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including schizophrenia (a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions), dysphagia (difficulty of swallowing), and unspecified dementia (loss of memory, language, problem-solving and other thinking abilities) During a review of Resident 11's Minimum Data Set (MDS-standardized assessment and care screening tool) dated 03/26/2024 indicated Resident 11 had severe cognitive impairment (ability to learn, understand, and make decisions) and dependent on all activities of daily living. During a review of Resident 15's Admission Order, the Admission Record indicated Resident 15 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including dysphagia, bipolar disorder (a serious mental illness that causes unusual shifts in mood, ranging from extreme highs to lows) and paranoid schizophrenia (a severe mental health condition). During a review of Resident 15's MDS dated [DATE] indicated Resident 15 had severe cognitive impairment and requires dependent assistance for all activities of daily living. During a review of Resident 57's Admission Order, the Admission Record indicated Resident 57 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses of congestive heart failure (occurs when either disease or defect causes the heart muscle to lose the ability to pump blood efficiently) , dysphagia, and ischemic cardiomyopathy (refers to the heart's decreased ability to pump blood properly, due to myocardial damage brought upon by ischemia). During a review of Resident 57's MDS dated [DATE] indicated Resident 57 had moderate cognitive impairment and requires dependent assistance for oral hygiene, toileting hygiene, shower/bath self and putting on/taking off footwear and maximum assistance for upper/lower body dressing and personal hygiene. During an interview on 06/27/2024 at 10:39 a.m., the Director of Nursing (DON) stated residents who are PASRR I positive needs PASARR II evaluation. The DON stated residents taking combinations of psychotropic medications needs to be re-evaluated to find out when those behavioral symptoms started and the reason why residents are taking those combinations of psychotropic medications and evaluate if it was really working and managing the symptoms. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the review of facility's policy and procedure (P&P) titled Psychotropic Medication Use undated, indicated: This Policy sets forth procedures relating to psychotropic medication use. Facility staff should inform the resident and/or resident representative of the initiation, reason for use, and the risks associated with the use of psychotropic medications, per facility policy or applicable state regulations.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36943 Based on observation, interview, and record review, the facility failed to obtain an orthopedic (branch of medicine dealing with the correction or prevention of deformities, disorders, or injuries of the bones and associated soft tissue) specialist appointment for one of eight residents (Resident 102) with limited range of motion [(ROM) full movement potential of a joint (where two bones meet)] and mobility (ability to move) in accordance with the physician's order, dated 6/25/2024. This deficient practice had the potential to prevent Resident 102 from receiving an assessment and possible intervention for Resident 102's left knee contracture (condition of shortening and hardening of muscles, tendons, or other tissue, often leading to joint stiffness), which caused Resident 102 pain, limited mobility, and affected Resident 102's quality of life and psychological (related to the mental and emotion state of a person) wellbeing. Findings: During a review of Resident 102's Admission Record, indicated the facility admitted Resident 102 on 1/9/2024 with diagnoses including pain in the right elbow, psychosis (severe mental disorder in which thought, and emotions are so impaired that contact is lost with external reality), and depression. During a review of Resident 102's Physical Therapy (PT, profession aimed in the restoration, maintenance, and promotion of optimal physical function) Evaluation and Plan of Treatment, dated 1/10/2024, the PT Evaluation indicated Resident 102's left hip was fixed (immovable) into 90-degrees of hip flexion (bending the leg at the hip joint toward the body, normal 0-120 degrees) and 140 degrees of knee flexion (bending the knee, normal 0-135 degrees). During a review of Resident 102's Physical Medicine and Rehabilitation Evaluation, dated 1/11/2024, indicated Resident 102 had a history of a washout surgery (procedure that involves washing or cleaning out the contents inside a joint space) for the left septic knee (inflammation of a joint caused by an infection) and a left leg contracture. During a review of Resident 102's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 1/15/2024, the MDS indicated Resident 102 had clear speech, expressed ideas and wants, clearly understood verbal content, and had intact cognition (ability to think, understand, learn, and remember). The MDS indicated Resident 102 had ROM limitations in both arms and one leg. The MDS indicated Resident 102 required partial/moderate assistance (helper does less than half the effort) for eating, oral hygiene, substantial/maximal assistance (helper does more than half the effort) for upper body dressing, and dependent (helper does all of the effort or the assistance of two or more helpers is required for the resident to complete the activity) for lower body dressing, rolling to both sides in bed, and moving from lying to sitting on the side of the bed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 102's Physical Medicine and Rehabilitation Evaluation, dated 2/19/2024, indicated Resident 102 complained of constant left knee pain level 7 out of 10 on a pain scale rating from zero to ten (pain screening tool using numerical value to assess the level of pain ranging from 0 to 3-mild pain, from 4 to 6- moderate pain, and from 7 to 9-severe pain, and 10- the worse pain possible). During a review of Resident 102's Physical Medicine and Rehabilitation Evaluation, dated 2/23/2024, indicated Resident 102 complained of dull and aching left knee pain with an intensity of 8 out of 10. During a review of Resident 102's PT Discharge Summary, dated 3/5/2024, the PT Discharge Summary indicated Resident 102 tolerated wearing the left knee extension (straightening out the knee) splint (material used to restrict, protect, or immobilize a part of the body to support function, assist and/or increase range of motion) for four hours. The PT Discharge Summary also indicated the Restorative Nursing Aide (RNA, certified nursing aide that helps residents to maintain their function and joint mobility) provided a 100 percent (%) return demonstration for exercises to both legs, including right leg active range of motion (AROM, performance of ROM of a joint without any assistance or effort of another person) exercises and left leg passive range of motion (PROM, movement of joint through the ROM with no effort from the person) exercises with left knee splint application. The PT Discharge Summary recommendations indicated for the RNA to provide right leg AROM, left leg PROM, and application of the left knee extension splint for four hours as tolerated. During a review of Resident 102's Physical Medicine and Rehabilitation Evaluation, dated 3/28/2024, indicated Resident 102's chief complaint included chronic (long-term) pain and had much left knee pain. During a review of Resident 102's MDS, dated [DATE], the MDS indicated Resident 102 had clear speech, expressed ideas and wants, clearly understood verbal content, and had intact cognition. The MDS indicated Resident 102 had ROM limitations in both arms and one leg. The MDS indicated Resident 102 required substantial/maximal assistance for oral hygiene and upper body dressing and dependent for lower body dressing, rolling to both sides in bed, and moving from lying to sitting on the side of the bed. During an interview on 6/24/2024 at 10:21 a.m. in Resident 102's room, Resident 102 stated feeling frustrated with the care at the facility and started to cry. Resident 102 stated he requested to speak to Resident 102's physician multiple times about the left knee but has not spoken to the physician. During a concurrent observation and interview on 6/24/2024 at 2:28 p.m. in Resident 102's bedroom, Resident 102 was lying awake in bed with conversational speech. Resident 102 had a knee extension splint applied to the left knee. Resident 102's left hip was positioned into flexion and the left knee remained bent while wearing the splint. Resident 102 stated he walked prior to 7/2023 when Resident 102 underwent surgery for the left knee, he did not receive adequate therapy, and did not attend any follow-up appointments after surgery. Resident 102 stated he wanted to speak to a physician to break the bones and muscles to straighten out the left leg. Resident 102 stated he laid in bed every day because the facility staff cannot put Resident 102 in a wheelchair. Resident 102 became tearful, stating he cannot return home since Resident 102 cannot walk and did not have anyone to care for Resident 102. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 102's physician orders, dated 6/25/2024, the physician orders included an orthopedic specialist consultation for pain after left knee surgery one year ago. During an observation on 6/25/2024 at 8:19 a.m. with Restorative Nursing Aide 2 (RNA 2) in Resident 102's bedroom, Resident 102 was lying awake in bed with the left hip and left knee bent. RNA 2 attempted to extend Resident 102's left knee but Resident 102 complained of left knee pain. RNA 2 stated Licensed Vocation Nurse 3 (LVN 3) already administered pain medication this morning. Resident 102 stated the left knee has not improved even with exercises and wanted to speak to the physician to perform surgery in the left knee. During an observation on 6/25/2024 at 3:08 p.m. with RNA 2 in Resident 102's bedroom, Resident 102 was lying in bed and agreeable to the left leg exercises. Resident 102 did not want RNA 2 to apply the left knee splint due to left knee pain. Resident 102 stated he told the facility staff, including the social worker, that he wanted to see a specialist for the left knee but did not receive any response from the facility. During an interview on 6/25/2024 at 4:22 p.m. with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated Resident 102 sometimes cries due to the left knee pain. During an interview and record review on 6/27/2024 at 9:48 a.m. with Registered Nurse Supervisor 1 (RNS 1), Resident 102's physician order, dated 6/25/2024, for the Orthopedic consultation was reviewed. RNS 1 stated she assessed Resident 102, including the left knee contracture, on 6/25/2024. RNS 1 stated Resident 102 started to cry while thanking RNS 1 for calling the physician for the orthopedic specialist consultation because Resident 102 felt frustrated about the left knee. RNS 1 stated Resident 102's physician provided orders for an orthopedic consultation and a physiatrist (medical doctor who specializes in physical medicine and rehabilitation) consultation on 6/25/2024. During an interview on 6/27/2024 at 11:48 a.m. with the Physiatrist (MD 1), MD 1 stated Resident 102 wanted to walk again and made a recommendation for a referral to an orthopedic surgeon for the left knee. MD 1 stated he had previously recommended a referral to an orthopedic surgeon and informed social work of the recommendation. During an interview on 6/27/2024 at 4:08 p.m. with the Social Service Assistant (SSA), SSA stated nursing was supposed to schedule the orthopedic specialist appointment and then the social services department will arrange transportation for the appointment. During an interview on 6/27/2024 at 5:09 p.m. with the Director of Social Services (DSS) and the Director of Nursing (DON), the DSS was not aware of Resident 102's physician order for an Orthopedic specialist appointment. DSS stated the nurse receiving the physician's order for the Orthopedic specialist was supposed to make the appointment. DSS stated social services will then arrange transportation for the appointment. During an interview on 6/27/2024 at 5:10 p.m. with the DON, the DON stated Resident 102's biggest concern was the left knee and RNS 1 should have made the orthopedic specialist appointment. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/28/2024 at 8:43 a.m. with RNS 1, RNS 1 stated Resident 102's physician orders for the Orthopedic consultation should have been printed out and provided to social services for additional guidance. RNS 1 stated she will contact three Orthopedic specialist offices on 6/27/2024 to make an appointment for Resident 102. During a review of the facility's policy and procedure (P&P) titled, Physician Orders, effective on 3/22/2022, the P&P indicated the Licensed Nurse receiving the order will be responsible for documenting and implementing the order. During a review of the facility's P&P titled, Referrals, Social Services, revised 12/2008, the P&P indicated social services will collaborate with nursing staff or other pertinent disciplines to arrange for services that have been ordered by the physician. Cross reference F697.

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F 0688 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36943 Based on observation, interview, and record review, the facility failed to provide services to maintain mobility (ability to move) for two of eight sampled residents (Resident 61 and Resident 102) with limited range of motion ([ROM] full movement potential of a joint {where two bones meet}) and mobility by failing to: 1. Monitor and assess Resident 61's ROM in each joint of both arms and legs during the quarterly Rehab Screening (brief assessment of a resident's abilities) from 11/5/2021 to 6/12/2022 in accordance with the facility's policy titled, Resident Mobility and Range of Motion, which indicated the facility will identify the resident's ROM of the joints as part of the resident's comprehensive assessment. 2. Provide Resident 61 with passive range of motion ([PROM] a movement of joint through the ROM with no effort from the person) to the left arm from 2/2/2022 to 6/11/2022, as ordered by Resident 61's physician on 3/26/2019, and in accordance with the Resident 61's request documented in Resident 61's Rehab Screening, dated 2/2/2022. 3. Monitor and assess Resident 61's ROM in each joint of both arms and legs quarterly from 9/2/2022 to 4/2/2024 in accordance with the facility policy titled, Resident Mobility and Range of Motion after Resident 61's discharge from Occupational Therapy ([OT] profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) on 9/2/2022. 4. Perform PROM exercises on 6/25/2024 to Resident 61 left elbow, wrist, hand, and ankle and the right leg in accordance with the physician's orders, dated 1/23/2024, to provide PROM to the left arm and both legs as tolerated. 5. Monitor and assess Resident 102's ROM in each joint of both arms and legs during Resident 102's quarterly Rehab Screening, dated 4/5/2024. These failures resulted in Resident 61 developing ROM limitations in the left elbow, forearm, and wrist on 6/12/2022, causing Resident 61 to develop contractures (condition of shortening and hardening of muscles, tendons, or other tissue, often leading to joint stiffness) in the left elbow, forearm, and wrist, experience pain with movement of the left arm, and prevented Resident 61 from participating in activities of daily living ([ADL], tasks related to personal care including bathing, dressing, hygiene, eating, and mobility), including dressing in normal clothes and getting out of bed. These failure also had the potential for Resident 61 to develop ROM limitations in both legs and Resident 102 to experience a decline in ROM in both arms and both legs without detection and intervention. Findings: (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	a. During a review of Resident 61's Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses including cerebral infarction (brain damage due to a loss of oxygen to the area) due to embolism (blood vessel blockage) of the right middle cerebral artery (largest of the major blood vessels in the brain), hemiplegia (paralysis of one side of the body) and hemiparesis (weakness of one side of the body), hypertensive (abnormally high blood pressure) heart disease, type 2 diabetes mellitus (high blood sugar), and major depressive disorder (depression, a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with daily functioning). During a review of Resident 61's OT Evaluation and Plan of Treatment, dated 3/22/2019, the OT Evaluation indicated Resident 61's ROM in the right arm was within functional limits ([WFL] sufficient movement without significant limitation) and the left arm was impaired. The OT Evaluation indicated Resident 61's left arm ROM impairments included left shoulder flexion (lifting the arm upward) 30 to 90 degrees (30-90 degrees, normal 0-180 degrees), left elbow flexion (bending the elbow) 40-140 degrees (normal 0-150 degrees), left wrist (unspecified ROM), and left-hand ring finger and small finger had flexion (bending) contractures. The OT Evaluation indicated Resident 61 had limited strength in both arms with weakness in the left arm. Resident 61's OT Plan of Treatment indicated an OT Evaluation only (no OT intervention) with recommendations for Resident 61 to receive a Restorative Nursing Aide ([RNA] a certified nursing aide program that helps residents to maintain their function and joint mobility) program to provide PROM to the left shoulder, elbow, and hand, five times per week. During a review of Resident 61's Physical Therapy ([PT] profession aimed in the restoration, maintenance, and promotion of optimal physical function) Evaluation and Plan of Treatment, dated 3/22/2019, the PT Evaluation indicated Resident 61's both legs were WFL except for left ankle stiffness. Resident 61's PT Plan of Treatment indicated a PT evaluation only. During a review of Resident 61's Physician's Orders, dated 3/26/2019, the Physician's Orders indicated for the RNA to provide PROM to the resident's left arm in all available planes (movement side-to-side, front, and back, or rotational), five times per week as tolerated. Another physician's order, dated 3/26/2019, indicated for the RNA to provide Resident 61 with active assistive range of motion ([AAROM] use of muscles surrounding the joint to perform the exercise but required some help from a person or equipment) exercises to both legs and sit to stand transfers with one siderail use, five times per week as tolerated. During a review of Resident 61's physician's orders, dated 10/29/2021, the physician orders indicated for the RNA to provide PROM to the resident's left leg, five times per week as tolerated. During a review of Resident 61's Rehab Screening, dated 11/5/2021, the Rehab Screening indicated Resident 61's ROM in the right arm and right leg were WFL. The Rehab Screening indicated Resident 61's ROM in the left arm and left leg were impaired (unspecified). During a review of Resident 61's Minimum Data Set ([MDS] a standardized assessment and care screening tool), dated 11/9/2021, the MDS indicated Resident 61 had intact cognitive (ability to think, understand, learn, and remember) skills for daily decision making. The MDS indicated Resident 61 had ROM limitations in one arm and one leg. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 61's Rehab Screening, dated 2/2/2022, and 5/2/2022 the Rehab Screening indicated Resident 61's ROM in the right arm and right leg were WFL. The Rehab Screening indicated Resident 61's ROM in the left arm and left leg were impaired (unspecified). The Rehab Screening indicated Resident 61 had left-sided hemiplegia with noted hypertonicity (increased tightness in the muscles). The Rehab Screening indicated Resident 61 verbalized a wish to continue with the RNA program for PROM to both arms and both legs. The Rehab Screening indicated Resident 61 was receiving RNA for PROM to the left arm and left leg, five times per week as tolerated. During a review of Resident 61's Documentation Survey Report (record of nursing assistant tasks) for RNA, dated for the month of 2/2022, 3/2022, and 4/2022, the Documentation Survey Report indicated Resident 61 received RNA for PROM to the left leg, five times per week as tolerated. The Documentation Survey Report did not include documentation from 2/2022 thru 4/2022 RNA for PROM to the left arm as ordered by Resident 61's physician (3/26/2019) and as indicated in the Rehab Screening, dated 2/2/2022. During a review of Resident 61's Documentation Survey Report (record of nursing assistant tasks) for RNA, dated for the months 5/2022 and 6/2022, the Documentation Survey Report indicated Resident 61 received RNA for PROM to the left leg, five times per week as tolerated. The Documentation Survey Report did not include documentation from 5/2022 thru 6/2022 RNA for PROM to the left arm as ordered by Resident 61's physician (3/26/2019) and indicated in the Rehab Screenings, dated 2/2/2022 and 5/2/2022. During a review of Resident 61's Rehab Screening, dated 6/12/2022, the Rehab Screening indicated Resident 61 required an OT Evaluation. During a review of Resident 61's OT Evaluation and Plan of Treatment, dated 6/12/2022, the OT Evaluation indicated Resident 61's ROM in the right arm was WFL but Resident 61's left arm ROM was impaired. The OT Evaluation indicated Resident 61's left arm ROM impairments included shoulder flexion 0-80 degrees, shoulder abduction (lifting the arm up and away from the body) 0-45 degrees (normal 0-180 degrees), elbow positioned in extension (straightened elbow) with 10 degrees of motion, wrist positioned in flexion (bent downward) to 90 degrees, wrist extension (bending the wrist upward) to neutral (wrist straightens but unable to bend further upward), the forearm positioned in increased pronation (rotation of the forearm that results in the palm facing downward), and the left-hand middle, ring, and small fingers were positioned in flexion. The OT Plan of Treatment included to provide therapeutic exercises (movement prescribed to correct impairments and restore muscle function), neuromuscular reeducation (technique used to restore movement patterns through repetitive motion to retrain the brain), therapeutic activities (tasks that improve the ability to perform ADLs), self-care management training, and orthotic (also known as a splint, material used to restrict, protect, or immobilize a part of the body to support function, assist and/or increase range of motion) management and training, five times per week for 30 days. During a review on Resident 61's PT Evaluation and Plan of Treatment, dated 6/11/2022, the PT Evaluation indicated Resident 61's ROM in the right leg, left hip, and left knee were WFL. The PT Evaluation indicated Resident 61's left ankle dorsiflexion (bending the ankle toward the body, normal 0-20 degrees) was impaired and positioned in 10 degrees of plantarflexion (ankle bent away from the body). The PT Plan of Treatment included therapeutic exercise, neuromuscular reeducation, and therapeutic activities five times per week. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Convalescent Center of North Long Beach	260 E Market St Long Beach, CA 90805

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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 0688 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 61's OT Discharge Summary, dated 7/29/2022, the OT Discharge Summary indicated Resident 61 tolerated wearing the left-hand wrist, hand, finger orthosis ([WHFO], material secured with straps that extends from the fingers to the forearm to properly position the fingers and wrist and prevent contractures) for five hours daily and the RNA (unknown) demonstrated 100 percent (%) good return demonstration of the left arm PROM exercises with prolonged stretch to maintain joint mobility, good hygiene, and prevent contractures. The OT Discharge Summary indicated recommendations for the RNA to provide Resident 61 with AAROM to the right arm, PROM to the left arm, and application of the left-hand WHFO for four to six hours, seven days a week as tolerated. During a review of Resident 61's PT Discharge Summary, dated 7/29/2022, the PT Discharge Summary indicated Resident 61 tolerated wearing pressure relief ankle-foot orthosis ([PRAFO] a device worn on the calf and foot to suspend the heel and hold the ankle in neutral [90 degree] position) to the left ankle for two hours five times per week. The PT Discharge Summary indicated recommendations for the RNA to provide Resident 61 with PROM of both legs and to apply the left ankle PRAFO as tolerated with skin checks, five times per week as tolerated. During a review of Resident 61's Physician's Orders, dated 7/29/2022, the physician's orders indicated the order for the RNA to perform AAROM to Resident 61's right arm, PROM to Resident 61's left arm, and to apply the left-hand WFHO for four to six hours as tolerated, seven days per week. Another physician's orders, dated 7/29/2022, indicated the order for the RNA to perform PROM to both of Resident 61's legs and to apply the left ankle PRAFO, five times per week as tolerated. During a review of Resident 61's PT Evaluation and Plan of Treatment, dated 8/19/2022, the PT Evaluation indicated Resident 61's ROM in the right leg was WFL but impaired on the left hip, knee, and ankle. The PT Evaluation indicated the ROM in Resident 61's left leg included left hip flexion 0-60 (bending the leg at the hip joint toward the body, normal 0-120), left knee fixed (immovable) into extension (straightening out the knee, normal 0-135 degrees), and the left ankle was positioned in 10 degrees of plantarflexion. During a review of Resident 61's OT Evaluation and Plan of Treatment, dated 8/20/2022, the OT Evaluation indicated Resident 61's ROM in the right arm was WFL but Resident 61's ROM in the left arm was impaired. The OT Evaluation and Plan of Treatment indicated Resident 61's left arm ROM impairments included shoulder flexion 0-70 degrees, shoulder abduction 0-45 degrees, elbow positioned in extension with 10 degrees of motion, wrist positioned in flexion to 90 degrees, wrist extension to neutral, the forearm positioned in increased pronation, and left-hand middle, ring, and small fingers were positioned in flexion. The OT Plan of Treatment included to provide therapeutic exercises, neuromuscular reeducation, therapeutic activities, and orthotic management and training, four times per week for two weeks. During a review of Resident 61's PT Discharge Summary, dated 8/25/2022, the PT Discharge Summary indicated Resident 61 tolerated wearing the left ankle PRAFO for two hours five times a week. The PT Discharge Summary indicated recommendations for the RNA to provide Resident 61 with PROM of both legs and to apply the left ankle PRAFO as tolerated with skin checks, five times per week as tolerated. During a review of Resident 61's Physician's Orders, dated 8/25/2022, the physician's orders indicated the order for the RNA to provide Resident 61 with PROM to both legs and to apply the left ankle PRAFO for two hours with skin checks, five times per week. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 61's OT Discharge Summary, dated 9/2/2022, the OT Discharge Summary indicated Resident 61 tolerated wearing the left-hand WHFO for four-and-a half hours (4.5 hours) and the RNA (unknown) demonstrated 100% good return demonstration of applying and removing Resident 61's left-hand WHFO. The OT Discharge recommendations included for the RNA to perform PROM to Resident 61's left arm and apply the left-hand WHFO for four to six hours, seven times per week. During a review of Resident 61's Physician Orders, dated 9/15/2022, the physician orders indicated for the RNA to provide PROM to Resident 61's left arm and to apply the left-hand WHFO for four to six hours, seven times per week as tolerated. During a review of Resident 61's Rehab Screening, dated 10/24/2022, 1/18/2023, 4/18/2023, 7/13/2023, and 10/12/2023, the Rehab Screen indicated Resident 61's ROM in the right arm and right leg were WFL and Resident 61's ROM in the left arm and left leg were impaired (unspecified). The Rehab Screenings indicated for Resident 61 to continue with the RNA program for the left arm and left leg exercises and application of the left-hand WHFO and left ankle PRAFO. During a review of Resident 61's Progress Note for Rehab Screening, dated 1/10/2024, the Progress Note for Rehab Screening indicated Resident 61's ROM in the right arm and right leg were WFL and Resident 61's ROM in the left arm and left leg were impaired (unspecified). The Progress Note indicated to continue with the established RNA program of left arm and left leg PROM exercises and application of the left hand WHFO and left ankle PRAFO. During a review of Resident 61's Physician's Order, dated 1/23/2024, the Physician's Order indicated there was an order for the RNA to perform PROM to both legs and apply the left ankle PRAFO for two hours, five times per week as tolerated. The physician's order, dated 1/23/2024, also indicated for the RNA to provide Resident 61 with PROM to the left arm and apply the left hand WHFO for four to six hours, seven days per week as tolerated. During a review of Resident 61's Progress Note for Rehab Screening, dated 4/2/2024, the Progress Note for Rehab Screening indicated Resident 61's ROM in the right arm and right leg were WFL and Resident 61's ROM in the left arm and left leg were impaired (unspecified). The Progress Note for Rehab Screening indicated Resident 61 did not have any significant decline with mobility, ADLs, and ROM (from the last Rehab Screening on 1/10/2024) and to continue with RNA. During a review of Resident 61's MDS, dated [DATE], the MDS indicated Resident 61 had clear speech, expressed ideas, and wants, understood verbal content, and had intact cognition. The MDS indicated Resident 61 had ROM limitations in one arm and one leg and was dependent on staff for showering/bathing, upper body dressing, lower body dressing, rolling to either side in bed, and tub/shower transfers. The MDS indicated chair/bed-to-chair transfers were not attempted with Resident 61 due to medical condition or safety concerns. During a review of Resident 61's Restorative Administration Record (record of RNA tasks) for 6/2024, the Restorative Administration Record indicated the RNA provided Resident 61 with PROM to both legs and applied the left ankle PRAFO, five times per week for two hours. The Restorative Administration Record also indicated the RNA provided PROM to the left arm and applied the left-hand WHFO for four to six hours, seven times per week. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	During an interview on 6/24/2024 at 9:14 a.m. with the Director of Rehabilitation (DOR), the DOR stated the Rehab Screening (in general) were completed on admission, quarterly, after a fall, after a change in the resident's condition, and from RNA referrals. The DOR stated the Rehab Screening monitored whether a resident had any declines in ROM, development of contractures, and decline in levels of assistance. The DOR stated the Rehab Screening indicated whether the extremity (arm and leg) was impaired. The DOR stated the Rehab Screening did not include a measurement of the resident's ROM at each joint. During a concurrent observation and interview on 6/24/2024 at 11:14 a.m. with Resident 61 in the room, Resident 61 was observed in bed and had active movement in the right arm. Resident 61 stated being unable to move the left side of the body and felt pain when Resident 61 tried to move the left side. Resident 61 stated the staff did not provide any ROM exercises (unknown length of time). During a concurrent observation and interview on 6/24/2024 at 1:34 p.m. in Resident 61's room, the resident was observed being awake in bed and wearing a hospital gown. Resident 61 stated he was unable to move the left arm and left leg since admission to the facility and did not receive exercises to arm and leg every day (unknown length of time). During a concurrent observation and interview on 6/25/2024 at 8:57 a.m. with Restorative Nursing Aide (RNA 1) in Resident 61's room, the resident was observed in bed awake and requested to receive pain medication prior to RNA exercises. Resident 61 stated he was having the left arm and the left leg pain level 10 out of 10 on a pain scale rating from zero to ten (a pain screening tool using numerical value to assess the level of pain ranging from 0 to 3-mild pain, from 4 to 6- moderate pain, and from 7 to 9-severe pain, and 10- the worse pain possible). During an observation on 6/25/2024 at 11:06 a.m. with RNA 1 in Resident 61's room, the resident was observed in bed, awake in a hospital gown with the left arm positioned directly on the left side of Resident 61's body. Resident 61's left shoulder was rotated toward the body, the left elbow was in an extended position, the forearm was excessively rotated inward in a position that made the left-hand palm face away from Resident 61's body, the wrist was bent downward in a 90-degree position, and the left-hand middle, ring, and small fingers had a claw-like appearance. RNA 1 was observed standing on the left side of Resident 61's bed and performing ROM exercises to the left arm, including shoulder flexion and shoulder abduction (lifting the arm up and away from the body). RNA 1 was observed not performing any ROM exercises to Resident 61's left elbow, forearm, wrist, and hand. Resident 61's left leg was observed straight on the bed and the left ankle was bent away from the body. RNA 1 was observed performing ROM exercises to Resident 61's left leg, including ROM into hip flexion with the knee extended and hip abduction (moving the leg away from the body) with the knee extended. RNA 1 was observed attempting to bend Resident 61's left knee but Resident 61 immediately complained of pain. Resident 61 agreed to allow RNA 1 to continue with ROM exercises to the left knee despite the pain. RNA 1 was observed not performing any ROM exercises to Resident 61's left ankle. Resident 61 declined to wear the left-hand WHFO and left ankle PRAFO splints (material used to restrict, protect, or immobilize a part of the body to support function, assist and/or increase range of motion). RNA 1 stated the last time Resident 61 wore both splints was on 6/21/2024. During an interview on 6/25/2024 at 11:14 a.m. RNA 1 stated he provided Resident 61 with PROM exercises to the left shoulder. RNA 1 stated PROM was not provided to Resident 61's left elbow, wrist, and hand because Resident 61 cannot bend at those joints. RNA 1 stated he forgot to perform PROM to the left ankle. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	During an interview on 6/25/2024 at 1:17 p.m., RNA 1 stated he usually provided Resident 61 with PROM exercises to the left shoulder, hip, knee, and ankle but forgot to perform PROM of the left ankle on 6/25/2024. RNA 1 stated Resident 61 refused the application of the left-hand WHFO and left ankle PRAFO splints on 6/25/2024. During a concurrent interview and record review on 6/25/2024 at 1:39 p.m. with RNA 1, Resident 61's Restorative Administration Record for the month of 6/2024 was reviewed. The Restorative Administration Record for Resident 61 indicated for the RNA to provide PROM to both legs. RNA 1 stated he did not provide PROM to Resident 61's right leg today (6/25/2024) because he (RNA 1) felt nervous. During an observation on 6/26/2024 at 8:35 a.m. in Resident 61's room, the resident was observed in bed, awake in a hospital gown, and asked to be turned to the left side. The Director of Nursing (DON) and Central Supply (CS) came to Resident 61's bedside to assist Resident 61 with turning toward the left. Resident 61 asked the DON and CS to be careful with the left arm due to pain. During an interview on 6/26/2024 at 9:37 a.m. a CS stated she was also a CNA. CS stated Resident 61 was repositioned to turn toward the left side and had pain in the left arm because of the left arm contracture. During a concurrent interview and record review on 6/26/2024 at 10:00 a.m. with the DOR, Resident 61's OT Evaluation, dated 3/22/2019, was reviewed. The DOR stated Resident 61 was admitted to the facility on [DATE] and received an OT Evaluation on 3/22/2019. The DOR reviewed Resident 61's OT Evaluation and stated Resident 61's ROM in the right arm was WFL which meant Resident 61 could use right arm functionally without limitations. The DOR stated Resident 61's ROM in the left shoulder was 30-90 degrees which meant Resident 61's left arm could be lifted to shoulder height. The DOR stated Resident 61's left elbow ROM was 40-140 degrees which meant Resident 61's left elbow could not completely straighten but could bend completely. The DOR stated Resident 61's left-hand ring finger and small finger were contracted into flexion. The DOR stated Resident 61 could partially move the left arm. The DOR stated Resident 61 did not receive OT therapy and was referred to the RNA program for PROM exercises to the left shoulder, elbow, and hand, five times per week. During a concurrent interview and record review on 6/26/2024 at 10:55 a.m. with the DOR, Resident 61's OT Evaluation, dated 6/12/2022, was reviewed. The DOR reviewed Resident 61's OT Evaluation, dated 6/12/2022, and stated Resident 61 was found to have a decline in ROM. The DOR stated Resident 61's right arm ROM was WFL but had impaired ROM in the left arm. The DOR stated Resident 61's left shoulder ROM included shoulder flexion 0-80 degrees and shoulder abduction 0-45 degrees. The DOR stated Resident 61's left elbow was positioned in complete extension, could bend 10 degrees, but could not completely bend. The DOR stated Resident 61's left forearm was positioned in increased pronation but stated Resident 61's OT Evaluation did not include ROM measurements of the left forearm. The DOR stated Resident 61's left wrist was positioned in 90 degrees of flexion but could extend the wrist to neutral. The DOR stated Resident 61's ROM in the left thumb and index finger were WFL but stated Resident 61's middle, ring, and small fingers were in bent positions. (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 0688 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 6/26/2024 at 11:16 a.m. with the DOR, Resident 61's OT Discharge Summary, dated 7/29/2022, was reviewed. The DOR stated the OT Discharge Summary indicated Resident 61 wore a left-hand WHFO for five hours and the RNA (unknown) demonstrated 100 % competence in performing Resident 61's left arm ROM exercises. The OT Discharge recommendations included RNA for PROM of the left arm and application of the left-hand WHFO splint for four to six hours. The DOR stated the PROM exercises the RNA should be performing with Resident 61 included shoulder flexion and extension (returning the arm downward), shoulder abduction and adduction (returning the arm downward to the side of the body), elbow flexion and extension, wrist flexion and extension (bending the wrist upward), forearm supination (rotating the forearm that results in the palm facing upward), and finger flexion and extension. During a concurrent interview and record review on 6/26/2024 at 12:23 p.m. with the DOR, Resident 61's OT Evaluation, dated 8/20/2022, and OT Discharge Summary, dated 9/2/2022, was reviewed. The DOR stated Resident 61's left arm ROM on 8/20/2022 did not change from the OT Evaluation, dated 6/12/2022. The DOR stated Resident 61's OT Discharge Summary, dated 9/2/2022, indicated Resident 61 wore the left-hand WHFO for 4.5 hours and the RNA (unknown) demonstrated 100% competence in applying the left-hand WHFO. The DOR stated Resident 61's OT Discharge recommendations included for RNA to provide PROM to the left arm and the application of the left hand WHFO for four to six hours, seven times per week. During a concurrent interview and record review on 6/26/2024 at 12:48 p.m. with the DOR, Resident 61's physician's orders, dated 1/23/2024, for RNA were reviewed. The DOR stated Resident 61's physician's orders indicated the order for the RNA to provide PROM to both legs, PROM to the left arm, and application of the left-arm WHFO and left ankle PRAFO. During a concurrent interview and record review on 6/26/2024 at 1:20 p.m. with the DOR, Resident 61's quarterly Rehab Screening, dated 11/5/2021, 2/2/2022, 5/2/2022, 6/12/2022, 8/1/2022, 10/24/2022, 1/18/2023, 4/18/2023, 5/31/2023, 7/13/2023, 10/12/2023, 1/10/2024, and 4/2/2024, were reviewed. The DOR stated Resident 61's Rehab Screening did not include ROM measurements because measuring a resident's ROM was an assessment and not a part of the screening. The DOR stated the RNAs provided ROM exercises to the residents (in general) and will verbally inform the DOR during weekly meetings whether the resident had a change in ROM and whether the resident did not tolerate wearing the splints. The DOR stated the quarterly Rehab Screening (in general) indicated whether a resident had an impairment in the arms and legs but did not indicate which joint was impaired and the severity of the impairment. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	During a concurrent observation and interview on 6/26/2024 at 1:37 p.m. with the DOR, in Resident 61's room, the resident was in bed wearing a hospital gown with the left arm positioned on the side of the body. Resident 61's left shoulder was rotated toward the body, the left elbow was in an extended position, the forearm was excessively rotated inward in a position that made the left-hand palm face away from Resident 61's body, the wrist was bent downward in a 90-degree position, and the left-hand middle, ring, and small fingers had a claw-like appearance. Resident 61 stated feeling pain throughout the left arm. Resident 61 allowed the DOR to move the left arm. The DOR stated Resident 61's ROM for left shoulder flexion was 0-70 degrees, left shoulder abduction was 0-45 degrees, left elbow ROM was 170-180 degrees, the left wrist moved from a flexed position to neutral, and the left thumb and index fingers were WFL. The DOR attempted to rotate Resident 61's left forearm into supination but Resident 61 immediately screamed in pain. The DOR stated Resident 61's left forearm ROM had a decline in ROM since the DOR could usually move the left forearm to neutral (rotating the forearm that results in the palm facing the body). The DOR stated the RNAs should be performing PROM to Resident 61's left shoulder, elbow, forearm, wrist, and hand prior to applying the left-hand WHFO. During an interview on 6/26/2024 at 1:45 p.m. the DOR stated the purpose of performing PROM to Resident 61's left arm was to maintain ROM, joint mobility, and prevent contractures. The DOR stated Resident 61's complaint of pain in the left arm and screaming in pain during forearm supination indicated Resident 61's left arm has not been moved (exercised). The DOR stated Resident 61's left arm experienced a ROM decline and increased pain. During a concurrent observation and interview on 6/27/2024 at 1:20 p.m. with Resident 61 in the bedroom, Resident 61 was in bed, awake in a hospital gown with the left arm positioned directly to the side of Resident 61's body. Resident 61 stated the left arm had some pain at rest that sharply increased when someone touched or moved the left arm for exercises. Resident 61 stated he wanted and encouraged the facility staff to perform left arm exercises (in general) but did not remember anyone performing any exercises to the left arm. Resident 61 stated he did not remember when or how long the left arm had a twisted appearance but stated it did not happen overnight. During an interview on 6/27/2024 at 1:42 p.m. a Certified Nursing Assistant (CNA 5) in Resident 61's room, CNA 5 stated Resident 61 was dressed in a hospital gown because Resident 61 had pain in the left arm, preventing Resident 61 from putting on a shirt. CNA 5 stated Resident 61 did not like to get out of bed because Resident 61 felt pain throughout the body. Resident 61 stated the left arm pain prevented Resident 61 from getting dressed and getting out of bed. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 6/27/2024 at 5:16 p.m. with the DON and DOR, Resident 61's Census List, OT Evaluation, dated 3/22/2019, Rehab Screening, dated 2/2/2022 and 5/2/2022, Documentation Survey Report for RNA for 2/2022, 3/2022, 4/2022, 5/2022, and 6/2022, and OT Evaluation, dated 6/12/2022, were reviewed. The DON and DOR reviewed Resident 61's Census List and stated Resident 61 never left the facility after admission on 3/21/2019. The DON and DOR reviewed Resident 61's OT Evaluation, dated 3/22/2019, which indicated Resident 61's ROM in the right arm was WFL but had impaired ROM in Resident 61's left shoulder, left elbow into extension but could bend completely, and left ring finger and small finger. The DON and DOR reviewed Resident 61's Rehab Screening, dated 2/2/2022. The DON stated the Rehab Screening, dated 2/2/2022, indicated the ROM in Resident 61's left arm and left leg were impaired but did not indicate which joints were impaired and the severity of the impairments. The DON stated Resident 61's Rehab Screening, dated 2/2/2022, indicated Resident 61 wanted an RNA program for ROM to both arms and both legs. The DON and DOR reviewed Resident 61's Documentation Survey Report for RNA from 2/2022 to 5/2022. The DOR stated Resident 61 did not receive PROM to the left arm from 2/2022 to 5/2022. The DOR and DON reviewed Resident 61's Rehab Screen, dated 5/2/2022. The DON stated the Rehab Screening, dated 5/2/2022, indicated the ROM in Resident 61's left arm and left leg were impaired but did not indicate which j [TRUNCATED]

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36943 Based on observation, interview, and record review, the facility failed to perform a quarterly pain evaluation for one of eight sampled residents (Resident 102) with limited range of motion [ROM, full movement potential of a joint (where two bones meet)] and mobility (ability to move). This deficient practice had the potential to prevent Resident 102 from receiving adequate pain management and additional intervention for Resident 102's left knee contracture (condition of shortening and hardening of muscles, tendons, or other tissue, often leading to joint stiffness). Findings: During a review of Resident 102's Admission Record, indicated the facility admitted Resident 102 on 1/9/2024 with diagnoses including pain in the right elbow, psychosis (severe mental disorder in which thought, and emotions are so impaired that contact is lost with external reality), and depression. During a review of Resident 102's Physical Therapy (PT, profession aimed in the restoration, maintenance, and promotion of optimal physical function) Evaluation and Plan of Treatment, dated 1/10/2024, the PT Evaluation indicated Resident 102's left hip was fixed (immovable) into 90-degrees of hip flexion (bending the leg at the hip joint toward the body, normal 0-120 degrees) and 140 degrees of knee flexion (bending the knee, normal 0-135 degrees). During a review of Resident 102's Physical Medicine and Rehabilitation Evaluation, dated 1/11/2024, indicated Resident 102 had a history of a washout surgery (procedure that involves washing or cleaning out the contents inside a joint space) for the left septic knee (inflammation of a joint caused by an infection) and a left leg contracture. During a review of Resident 102's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 1/15/2024, the MDS indicated Resident 102 had clear speech, expressed ideas and wants, clearly understood verbal content, and had intact cognition (ability to think, understand, learn, and remember). The MDS indicated Resident 102 had ROM limitations in both arms and one leg. The MDS indicated Resident 102 required partial/moderate assistance (helper does less than half the effort) for eating, oral hygiene, substantial/maximal assistance (helper does more than half the effort) for upper body dressing, and dependent (helper does all of the effort or the assistance of two or more helpers is required for the resident to complete the activity) for lower body dressing, rolling to both sides in bed, and moving from lying to sitting on the side of the bed. During a review of Resident 102's Physical Medicine and Rehabilitation Evaluation, dated 2/19/2024, indicated Resident 102 complained of constant left knee pain level 7 out of 10 on a pain scale rating from zero to ten (pain screening tool using numerical value to assess the level of pain ranging from 0 to 3-mild pain, from 4 to 6- moderate pain, and from 7 to 9-severe pain, and 10- the worse pain possible). (continued on next page)

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	055995	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Convalescent Center of North Long Beach	260 E Market St Long Beach, CA 90805

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 102's Physical Medicine and Rehabilitation Evaluation, dated 2/23/2024, indicated Resident 102 complained of dull and aching left knee pain with an intensity of 8 out of 10. During a review of Resident 102's PT Discharge Summary, dated 3/5/2024, the PT Discharge Summary indicated Resident 102 tolerated wearing the left knee extension (straightening out the knee) splint (material used to restrict, protect, or immobilize a part of the body to support function, assist and/or increase range of motion) for four hours. The PT Discharge Summary also indicated the Restorative Nursing Aide (RNA, certified nursing aide that helps residents to maintain their function and joint mobility) provided a 100 percent (%) return demonstration for exercises to both legs, including right leg active range of motion (AROM, performance of ROM of a joint without any assistance or effort of another person) exercises and left leg passive range of motion (PROM, movement of joint through the ROM with no effort from the person) exercises with left knee splint application. The PT Discharge Summary recommendations indicated for the RNA to provide right leg AROM, left leg PROM, and application of the left knee extension splint for four hours as tolerated. During a review of Resident 102's Physical Medicine and Rehabilitation Evaluation, dated 3/28/2024, indicated Resident 102's chief complaint included chronic (long-term) pain and had much left knee pain. During a review of Resident 102's MDS, dated [DATE], the MDS indicated Resident 102 had clear speech, expressed ideas and wants, clearly understood verbal content, and had intact cognition. The MDS indicated Resident 102 had ROM limitations in both arms and one leg. The MDS indicated Resident 102 required substantial/maximal assistance for oral hygiene and upper body dressing and dependent for lower body dressing, rolling to both sides in bed, and moving from lying to sitting on the side of the bed. During an observation on 6/25/2024 at 8:19 a.m., with Restorative Nursing Aide 2 (RNA 2) in Resident 102's bedroom, Resident 102 was lying awake in bed with the left hip and left knee bent. RNA 2 attempted to extend Resident 102's left knee but Resident 102 complained of left knee pain. RNA 2 stated Licensed Vocation Nurse 3 (LVN 3) already administered pain medication this morning. Resident 102 stated the left knee has not improved even with exercises. During an observation on 6/25/2024 at 3:08 p.m., with RNA 2 in Resident 102's bedroom, Resident 102 was lying in bed and agreeable to the left leg exercises. Resident 102 did not want RNA 2 to apply the left knee extension splint due to left knee pain. During an interview on 6/25/2024 at 4:22 p.m. with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated Resident 102 sometimes cried due to the left knee pain. During an interview on 6/26/2024 at 12:34 p.m. with the Director of Rehabilitation (DOR), the DOR stated contractures, including Resident 102's left knee contracture, caused pain because the muscles and soft tissue placed the bones at a different position. During an interview on 6/27/2024 at 9:48 a.m. with the Registered Nurse Supervisor 1 (RNS 1), RNS 1 stated the facility was supposed to assess a resident's pain (in general) during admission and quarterly. (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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and record review on 6/27/2024 at 11:03 a.m. with the Director of Nursing (DON), Resident 102's pain assessments were reviewed. The DON stated Resident 102's pain assessment was completed upon admission on 1/9/2024. The DON reviewed Resident 102's assessments and stated the facility did not complete a quarterly pain assessment in accordance with the facility's policy. During an interview on 6/27/2024 at 12:26 p.m. with the DON, the DON stated pain assessments were completed (in general) to ensure the facility was addressing the resident's needs. During a review of the facility's policy and procedure (P&P) titled, Pain Management, effective date 8/25/2021, the P&P indicated the facility maintained the highest possible level of comfort for residents By providing a system to identify, assess, treat, and evaluate pain. The P&P also indicated residents will be evaluated for the presence of pain upon admission, re-admission, quarterly, and with change in condition or change in pain status. Cross reference F684 and F755.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49130 Based on observation, interview, and record review, the facility failed to: 1. Ensure availability and administration of Restasis ([Generic name cyclosporine] a medication used to treat dry eye disease) in accordance with physician orders or professional standards of practice for one of three sampled residents (Resident 60.) This deficient practice increased the risk for Residents 60 to suffer from eye complications including dry eyes. 2. Maintain accurate documentation of administered clonazepam (a medication used to treat panic disorder and seizure [a medical term used to describe sudden, uncontrolled burst of electrical activity in the brain] on controlled drug record (a document indicating perpetual inventory and administration of controlled substances [a term used for medications with high level of abuse and dependence]) for Resident 45 as per facility's policies and procedures (P&P) titled, Controlled Medications in one of three inspected medication carts (Medication Cart 1B.) This deficient practice had the potential to result in misuse, drug loss and/or diversion of controlled substances. 3. Ensure facility apply a lidocaine cream (pain medication cream) to Residents 102's right shoulder in accordance with Resident 102's physician's order, dated 1/9/2024, by applying the cream to the left knee during multiple administrations from 3/1/2024 to 6/7/2024. This deficient practice had the potential to prevent Resident 102 from receiving adequate pain relief to the right shoulder and the left knee. Findings: 1. During a review of Resident 60's Admission Record dated 6/25/2024, the Admission Record indicated, Resident 60 was admitted to the facility on [DATE] with diagnosis including dry eye syndrome of bilateral (a term used to describe two sides) lacrimal glands (a term used for tear glands that supplies tear fluid in the eyes). During a review of Resident 60's History and Physical (H&P), dated 6/3/2024, indicated resident could not make decisions but could make needs known. During a review of Resident 60's Minimum Data Set ([MDS], a standardized assessment and care screening tool) dated 5/22/2024, the MDS indicated Resident 60 has intact cognition (ability to think, understand, learn, and remember) and required moderate to complete assistance from facility staff for activities of daily living (ADL tasks of everyday life that include personal hygiene, dressing, getting in and out of bed or chair, bathing, and toileting). (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 60's Physician Order Summary Report dated 6/25/2024, indicated the following medication: Restasis Ophthalmic (a term used for eyes) Emulsion (a mixture of two or more liquids) 0.05 percent (% - a term used to indicate concentration) (Cyclosporine) instill one drop in both eyes two times a day for dry eye syndrome .order date: 9/18/2023, start date: 9/19/2023 During a concurrent observation and interview during medication administration on 6/25/2024 at 8:13 a.m., with the Licensed Vocational Nurse (LVN) 2, LVN 2 prepared medications to administer to Resident 60. LVN 2 stated Resident 60 was supposed to receive Restasis ophthalmic emulsion, but the facility did not have medication in stock. During a review of Resident 60's Medication Administration Record for the month of June 2024, the MAR indicated LVN 2 marked ZZ for 6/25/2024 9:00 a.m. administration with progress note that stated to follow up with pharmacy. During an interview on 6/25/2024 at 1:26 p.m. with LVN 2, LVN 2 stated medication should have been ordered from pharmacy three to five days before running out of the medication. LVN 2 stated Resident 60 would suffer from discomfort and dryness in the eyes because of not receiving Restasis per physician order. During an interview on 6/26/2024 at 2:06 p.m. with the Director of Nurses (DON), the DON stated best practice to order medication seven days before running out. DON stated Restasis was used to treat Resident 60's dry eyes and resident would have pain and discomfort in his eyes from not receiving medication as ordered. DON stated Resident 60's physician should be notified, and resident should be monitored for adverse effects. During a review of the facility's policy and procedure (P&P) titled, Medication Administration- General Guidelines, dated 10/2017, the P&P indicated, Medications are administered without unnecessary interruptions. Unless otherwise specified by the prescriber, routine medications are administered according to the established medication administration schedule for the facility. During a review of the facility's P&P titled, Medication Orders, dated 4/2008, the P&P indicated, The prescriber is contacted for direction when the medication will not be available. 2. During a review of Resident 45's Admission Record, dated 6/26/2024, indicated, Resident 45 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including generalized anxiety disorder (a medical condition in which the person feels extremely worried or nervous more frequently). During a review of Resident 45's H&P, dated 5/31/2023, indicated Resident 45 did not have the capacity to make medical decisions. During a review of Resident 45's MDS, dated [DATE], the MDS indicated Resident 45 required full assistance from facility staff for activities of daily living (tasks of everyday life that include personal hygiene, dressing, getting in and out of bed or chair, bathing, and toileting). (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 45's Physician Order Summary Report, dated 6/26/2024, indicated the following medication: Clonazepam oral tablet 0.5 milligrams (mg - a unit of measurement), give 0.5 (one-half) tablet by mouth one time a day as manifested by constant yelling related to generalized anxiety disorder (0.5 tabs = 0.25 mg); order date: 2/8/2024, start date: 2/9/2024. During a concurrent interview and record review on 6/26/2024 at 3:16 p.m. with LVN 4 during medication cart inspection, Medication Cart 1B, clonazepam's bubble pack, controlled drug record and medication administration details were reviewed. The Medication Cart 1B contained medication bubble pack for clonazepam 0.5 mg with quantity of 13 one-half tablets sealed and visible. The Controlled Drug Record, undated, indicated a pharmacy label for Resident 45's clonazepam, and a quantity of 14 circled. LVN 4 stated, she failed to document in the controlled drug record the one-half tablet of clonazepam 0.5 mg that was given to Resident 45 on 6/26/2024 at 8:01 a.m. LVN 4 stated he documented on electronic health record but forgot to document on the controlled drug record. LVN 4 stated it was important to document clonazepam on medication administration record and controlled drug record after it was administered to Resident 45 because of its high risk for abuse. LVN 4 stated there would be a risk for misunderstanding between nurses about medication administered to Resident 45, which could increase the risk for misuse, loss, and abuse if accurate records were not maintained. During an interview on 6/27/2024 at 3:05 p.m. with the DON, the DON stated LVN should sign in electronic medical record and the controlled drug record after medication was removed from the medication bubble pack and administered to the resident. DON stated it was important for licensed nurses to account for medications during the shift change to prevent controlled substance discrepancy, diversion, and abuse. During a review of the facility's P&P titled, Controlled Medications, dated 4/2008, the P&P indicated, When a controlled medication is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and the medication administration record (MAR): 1) date and time of administration, 2) amount administered, 3)signature of the nurse .on the accountability record at the time removed from the supply, 4) initials of the nurse administering .on the MAR after the medication is administered. Cross Reference: F759 36943 3. During a review of Resident 102's Admission Record, indicated the facility admitted Resident 102 on 1/9/2024 with diagnoses including pain in the right elbow, psychosis (severe mental disorder in which thought, and emotions are so impaired that contact is lost with external reality), and depression. During a review of Resident 102's Physician Orders, dated 1/9/2024, indicated to apply lidocaine external cream to the right shoulder topically one time a day for shoulder pain. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 102's Physical Therapy (PT, profession aimed in the restoration, maintenance, and promotion of optimal physical function) Evaluation and Plan of Treatment, dated 1/10/2024, the PT Evaluation indicated Resident 102's left hip was fixed (immovable) into 90-degrees of hip flexion (bending the leg at the hip joint toward the body, normal 0-120 degrees) and 140 degrees of knee flexion (bending the knee, normal 0-135 degrees). During a review of Resident 102's Physical Medicine and Rehabilitation Evaluation, dated 1/11/2024, indicated Resident 102 had a history of a washout surgery (procedure that involves washing or cleaning out the contents inside a joint space) for the left septic knee (inflammation of a joint caused by an infection) and a left leg contracture. During a review of Resident 102's Physical Medicine and Rehabilitation Evaluation, dated 2/19/2024, indicated Resident 102 complained of constant left knee pain level 7 out of 10 on a pain scale rating from zero to ten (pain screening tool using numerical value to assess the level of pain ranging from 0 to 3-mild pain, from 4 to 6- moderate pain, and from 7 to 9-severe pain, and 10- the worse pain possible). During a review of Resident 102's Physical Medicine and Rehabilitation Evaluation, dated 2/23/2024, indicated Resident 102 complained of dull and aching left knee pain with an intensity of 8 out of 10. During a review of Resident 102's PT Discharge Summary, dated 3/5/2024, the PT Discharge Summary indicated Resident 102 tolerated wearing the left knee extension (straightening out the knee) splint (material used to restrict, protect, or immobilize a part of the body to support function, assist and/or increase range of motion) for four hours. The PT Discharge Summary also indicated the Restorative Nursing Aide (RNA, certified nursing aide that helps residents to maintain their function and joint mobility) provided a 100 percent (%) return demonstration for both leg exercises, including right leg active range of motion (AROM, performance of ROM of a joint without any assistance or effort of another person) exercises and left leg passive range of motion (PROM, movement of joint through the ROM with no effort from the person) exercises with left knee splint application. The PT Discharge Summary recommendations indicated for the RNA to provide right leg AROM, left leg PROM, and application of the left knee extension splint for four hours as tolerated. During a review of Resident 102's Medication Administration Record (MAR) for 3/2024, the MAR indicated Resident 102's lidocaine external cream was applied to the left knee on 3/19/2024, 3/27/2024, 3/28/2024, 3/29/2024, and 3/30/2024. During a review of Resident 102's Physical Medicine and Rehabilitation Evaluation, dated 3/28/2024, indicated Resident 102's chief complaint included chronic (long-term) pain and had much left knee pain. During a review of Resident 102's MAR for the month of 4/2024, the MAR indicated Resident 102's lidocaine external cream was applied to the left knee on 4/1/2024, 4/10/2024, 4/23/2024, 4/24/2024, and 4/25/2024. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 102's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 4/12/2024, the MDS indicated Resident 102 had clear speech, and intact cognition (ability to think, understand, learn, and remember). The MDS indicated Resident 102 had ROM limitations in both arms and one leg. During a review of Resident 102's MAR for the month of 5/2024, the MAR indicated Resident 102's lidocaine external cream was applied to the left knee from 5/1/2024 to 5/25/2024. During a review of Resident 102's MAR for month 6/2024, the MAR indicated Resident 102's lidocaine external cream was applied to the left knee on 6/2/2024, 6/3/2024, 6/4/2024, 6/5/2024, 6/6/2024, and 6/7/2024. During an observation on 6/25/2024 at 8:19 a.m., with Restorative Nursing Aide 2 (RNA 2) in Resident 102's bedroom, Resident 102 was lying awake in bed with the left hip and left knee bent. RNA 2 attempted to extend Resident 102's left knee but Resident 102 complained of left knee pain. RNA 2 stated Licensed Vocation Nurse 3 (LVN 3) already administered pain medication on 6/25/2024 a.m. Resident 102 stated the left knee has not improved even with exercises. During an observation on 6/25/2024 at 3:08 p.m. with RNA 2 in Resident 102's bedroom, Resident 102 was lying in bed and agreeable to the left leg exercises. Resident 102 did not want RNA 2 to apply the left knee extension splint due to left knee pain. During an interview on 6/25/2024 at 4:22 p.m. with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated Resident 102 sometimes cried due to the left knee pain. During a concurrent interview and record review on 6/27/2024 at 11:03 a.m. with the Director of Nursing (DON), Resident 102's physician orders for lidocaine cream to the right shoulder, dated 1/9/2024, and the MAR for 4/2024 and 5/2024 were reviewed. The DON stated Resident 102's physician orders for the lidocaine cream indicated to apply the cream to Resident 102's right shoulder. The DON reviewed Resident 102's MAR for 4/2024 and 5/2024 and stated the licensed nurses were applying the lidocaine cream to Resident 102's left knee to address Resident 102's left knee pain. The DON stated the licensed nurses were not applying the lidocaine cream to the right shoulder in accordance with Resident 102's physician orders. During a review of the facility's policy and procedure (P&P) titled, Mediation Administration - General Guidelines, the P&P indicated medications were administered in accordance with written orders of the attending physician. Cross reference F697.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45269 Based on interview and record review, the facility failed to ensure one of five sampled residents (Resident 74) did not receive unnecessary psychotropic medications (medications which affect perception, mood, consciousness, and behavior). This deficient practice had the potential to place Resident 74 at risk for adverse consequences due to unnecessary prolonged use of psychotropic medication. Findings: During a review of Resident 74's Admission Record , the Admission Record indicated Resident 74 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills and eventually the ability to carry out the simplest tasks), unspecified dementia (loss of cognitive functioning such as thinking, remembering and reasoning) , history of falling, and depression(mood disorder that causes a persistent feeling of sadness). During a review of Resident 74's Minimum Data Set([MDS] a standardized assessment and care screening tool) dated 4/5/20204, the MDS indicated Resident 74 had impaired cognitive skills (ability to think, understand, learn, and remember) and was dependent on staff with bathing, oral hygiene, toileting hygiene and dressing. During a review of Resident 74's Physician Order Summary Report, indicated a physician order of Ativan (Lorazepam, medicine used to treat anxiety and insomnia [difficulty sleeping]) oral tablet 1 milligram ([mg.] unit of measurement) give one mg. by mouth every 6 hours as needed for constant chanting related to anxiety for 30 days. The Physician Order Summary Report indicated the start date of the order was 6/16/2024 and the end date was 7/16/2024. During a review of Resident 74's IDT Psychotropic ([IDT] group of professional and direct care staff that have primary responsibility for the development of a plan for the care and treatment of a resident) dated 4/23/2024, the IDT Psychotropic indicated the psychiatrist nurse practitioner (health professional specialize in mental disorder) recommended to add a stop date of 14 days to Lorazepam (Ativan). (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 6/27/2024, at 4:07 p.m. with Assistant Director of Nursing (ADON), Resident 74's Physician Order and facility's policy and procedure for psychotropic medication use were reviewed. The ADON confirmed Ativan one mg. every 6 hours as needed manifested by constant chanting was ordered for 30 days. The ADON stated Resident 74 was under hospice care that is why it was ordered for 30 days. The ADON confirmed through record review of facility's P&P on psychotropic medication use prn (as needed) psychotropic medications should be ordered for no more than 14 days. The ADON stated the facility was not following its own P&P. The ADON stated there was no documentation from the physician what was the reason it was ordered for 30 days and agreed psychotropic medication like Ativan required reassessment and reevaluation of its use because of the adverse drug reactions (unintended, harmful effects attributed to the use of medication). During an interview on 6/28/2024, at 6:14 p.m., with the Director of Nursing (DON), the DON stated facility's P&P was 14 days for prn psychotropic medication because Ativan could act as a chemical restraint (a form of medical restraint in which a drug is used to restrict the freedom or movement of a resident). The DON stated there should be a documentation from the physician of the use of Ativan if it will be used for 30 days. During a review of facility's policy and procedure (P&P) untitled and undated, indicated the Policy sets forth procedures relating to psychotropic medication use. For prn psychotropic medications should be ordered for no more than 14 days and each resident who was taking a prn psychotropic drug will have his or her prescription reviewed by the physician or prescribing practitioner every 14 days.

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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** 49130 Based on observation, interview, and record review, the facility failed to maintain a medication error rate of less than less than five percent (%) affecting three of three residents observed for medication administration (Residents 60, 80 and 106) by failing to: a. Ensure availability and administration of Restasis ([Generic name - cyclosporine] a medication used to treat dry eye disease) for Resident 60 in accordance with physician orders. b. Ensure proper administration of Advair Diskus ([Generic name - fluticasone-salmeterol] a combination medication delivered through a device in the form of inhalation powder to treat breathing problems) for Resident 80 by ensuring rinsing of mouth after use per prescriber instructions. c. Hold amlodipine (a medication used to treat high blood pressure) dose administration for Resident 106 per prescribed blood pressure parameters. These deficient practice resulted in an overall medication error rate of 11.59 % exceeding 5% threshold and placed Residents 60, 80 and 106 at risk to experience significant medical complications including, dry eyes, oral thrush (a medical term used to describe fungal infection in mouth region) and low blood pressure. Findings: a. During a review of Resident 60's Admission Record, dated 6/25/2024, indicated, Resident 60 was admitted to the facility on [DATE] with diagnosis including dry eye syndrome of bilateral (a term used to describe two sides) lacrimal glands (a term used for tear glands that supplies tear fluid in the eyes). During a review of Resident 60's History and Physical (H&P), dated 6/3/2024, indicated patient could not make decisions but could make needs known. During a review of Resident 60's Minimum Data Set ([MDS], a standardized assessment and care screening tool) dated 5/22/2024, the MDS indicated Resident 60 had intact cognition (ability to think, understand, learn, and remember) and required moderate to complete assistance from facility staff for activities of daily living (tasks of everyday life that include personal hygiene, dressing, getting in and out of bed or chair, bathing, and toileting). During a review of Resident 60's Physician Order Summary Report, dated 6/25/2024, the order summary report indicated the following medication: Restasis Ophthalmic (a term used for eyes) emulsion (a mixture of two or more liquids that do not form uniform composition) 0.05 percent (% - a term used to indicate concentration) (Cyclosporine) instill one drop to both eyes two times a day for dry eye syndrome order date: 9/18/2023, start date: 9/19/2023. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview during medication administration on 6/25/2024 at 8:13 a.m., with the Licensed Vocational Nurse (LVN) 2, LVN 2 prepared medications to administer to Resident 60. LVN 2 stated Resident 60 was supposed to receive Restasis ophthalmic emulsion, but the facility did not have medication in stock. During a review of Resident 60's Medication Administration Record (MAR, for June 2024, the MAR indicated LVN 2 marked ZZ for 6/25/2024 9:00 a.m. administration with progress note that stated to follow up with pharmacy. During an interview on 6/25/2024 at 1:26 p.m. with LVN 2, LVN 2 stated medication should have been ordered from pharmacy three to five days before running out of the medication. LVN 2 stated Resident 60 would suffer from discomfort and dryness in the eyes because of not receiving Restasis per physician order. During an interview on 6/26/2024 at 2:06 p.m. with the Director of Nurses (DON), the DON stated best practice was to order medication seven days before running out. DON stated Restasis was used to treat Resident 60's dry eyes and resident would have pain and discomfort in his eyes from not receiving medication as ordered. DON stated Resident 60's physician should be notified, and resident should be monitored for adverse effects. b. During a review of Resident 80's Admission Record, dated 6/25/2024, the admission record indicated Resident 80 was admitted to the facility on [DATE] with diagnoses including unspecified asthma (a medical condition with symptoms of breathing problems) and chronic obstructive pulmonary disease (COPD - a common lung disease causing restricted airflow and breathing problems). During a review of Resident 80's H&P, dated 6/4/2024, indicated Resident 80 was capable of making medical decisions. During a review of Resident 80's MDS dated [DATE], the MDS indicated Resident 80 had intact cognition and required maximal to full assistance from facility staff for activities of daily living (tasks of everyday life that include personal hygiene, dressing, getting in and out of bed or chair, bathing, and toileting). During a review of Resident 80's Physician Order Summary Report, dated 6/25/2024, the order summary report indicated the following medication: Advair Diskus Aerosol Powder Breath Activated 100-50 microgram (mcg - a unit of measurement) (fluticasone-salmeterol) one inhalation inhale orally two times a day for COPD rinse mouth after use; order date: 4/28/2024, start date: 4/29/2024. During an observation on 6/25/2024 at 9:00 a.m. in Resident 80's room during medication administration, LVN 2 administered 12 medications including Advair Diskus inhalation. LVN 2 did not instruct Resident 80 to rinse mouth after use of Advair Diskus. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/25/2024 at 2:02 p.m., with LVN 2, LVN 2 stated resident did not rinse his mouth after using the Advair. LVN 2 stated, Resident 80 will curse you out and gets mad if he was instructed to do something and he thinks he does not need to do it. LVN 2 stated not rinsing his mouth would affect Resident 80's teeth and mouth. LVN 2 stated Resident 80 would be at risk for oral thrush and mouth infection. LVN 2 stated Resident 80 was set in his own ways and did not understand the risk of side effects and infection if medication administration instructions were not followed as prescribed. During an interview on 6/26/2024 at 2:06 p.m., with the DON, the DON stated Advair was an inhaled corticosteroid and Resident 80 should rinse mouth after use to prevent mucosal (mouth) infection such as oral thrush (infection in the mouth) or a fungal infection. The DON stated nurses should read the pharmacy label before administering medications to ensure all instructions about the medication were followed. The DON stated if the resident refused to follow instructions, it would be important to educate the patient about the risk and benefit of not following the instructions, risk of mouth infection that could require additional treatment and/or hospitalization . c. During a review of Resident 106's Admission Record, dated 6/25/2024, indicated Resident 106 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including unspecified hypotension (a medical term to describe low blood pressure), hypertensive heart disease with heart failure (a medical condition with high blood pressure along with failure of heart to circulate blood throughout the body) and chronic diastolic (congestive) heart failure (a medical condition where heart cannot pump blood well enough to give normal supply throughout body). During a review of Resident 106's MDS, dated [DATE], the MDS indicated Resident 106 had intact cognition and required moderate assistance from facility staff for activities of daily living. During a review of Resident 106's Physician Order Summary Report, dated 6/25/2024, the order summary report indicated the following medication: amlodipine oral tablet 2.5 milligrams (mg - a unit of measurement) give 1 tablet by mouth one time a day for hypertension hold for systolic blood pressure (SBP - the pressure caused by heart while contracting) less than 100 millimeters of mercury ([mmHg] - a unit measurement of pressure or diastolic blood pressure ([DBP] a pressure in the arteries when the heart rests between beats) less than 70 mmHg; order date: 4/18/2024, start date: 4/19/2024. During a concurrent observation and interview on 6/25/2024 at 9:40 a.m., with LVN 3, LVN 3 prepared and administered six medications including amlodipine for Resident 106 during medication administration. LVN 3 stated Resident 106's blood pressure was recorded to be 122/64 on 6/25/2024 at 8:45 a.m. During an interview on 6/25/2024 at 2:06 p.m. with LVN 3, LVN 3 stated Resident 106's blood pressure reading was 122/64. LVN 3 stated Resident 106's amlodipine parameters were to hold amlodipine 2.5 mg if SBP was less than 100 or DBP was less than 70. LVN 3 stated she did not realize but she was supposed to hold the medication and should have told the resident that amlodipine would need to be held. LVN 3 stated she checked on the resident, and he looked relaxed and alert with no signs of respiratory distress. LVN 3 stated giving amlodipine outside of prescribed parameters, would cause blood pressure to drop. LVN 3 stated if blood pressure went extremely low, Resident 106 would get sluggish and dizzy, and placed at risk for respiratory distress and hospitalization . (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/26/2024 at 2:06 p.m. with the DON, the DON stated amlodipine was used to treat hypertension. The DON stated there were prescriber parameters which need to be used to monitor blood pressure. The DON stated Resident 106 would get hypotensive (a condition with low blood pressure) and dizzy. The DON stated low blood pressure would increase the risk for falls, bradycardia (a condition with slow heart rate) and hospitalization . During a review of the facility's policy and procedure (P&P) titled, Medication Administration- General Guidelines, dated 10/2017, the P&P indicated, Medications are administered without unnecessary interruptions. Unless otherwise specified by the prescriber, routine medications are administered according to the established medication administration schedule for the facility. Prior to administration, the medication and dosage schedule on the resident's medication administration record (MAR) is compared with the medication label. Medications are administered in accordance with written orders of the attending physician. During a review of the facility's P&P titled, Medication Orders, dated 4/2008, the P&P indicated, the prescriber is contacted for direction when the medication will not be available. Cross Reference F755

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49130 Based on observation, interview, and record review, the facility failed to: 1. Ensure removal of expired calcium plus vitamin D3 ([D3 - cholecalciferol a form of vitamin D] a dietary supplement to treat calcium and vitamin D deficiency, and promote bone health), bisacodyl (a medication used to treat constipation and bowel irregularity), vitamin B12 (a vitamin used to treat anemia and prevent vitamin B12 deficiency), simethicone (a medication used to relieve bloating and discomfort of gastrointestinal [the organs through which food passes after swallowing and digestion] gas) and cranberry (a dietary supplement used to prevent urinary tract [a medical term used to describe drainage system for removing urine] infection) tablets, per manufacturer requirements, from one of one inspected medication room (Medication Room Station 1). 2. Ensure latanoprost (a medication in form of eye drops used to treat high pressure in the eyes) eye drops, Humulin R insulin (a medication used to treat high blood sugar) and gabapentin (a medication used to treat seizures [a medical term used to describe sudden, uncontrolled burst of electrical activity in the brain] and nerve pain) were stored and labeled according to manufacturer's requirements affecting four residents (Residents 22, 46, 104 and 107) in two of three inspected medication carts (Medication Cart 1A and Medication Cart 1B). These failures increased the risk that: Residents 22, 46, 104, 107, and other facility residents could have received medications that had become ineffective or toxic due to improper storage or labeling possibly leading to health complications resulting in vitamin deficiency, hospitalization , or death. Findings: 1. During a concurrent observation and interview on 6/25/2024 at 4:04 p.m. with Assistant Director of Nursing (ADON) in the Medication Room Station 1, the following medications and/or dietary supplements were found to be expired: 1a. Four unopened bottles of cranberry 450 milligrams (mg - a unit of measurement) tablets; expiration date: 05/2024 1b. One unopened bottle of simethicone 80 mg chewable tablets; expiration date: 03/2024 1c. Four unopened bottles of calcium 600 mg plus vitamin D 5 micrograms (mcg - a unit of measurement) or 200 international units (IU - a unit of measurement) tablets; expiration date: 04/2024 1d. Two unopened bottles of vitamin B12 500 mcg tablets; expiration date: 03/2024 1e. One unopened bottle of vitamin B12 1000 mcg tablets; expiration date: 02/2024 1f. One unopened bottle of bisacodyl 5 mg tablets, expiration date: 04/2024 (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1g. One unopened bottle of bisacodyl 5 mg tablets, expiration date: 03/2024 The ADON stated, the facility missed to remove expired bottles of medications and dietary supplements. TheADON stated it was important to remove outdated and/or expired medications and dietary supplements from the stock to prevent medication errors and health complications from administering these expired medications to facility residents. The ADON stated residents could suffer from a variety of health complications depending on the expired medication or dietary supplement that was administered. During an interview on 6/26/2024 at 1:38 p.m., with the Director of Nurses (DON), the DON stated she reviewed medication room twice a month to ensure proper storage and removal of expired medications. DON stated it would not be safe to administer expired medications to facility residents and there would be a risk of that if expired medications are not removed from medication room. DON stated residents could suffer from multiple side effects leading to health complications from receiving expired medications that are unsafe and ineffective. 2a. During an observation and inspection on 6/26/2024 at 12:21 p.m. of Medication Cart 1A with Licensed Vocational Nurse (LVN) 3, an unopened bottle of latanoprost eyes drops for Resident 46 was found in the medication cart with no opened date and/or no expiration date, which was not in accordance with manufacturer's requirements. According to the manufacturer's product labeling, unopened bottle(s) should be stored under refrigeration at 2-to-8 degree Celsius [(C) a unit of temperature] (36-to-46-degree Fahrenheit [(F) is a unit of temperature] and open or in-use bottle may be stored at room temperature up to 25 C (77 F) for six weeks. During a subsequent interview on 6/26/2024 at 12:21 p.m. with LVN 3, LVN 3 stated she was not sure why the medication was in the medication cart. LVN 3 stated medications requiring refrigeration should be labeled with opened date when removed from the refrigerator. LVN 3 stated latanoprost eye drops were not safe to be administered because it was not known when it was removed from the refrigerator. LVN 3 stated Resident 46 could suffer from blurred vision, irritation, redness in the eyes and other eye complications if she received improperly stored eye drops. During an interview on 6/26/2024 at 2:06 p.m. with the DON, the DON stated she thought latanoprost was supposed to be stored at room temperature. After checking package insert, the DON stated latanoprost should be refrigerated and if removed from the refrigerator or opened, it should have an open date to ensure that the med is removed from stock six weeks after opening or removing from refrigerator. The DON stated administering eye drops that were not stored per manufacturer requirements could cause eye irritation and other complications for Resident 46. 2b. During an observation and inspection on 6/26/2024 at 3:16 p.m. of Medication Cart 1B with LVN 4, the following medications were stored in a manner contrary to their respective manufacturer's requirements, or not labeled with an open date as required by their respective manufacturer's specifications. 1) Humulin R 100 units (a unit of measurement for insulin) / milliliters (mL - a unit of measurement) for Resident 107 unsealed and with no open date. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Per the manufacturer's product labeling, in-use (opened) vial must be used within 31 days. 2) Gabapentin 250 mg/5 mL solution stored in medication cart for Resident 22 with an opened date of 5/27/2024 3) Gabapentin 250 mg/5 mL solution stored in medication cart for Resident 104 with an opened date of 6/22/2024 Per the manufacturer's product labeling, solution should be stored in refrigerator at 2 -8 C (36 -46 F) During an interview on 6/26/2024 at 3:16 p.m. with LVN 4 stated Humulin R for Resident 107 should have an open date to determine expiration date after being removed from the refrigerator. LVN 4 stated the vial was almost full and he did not use much insulin from that vial. During a concurrent interview on 6/26/2024 at 3:35 p.m. with LVN 4 and LVN 5, LVN 5 stated gabapentin should be stored in refrigerator according to manufacturer and pharmacy label on the bottle but did not know what to do after removing from refrigerator. During an interview on 6/26/2024 at 4:43 p.m. with LVN 4, LVN 4 stated gabapentin was placed in medication cart by the nighttime nurse. LVN 4 stated gabapentin should be stored in the refrigerator otherwise the medication may lose its effectiveness and safety. LVN 4 stated Resident 22 would be at increased risk for seizures, injury, and hospitalization if medication was not effective for the resident. LVN 4 stated Resident 104 was prescribed gabapentin for seizures (sudden, uncontrolled burst of electrical activity in the brain) and pain. LVN 4 stated due to improper storage of gabapentin, there was a risk that Resident 104 would get agitated if not adequately treated for pain and would also be at risk for seizures and hospitalization . LVN 4 stated Humulin R for Resident 107 should have an opened date after removing from the refrigerator. LVN 4 stated Humulin R would not be safe or effective to treat high blood sugar, which would increase the risk for hospitalization or even death for Resident 107 due to the insulin not being stored according to manufacturer's requirements. During an interview on 6/27/2024 at 9:34 a.m. with the registered pharmacist (RPH) 1 at pharmacy (PH), RPH 1 stated the pharmacy provided gabapentin solution to the facility for Resident 22 and Resident 104. RPH 1 stated both gabapentin solutions were supplied in manufacturer bottle, not an extemporaneous preparation. RPH 1 stated gabapentin solution bottles for Residents 22 and 104 were required to be stored in refrigerator at 2 C-8 C (36 F to 46 F). RPH 1 stated gabapentin solution for Resident 22 was filled on 6/15/2024, and gabapentin solution for Resident 104 was filled on 6/24/2024 or 6/25/2024. During an interview on 6/27/2024 3:05 p.m. with the DON, the DON stated gabapentin should be stored in refrigerator to maintain safety and effectiveness. DON stated Resident 22 and Resident 104 would be at high risk for seizures and hospitalization if the condition was not well controlled with gabapentin that was inappropriately stored. DON stated Humulin R insulin should be stored in refrigerator and labeled with an open date once removed from the refrigerator. DON stated Resident 107's blood sugar would not be well controlled, and resident would be at risk for hospitalization if the insulin was not effective due to inappropriate storage conditions. (continued on next page)

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F 0761 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, Storage of Medications, dated 04/2008, the P&P indicated, Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. Medications requiring refrigeration or temperatures between 2 C (36 F) and 8 C (46 F) are kept in a refrigerator with a thermometer to allow temperature monitoring. Outdated, contaminated, or deteriorated medications are immediately removed from stock, disposed of according to procedures for medication disposal.

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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. 39028 Based on observation, interview and record review facility failed to follow their policy on food handling and storage in the refrigerator by not dating prepared food stored in the refrigerator. This deficient practice had the potential to cause food borne (illness caused by food contaminated with germs or toxins) diseases among the facility residents who depend on facility prepared food for daily feeding, Findings: During a concurrent kitchen observation and interview with the Dietary Supervisor (DS) on 6/27/2024 at 12:06 p.m., observed snacks/nourishment stored in the refrigerator were not labeled with preparation date or expiration date. DS stated the snacks were just prepared and stored in the refrigerator to cool down for lunch service. The DS stated it was not labeled with the date of preparation. During a review of facility's policy and procedure (P&P) titled, Food receiving and storage, (undated) the P&P indicated all foods stored in the refrigerator or freezer must be covered labelled and dated.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 46415 Based on interview and record review, the facility's Quality Assessment and Assurance Committee (QAA) failed to provide documented evidence of the implementation of their Quality Assurance and Performance Improvement (QAPI-data driven approach to quality improvement) plan in reference to facility falls, weight management and wound management issues identified. This deficient practice had the potential to have reoccurring deficient practices that can impact the quality of care for the residents. Findings: During a review of the QAPI plan received, the active QAPI plan included falls, wounds, and weights. During a concurrent interview and record review of the QAPI plan on 6/28/2024 at 6:50 p.m., with the Assistant Director of Nursing (ADON), the ADON stated the QAPI plan for weight variance and wound management was initiated. The ADON stated cannot provide documented evidence QAPI plan was being implemented. The ADON also indicated they wish they had a map they can use to compare the different months for the weight variance. During a concurrent interview and record review of QAPI plan on 6/28/2024 at 8:54p.m. with the DON, the DON stated the facility had initiated a QAPI plan for weight variance in May 2024. The DON stated the plan was to look at the interventions in place if the intervention was not working for the first month, they will change the plan and have more huddles. The DON stated the facility cannot provide documented evidence they implemented this plan. The DON stated they have a process in place but does not have a list of how many residents had weight variance. The DON could not provide documented evidence of the implementation or evaluation of QAPI plan for weight variance, falls or wound management. During a review of the facility's policy and procedure (P&P) titled, Quality Assurance and Performance Improvement (QAPI) Program-Governance and Leadership, revised March 2020, the P&P indicated the responsibilities of the QAPI Committee were to collect and analyze performance indicator data and other information, identify, evaluate, monitor, and improve facility systems and processes that support the delivery of care and services. The P&P indicated the facility has the full authority to oversee the implementation of the QAPI Program, including appropriately interpreting data within the context of standards of care, benchmarks, targets and the strengths and challenges of the facility.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45269 Based on observation, interview and record review, the facility failed to observe infection control measures on two of six sampled residents (Resident 48 and Resident 80) by failing to: a.Ensure doffing of (removal) personal protective equipment ([PPE] specialized clothing or equipment worn by an employee for protection against infectious materials) properly after rendering care to Resident 48. b.Practice infection prevention measures by placing medications in unclean and unsanitary conditions for one of three observed residents during medication administration (Resident 80). These failures had the potential to spread infection among residents, staff, and visitors. Findings: a.During a review of Resident 48's Admission Record, the Admission Record indicated Resident 48 was admitted to the facility on [DATE] to the facility with diagnoses that included dependence on renal dialysis (kidneys are no longer working adequately and depends on dialysis to detoxify the body), diabetes(high blood sugar), and gastrostomy status(tube inserted through the wall of the abdomen directly into the stomach which is used to give medicine and liquid food to the patient). During a review of Resident 48's Minimum Data Set ([MDS] standardized screening tool) dated 6/3/2024, the MDS indicated the resident had severely impaired cognitive skills (person had trouble making decisions, remembering, concentrating, or learning) and dependent on the staff with bed mobility, transfer, bathing, toileting hygiene and oral hygiene. During a review of Resident 48's Order Summary Report dated 5/29/2024, the Order Summary Report indicated to observe Enhanced Barrier Precaution (infection control intervention designed to reduce transmission of multi-drug resistant organisms([MDRO]bacteria that resist treatment with more than one antibiotic) which involves use of glove and gown during high contact resident care activities every shift. During a concurrent observation and interview on 6/25/2024, at 8:11 a.m. in Resident 48's room with Assistant Minimum Data Set Coordinator (AMDSC), Resident 48's feeding pump (medical device used to deliver liquid nutrients directly into the digestive tract of a resident who is unable to take food or liquids by mouth) was alarming continuously, and the feeding pump's screen indicated hold error. AMDSC entered the room, practiced hand hygiene then wore a gown and gloves and tried to trouble shoot why the feeding pump was alarming. Observed AMDSC checked the feeding pump and the connection between the gastrostomy tube to the feeding pump and then reset the pump. AMDSC removed her gown first and the used gloves threw them all into the trash can. AMDSC admitted she did not doff her PPE properly and was nervous that she forgot the correct way of doffing PPE. AMDSC stated she should have removed her gloves and then gown to prevent contaminating herself and spread infection to other staff and residents. (continued on next page)

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	055995	A. Building B. Wing	06/28/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/25/2024, at 2:58 p.m. with Infection Preventionist Nurse (IPN), IPN stated the staff member should have removed her gloves first, gown and face mask. IPN stated not doffing PPE correctly could lead to possible spread of infection among the residents and staff. During a review of facility's policy and procedure (P&P) titled Enhanced Standard /Barrier Precautions undated, the P&P indicated refers to the use of gown and gloves for use during high contact resident care activities like device care or any care contact such as involving device care or any care activity involving contact with environmental surfaces likely contaminated by the resident. During a review of an online article the online article titled Sequence for Removing PPE (ca.gov) indicated the sequence for removing PPE is intended to limit self-contamination. The online article indicated the sequence of removal is as follows 1.) gloves, 2.) gown, 3) face shields or goggles, 4.) mask or respirator (high filtering mask) and then perform hand hygiene after PPE removal. 49130 During a review of Resident 80's Admission Record dated 6/25/2024, the Admission Record indicated Resident 80 was admitted to the facility on [DATE] with diagnoses including type 2 diabetes mellitus (a medical condition with high blood sugar) with diabetic neuropathy (a medical condition with nerve pain), elevated (increased) white blood cell (blood cells that help body fight infections and diseases) count, dermatitis (a condition described as irritation and swelling of skin) and urinary tract (a medical term used to describe drainage system for removing urine) infection. During an observation on 6/25/2024 at 9:00 a.m. in Resident 80's room during medication administration, Licensed Vocational Nurse (LVN) 2 placed the medication tray next to resident's urinal (a receptacle typically used by bedridden men to urinate) on the bedside table. There was an empty urinal placed horizontally and a urinal with yellow colored liquid placed vertically on the bedside table. LVN 2 proceeded to administer twelve medications to Resident 80. During an interview on 6/25/2024 at 2:20 p.m. with LVN 2, LVN 2 stated Resident 80 was made aware about the urinal to be placed at the bedside with the holder, but the resident argued and wanted both urinals on the table. LVN 2 stated Resident 80 was really set in his own ways and did not understand the risk of infection if urinal was placed near personal belongings and medications. LVN 2 stated this was also a dignity issue and facility policy indicated urinal should be in a container. During an interview on 6/26/2024 2:06 p.m. with the Director of Nurses (DON), the DON stated urinals should be hung with the dignity bag next to the bed where resident can grab comfortably depending on their limitations. The DON stated there would be a risk of cross-contamination, infection and hospitalization for facility staff and residents. DON stated, licensed staff should have cleaned the bedside table, drained the urine, then give the meds and inform resident if she can administer medications first and then bring the urinal. The DON stated Resident 80 did not understand this precautionary measure, so she would continue to educate the resident about the risks of having medications next to open urinal on the bedside table. (continued on next page)

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F 0880 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, Infection Prevention and Control Program, dated 09/18/2023, the P&P indicated, An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and . to help prevent the development and transmission of communicable diseases and infections. Important facets of infection prevention include educating staff and ensuring that they adhere to proper techniques and procedures; communicating the importance of standard precautions.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41699 Based on interview and record review, the facility failed to implement antibiotic stewardship program (measures used by the facility to ensure antibiotics [drug to treat infection] are used only when necessary and appropriate) for three of seven sampled residents (Resident 12,47, and 111), by prescribing an antibiotic without meeting the criteria of their protocol (checklist or guide to initiate antibiotic). This deficient practice had the potential to put Resident 12,47, and 111 at risk for antibiotic resistance (not effective to treat infection) and inappropriate use of antibiotic. Findings: During a review of Resident 12's Admission Order indicated Resident 12 was admitted to the facility on [DATE] with diagnoses including hemiplegia (paralysis of one side of the body) and hemiparesis (weakness of one side of the body) following cerebral infarction (damage to the brain from interruption of its blood supply) , bipolar disorder (a serious mental illness that causes unusual shifts in mood), and chronic obstructive pulmonary disease ([COPD] a common lung disease causing restricted airflow and breathing problems). During a review of Resident 12's Minimum Data Sheet (MDS- a standardized assessment and care screening planning tool) dated 03/27/24 indicated Resident 12 had no cognitive impairment (ability to learn, understand, and make decisions) and requires dependent assistance for all activities of daily living. During a record review of Resident 12's Physician Order Audit Report dated 06/06/2024 indicated Resident 12 had an order for Ketoconazole external cream (treat skin infection) 2 percent (%) to apply to bilateral legs topically two times a day for eczema (skin condition) for four weeks until finished. During a review of Resident 47's Admission Order indicated Resident 47 was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction, bipolar disorder, and hypertensive heart disease with heart failure (a long-term condition that develops over many years in people who have high blood pressure. During a review of Resident 47's MDS dated [DATE] indicated Resident 47 had no cognitive impairment and requires dependent assistance for all activities of daily living. During a record review of Resident 47's Physician Order Audit Report dated 06/06/2024 indicated Resident 47 had an order of Ketoconazole external cream 2% to apply to face and neck topically two times a day for seborrheic dermatitis (skin condition) for four weeks until finished. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 111's Admission Order indicated Resident 111 was admitted to the facility on [DATE] with diagnoses including end stage renal disease (a medical condition in which a person's kidneys cease functioning on a permanent basis), type 2 diabetes mellitus (a condition in which the body fails to metabolize (process) glucose (sugar) correctly) and unspecified convulsions (rapid, involuntary muscle contractions that cause uncontrollable shaking and limb movement). During a review of Resident 111's MDS dated [DATE] indicated Resident 47 had moderate cognitive impairment and requires moderate assistance for all activities of daily living. During a record review of Resident 111's Physician Order Audit Report dated 06/06/2024 indicated Resident 111 had an order of clindamycin phosphate (topical antibiotic used to treat acne [pimple]) used to external solution 1% to apply to lower back topically two times a day for furunculosis (painful, pus-filled bump under the skin caused by infected, inflamed hair follicles) for four weeks until finished. During a concurrent interview on 6/27/2024 at 9:19 a.m., with the Infection Preventionist (IP), the IP stated the facility used Mcgeers criteria (infection surveillance guidance) before resident will start on antibiotic treatment and it was a requirement to make sure the facility was compliant with the standard practice. IP stated that at least three criteria are present before resident can start on antibiotic treatment. During a concurrent interview and record review on 06/27/2024 at 3:01 p.m., with IP, RR indicated there was no documentation in all three residents (Resident 12, 47, and 111) meeting the criteria that all three residents need to take antibiotic treatment. IP stated that if resident was taking antibiotic and was not necessary then it puts the resident at high risk to developing resistant to the medication. During a review of the facility's policy and procedure titled, Antibiotic Stewardship dated 09/18/2023 indicated Antibiotics will be prescribed and administered to residents under the guidance of the facility's Antibiotic Stewardship Program. The purpose of our antibiotic stewardship program is to monitor the use of antibiotics in our residents. When a culture and sensitivity (C&S) is ordered lab results and the current clinical situation will be communicated to the prescriber as soon as available to determine if antibiotic therapy should be started, continued, modified, or discontinued.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45269 Based on interview and record review, the facility failed to offer pneumococcal (Pneumococcal vaccines are vaccines against the bacterium Streptococcus pneumoniae) vaccines on one of five sampled resident (Resident 112). This deficient practice placed Resident 112 at a higher risk of acquiring and transmitting pneumonia to other residents of the facility. Findings: During a review of Resident 112's Admission Record, the Admission Record indicated the resident was admitted on [DATE] to the facility with diagnoses that included respiratory failure with hypoxia (condition where the body does not have enough oxygen in the tissues due to tissue damage, fluid buildup or muscular spasms),personal history of nicotine dependence(addiction to tobacco products caused by drug nicotine) and chronic obstructive pulmonary disease([COPD] group of lung diseases causing restricted airflow and breathing problems). During a review of Resident 112's Minimum Data Set ([MDS] standardized screening tool) dated 6/6/2024, the MDS indicated the resident had severely impaired cognitive skills (person had trouble remembering, learning new things, making decisions)and required maximal assistance with bed mobility, oral hygiene, and toileting hygiene. The MDS indicated the resident did not receive the pneumococcal vaccine because it was not offered. During a review of Resident 112s Care Plan initiated 6/19/2024, the Cre Plan indicated the resident is at risk for respiratory complications related to COPD, respiratory failure, and recent pneumonia. The Care Plan's interventions included observing resident's respiratory status and assess for changes, signs, and symptoms of dyspnea (difficulty of breathing) and report to physician. During a concurrent interview and record review of Resident 112's Immunization Records with Infection Preventionist Nurse (IPN) on 6/26/2024, at 4:41 p.m. IPN stated could not find any consents or documentation that the resident had declined pneumococcal vaccine or informed consent(the process in which a healthcare provider educates a patient about the risks and benefits of the treatment or drug) was provided. IPN stated her role with immunizations was to verify consent but was not done due to miscommunication with admitting licensed nurses. IPN stated the admitting licensed nurse are supposed to compare and check the California Immunization Registry([CAIR] secure , confidential, statewide, and computerized immunization information system for California residents) to ensure the residents had received the appropriate vaccines. IPN stated the nurses did not communicate with her and it was her responsibility to track and check if the residents had received their immunizations. IPN stated Resident 112 would be at risk from getting sick from pneumonia and this can cause spread of infection among residents. During an interview on 6/28/2024, at 6:22 p.m., DON stated residents should be offered immunizations for flu, covid and pneumococcal to prevent residents from getting sick and this will help prevent spread of infection among the staff and residents. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of facility's policy and procedure (P/P) titled Pneumococcal Vaccine undated, the P/P indicated all residents will be offered pneumococcal vaccines prior to or upon admissions to aid in preventing pneumonia (infections in the lungs) and pneumococcal infections. The P/ P indicated assessments of pneumococcal vaccination status are conducted within five days of the resident's admission if not conducted prior to admission.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 45269 Based on interview and record review , the facility failed to track and update Covid 19 (contagious and highly transmissible respiratory disease caused by a virus) immunizations among the staff and residents. This deficient practice had the potential to cause an outbreak of Covid among the staff members and residents in the facility. Findings: During an interview on 6/25/2024 at2:58 p.m. with Infection Preventionist Nurse (IPN), IPN stated the facility had no updated list of Covid vaccination status of residents and staff. IPN stated she took over as an IPN nurse last April 2024 and the last time it was updated was March 2024. IPN stated she did not have the current listing of staff and residents who are vaccinated and unvaccinated. IPN further added she did not have the information or in-services about educating staff about Covid vaccines. IPN stated as part of their Quality Improvement Activities the facility will offer a vaccine clinic for this coming July 2024. IPN stated staff and residents should be educated about the importance of Covid vaccinations to ensure residents safety and to prevent putting residents at risk from getting sick from Covid 19 infections. During a review of Facility's Covid 19 Staff Vaccine Log , the Covid 19 Staff Vaccine Log indicated seven staff members had no documentation about their vaccination status. During a review of facility's document indicating names of new hires since April 2024 to present showed 11 staff members were not listed on the Covid 19 Staff Vaccine Log. During a review of facility's Residents Vaccination Status Log , the Residents Vaccination Log indicated no information of residents regarding their Covid 19 Vaccination Status. The Log did not indicate if the residents were vaccinated or unvaccinated. During an interview on 6/28/2024, at 6:22 p.m. with Director of Nursing(DON), DON stated Covid 19 immunization should be offered to staff and residents to prevent residents from getting sick of Covid and this will help prevent spreading the infection to other residents and staff. During a review of facility's policy and procedure (P&P) titled Coronavirus Disease (Covid-19) - Vaccination of Residents undated, the P/P indicated each resident is offered the Covid-19 vaccine unless the immunization is medically contraindicated, or the resident has already been immunized. The P&P indicated Covid-19 vaccine education, documentation and reporting are overseen by Infection Preventionist Nurse. The P&P indicated a vaccine administration record is provided to the resident and a copy is filed in the resident record and if the resident did not receive the Covid-19 vaccine due to medical contraindications, prior vaccination or refusal, appropriate documentation is made in the resident's record. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of facility's P&P titled Coronavirus Disease (Covid-19)- Vaccination of Staff undated, the P&P indicated before offering Covid-19 vaccine , the staff member is provided with education regarding the risks and benefits , and the potential side effects associated with the vaccine. The P&P indicated the Infection Preventionist Nurse maintains a tracking worksheet of staff members and their vaccination status and vaccine administration record is provided to the individual with a copy filed in the secure employee health file. The P&P indicated the tracking worksheet provides the most current vaccination status of all staff who provide any care, treatment or other services for the facility and its residents which includes: a. staff name b. initial start of employment c. Termination of employment d. job title or role e. assigned work area f. a brief description of how they interact with residents. g. vaccination status 1. specific vaccine received 2. dates of each dose 3. dates of the next scheduled dose 4. any booster doses, exemption status, delays.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 36943 Based on observation, interview, and record review, the facility failed to ensure one of one adjustable height therapy mats located in the therapy gym had a flat surface instead of a slanted position. This deficient practice had the potential to cause a safety and fall hazard for resident requiring the mat for therapy intervention. Findings: During a concurrent observation and interview on 6/24/2024 at 9:00 a.m. with Occupational Therapist 1 (OT 1 profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) in the therapy gym, a grey-colored adjustable height therapy mat was located against the wall next to the door. The therapy mat appeared slanted with one side of the mat, closet to the door, lower than the opposite site of the mat. OT 1 raised the height of the mat using a remote and stated the therapy mat continued to have a slanted position. OT 1 stated residents used the therapy mat at the lowest position. During a concurrent observation and interview on 6/25/2024 at 1:50 p.m. with the Director of Rehabilitation (DOR) in the therapy gym, the DOR stated the adjustable height therapy mat was replaced with another therapy mat today. The DOR stated an outside company inspected the equipment on 11/2023 and did not know the reason the adjustable height therapy mat was not replaced at that time. During an interview on 6/26/2024 at 10:00 a.m. with the DOR, the DOR stated the adjustable height therapy mat was replaced because the surface was uneven, which could potentially cause injury or falls to the residents. During an interview on 6/28/2024 at 10:58 a.m. with the Maintenance Supervisor (MS), the MS stated an outside company inspected the therapy gym and equipment but did not routinely check the therapy mat and equipment. During a review of the facility's policy and procedure (P&P) titled, Maintenance Service, revised 12/2009, the P&P indicated the Maintenance Department was responsible for maintain the building, grounds, and equipment in a safe and operable manner at all times. The P&P also indicated the maintenance staff provided routine maintenance service to all areas.