STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056007	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pacific Care Nursing Center	3355 Pacific Place Long Beach, CA 90806

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49606 Based on observation, interview and record review, the facility failed to ensure one of six sampled residents' (Resident 19) call light was within reach. This deficient practice had the potential to negatively impact Resident 19's quality of life and resident rights to have reasonable accommodations of needs. Findings: A review of Resident 19's, Admission Record (Face Sheet), the Admission Record indicated Resident 19 was admitted to the facility on [DATE] with diagnoses including cerebellar ataxia (poor muscle control that causes clumsy movements) and parkinsonism (slowed movements, stiffness, and tremors). A review of Resident 19's, Minimum Data Set ([MDS] a standardized assessment and care screening tool), dated on 7/5/2024, the MDS indicated Resident 19 was cognitively intact (having the ability to think, learn, and remember clearly) and required substantial/maximal assistance (Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) from staff. During an observation on 7/22/2024 at 1:55 p.m., Resident 19 was lying on the bed and observed trying to reach for her call light. The call light was observed on the floor beside the bed. During an observation on 7/23/2024 at 8:45 a.m., in Resident 19's room, the resident was observed watching television. The call light was observed on the floor. During an interview on 7/25/2024 at 8:20 a.m., with Certified Nurse Assistant (CNA) 3 stated resident's call light needs to be within reach because if residents need help, staff will not know the resident is requesting for assistance. During an interview on 7/25/23 at 8:24 a.m., with Licensed Vocational Nurse (LVN) 2 stated call lights should be within reach of residents. LVN 2 stated when residents have trouble keeping their call lights within reach, it should be clipped to the bed by staff. (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: 056007	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/25/2024
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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/25/24 at 2:17 p.m., The Director of Nursing (DON) stated the residents' call light should be within reach for all residents. The DON stated residents should not be reaching too far for the call light or they might fall. A review of facility's Policy and Procedure (P & P) titled, Call Lights, dated 1/2017, indicated when the resident is in bed or in the wheelchair or chair in the room, staff should make sure that the call light is within easy reach of the resident.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48343 Based on interview, and record review, the facility staff failed to notify the psychiatrist when resident developed episodes of yelling for one of three sampled residents (Resident 19). This deficient practice had the potential to result in lack of necessary care, treatment, and delay medical interventions for Resident 19. Findings: During a review of Resident 19's Admission Record (Face Sheet), the Face Sheet indicated Resident 19 was admitted to the facility on ,d+[DATE] with diagnoses including schizophrenia (a serios mental illness that effects how a person thinks, feels, and behaves), anxiety (feeling of fear, restless, and tense), parkinsonism (a brain condition that causes slowed movement, and tremors), and hypertension (high blood pressure). During a review of Resident 19's Minimum Data Set ([MDS] a standardized assessment and care planning tool), dated 7/5/2024, the MDS indicated Resident 19 require maximum assistance (helper does more than half the effort) from staff for toileting hygiene, oral hygiene, and personal hygiene. During a review of Resident 19's History and Physical (H&P), dated 12/20/2023, the H&P indicated Resident 19 did not had the capacity to understand and make decisions. During a review of Resident 19's Situation, Background, Assessment, and Recommendation communication form ([SBAR] a form that health professionals communicate clear elements of a patient condition), dated 7/18/2024, the SBAR indicated change in Resident 19's condition, symptoms and signs increased yelling. The SBAR indicated Primary Care Clinician (PCC) was notified on 7/18/2024 at 07:00 p.m., and PCC recommendation was psychiatrist evaluation (evaluation conducted by qualified mental health professional to assess resident emotional, psychological, and behavioral well-being). During a concurrent interview and record review on 7/24/2024 at 7:45 a.m., with Registered Nurse (RN1), Resident 19's order summary, dated 7/18/2024 was reviewed. The order summary indicated, on 7/18/2024 PCC ordered psychiatrist evaluation for Resident 19 due to increased yelling. RN1 stated there was not documentation that facility licensed staff notified Resident 19's physiatrist. RN1 stated licensed staff should have call Resident 19's psychiatrist after the order was received from PCC and notify psychiatrist of Resident 19's change of condition. RN1 stated not notifying psychiatrist timely puts Resident 19 at risk for emotional, behavioral, and mental distress. During an interview 7/25/2024 at 2:17 p.m., with Director of Nursing (DON). The DON stated residents' change of condition must be reported to the residents' attending physicians' right way when change of condition was observed, and when new order was received. The DON stated the PCC order must be carried out (complete it) immediately. The DON stated not notifying Resident 19's psychiatrist timely about Resident 19's change of condition puts Resident 19 at risk for delay care, treatment, and medical interventions if applicable. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of facility's policy and procedure (P&P) titled Change in Condition Signs and Symptoms-SBAR, revised 3/2021, the P&P indicated: 1. Facility is responsible for a thorough assessment of the resident's change in condition signs and symptoms. 2. Ensure timely assessments, and contacts with primary care providers. 3. Assessing residents with changes in status and contact the physician.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50391 Based on observation, interview, and record review, the facility failed to transmit to Centers for Medicare & Medicaid Services (CMS) the quarterly Minimum Data Set ([MDS] a resident screening and assessment tool) according to regulatory requirements for one of one resident (Resident 65) in a timely manner due to incomplete Section D (Mood) and E (Behavior). This deficient practice can potential negatively affect the delivery of necessary care and services for Resident 65. Findings: During a review of Residents 65 Admission Record (Face Sheet), the Admission Record indicated Resident 65 was initially admitted to the facility on [DATE] with diagnoses that include but not limited to quadriplegia (a form of paralysis that affects all four limbs plus the torso), muscle weakness (lack of muscle strength), osteoarthritis unspecified (degenerative joint disease in which the tissue in the joint break down over time), neuromuscular dysfunction of bladder (lack of bladder control due to brain or spinal cord injury). During a review of Resident 65's History and Physical (H&P), dated 5/7/2024, the H&P indicated Resident 65 had the capacity to understand and can make decisions. During a review of Resident 65's Minimum Data Set ([MDS] a specialized resident screening and assessment tool), dated 4/5/2024, the MDS indicated Resident 65 was able to understand and be understood by others. The MDS indicated Resident 65 had impairments (the state of function being weakened or damaged) on both sides of his upper extremities (upper part of the body that includes the shoulder, elbow, wrist, and hand) and on both sides of the lower extremities (lower part of the body that includes the hip, knee, ankle, and foot). The MDS indicated that Resident 65 was dependent on staff for toileting, bathing, dressing, and personal hygiene. Section D and E were not completed and there were missing signatures on the MDS. During an interview on 7/24/2024 at 1:00 p.m. with the Minimum Data Set (MDS) Nurse, the MDS nurse stated completing MDS assessment withing a week of admission or during the quarterly due date allows for optimal care to be given for the resident and for billing to take place. The MDS nurse stated that MDS assessments should be completed upon admission, quarterly, and if there is a change in condition. The MDS nurse stated that all parts of the MDS assessment should be finished and completed by the date stated completed on the document. The MDS nurse stated if an assessment was not completed in a timely manner direct care of the resident was affected. During an interview on 7/25/2024 at 11:00 a.m. with the Director of Nursing (DON), the DON stated that all dates should match when the MDS assessment was completed, and records updated. The DON stated all sections of the MDS must be completed by the two-week mark, after admission or the 3-month mark for quarterly submissions. The DON stated that residents are at an increased risk of decreased care quality when MDS assessments are delayed. (continued on next page)

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	056007	A. Building B. Wing	07/25/2024

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure (P&P) titled, Minimum Data Set, revised 3//2021, the P&P indicated, Providing evidence-based assessments and management of common conditions ensure timely assessments, contacts with providers and transfers to hospital in a timely update to residents care record.

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F 0656

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 47679

48131

50391

Based on observation, interview, and record review, the facility failed to develop a person-centered care plan (document that helps nurses and other team care members organize aspects of resident care) with interventions (actions a nurse takes to implement a care plan, intend to improve the patient's comfort and health) for three of 12 sampled residents (Resident 1, 3, and 15) by failing to:

1. Develop a care plan for Resident 3 who required maximal assistance (helper does more than half of the effort) to dependent assistance with her activities of daily living ([ADLs], self-care activities such as bathing, toileting, and eating) and had unclear speech.

2. Develop a care plan for Resident 15 who received oxygen administration.

3. Develop a care plan for Resident 65 who required maximal assistance with his ADLs.

These failures had the potential to negatively affect the delivery of necessary care and services for Resident 3, 15, and 65.

Findings:

a. During a review of Resident 3's Admission Record (Face Sheet), indicated Resident 3 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that include but not limited to heart failure (a chronic condition in which the heart does not provide adequate blood flow to meet the body's needs), aphasia(an impairment of language affecting the ability to express or understand speech), and cerebral infarction (also known as a stroke; refers to damage to the tissues in the brain due to a loss of oxygen to the area).

During a review of Resident 3's Minimum Data Set ([MDS], a standardized screening and assessment tool), dated 5/9/2024, the MDS indicated Resident 3 had unclear speech, such as slurred or mumbled words. The MDS indicated Resident 3 was usually understood by others by having difficulty communicating some words. The MDS indicated Resident 3's cognition (process of thinking) was intact. The MDS indicated Resident 3 had an impairment (decrease in function) on one side of her upper extremity (includes the shoulder, elbow, wrist, and hand) and lower extremity (includes the hip, knee, ankle, and foot).

During an interview on 7/24/2024 at 12:17 p.m., with Certified Nursing Assistant (CNA1), CNA 1 stated Resident 3 required maximal assistance with many of her ADLs and she would use the call light to ask for assistance. CNA 1 stated Resident 3 had difficulty with her speech at times due to her stroke.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/25/2024 at 9:45 a.m., with Minimum Data Set Nurse (MDSN 1), MDSN 1 stated her role in the facility was to conduct assessments for the residents, which would coordinate the individualized care the residents would need. MDSN 1 stated she would also develop care plans based on the MDS triggers to direct the action that had to be taken for the issue or concern that the resident had. During a concurrent interview and record review on 7/25/2024 at 9:49 a.m., with MDSN 1, Resident 3's care plans were reviewed. Resident 3 did not have a care plan that addressed her difficulty in speech, nor her assistance levels with her ADLs. MDSN 1 stated Resident 3 had slurred speech and had difficulty communicating at times and required maximal to dependent assistance with her ADLs. MDSN 1 stated Resident 3 did not have a care plan that addressed those issues and concerns. MDSN 1 stated a care plan should have been developed and interventions implemented to monitor Resident 3's baseline and to provide care to prevent any decline in Resident 3's status. During an interview on 7/25/2024 at 11:09 a.m., with the Director of Nursing (DON), the DON stated the purpose of residents' care plan was to address the issue, create goals, and implement interventions to reach the goals. The DON stated many of the residents' care plans were developed based on the assessments done on their MDS. The DON stated Resident 3's assistance level with ADLs and her unclear speech should have been care planned. The DON stated a care plan for Resident 3's ADL assistance level would communicate to the staff the amount of assistance Resident 3 required and how to provide it safely. The DON stated a care plan for Resident 3's unclear speech would communicate to the staff how to provide the care necessary to ensure Resident 3 could communicate effectively. The DON stated because Resident 3 did not have that care plan, Resident 3 was at risk for a decline in her communication skills and could potentially put Resident 3 at risk for injury if the correct assistance level was not provided to her. During a review of the facility's P&P titled, Activities of Daily Living, Quality of Care, routine Resident Monitoring, and Scope of Services, dated June 2022, the P&P indicated The facility will provide care for residents who require respiratory care, so they receive care and treatment in accordance with professional standards of practice, the comprehensive resident centered care plan, as well as the resident's goals and preferences. b. During a review of Resident 15's Face Sheet dated 5/31/2024, the Face Sheet indicated Resident 15 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident 15's diagnoses included cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area), dysphagia (difficulty swallowing), gastroparesis (a disorder that slows or stops the movement of food from your stomach to the small intestine), hyperlipidemia (an excess of fats in the blood), and hypertension (high blood pressure). During a review of Resident 15's MDS dated [DATE], the MDS indicated Resident 15's cognitive skills (ability to learn, reason, remember, understand, and make decisions) were severely impaired (never or rarely able to make decisions regarding tasks of daily life). The MDS indicated Resident 15 had impairments to both lower and upper extremities and required assistance of two or more helpers to complete activities such as eating, toileting, bathing, and personal hygiene. The MDS indicated Resident 15 received oxygen therapy while in the facility. During a review of Resident 15's Order Summary Report, dated 6/27/2024, the order summary report indicated an active order for continuous oxygen at 3 liters per minute via nasal cannula. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 15's medical records, the medical records did not include a care plan or interventions for oxygen administration or a care plan that indicated Resident 15 frequently removed the nasal cannula that provided supplemental oxygen from his nose. During a concurrent observation and interview on 7/24/2024 at 3:35 p.m. with Licensed Vocational Nurse (LVN) 3 at Resident 15's bedside, LVN 3 stated that Resident 15 was receiving continuous oxygen. During a concurrent interview and record review on 7/24/2024 at 4:27 p.m. with Registered Nurse (RN) 1, Resident 15's medical record was reviewed. RN 1 searched Resident 15's medical record for a care plan related to oxygen administration. RN 1 stated she was unable to find a care plan for Resident 15's oxygen therapy in the medical record. RN 1 stated if a resident is receiving oxygen, the resident should have a care plan with interventions. RN 1 stated that the care plan is important to know the oxygen parameters and to report abnormal respirations. During an interview on 7/25/2024 at 12:46 p.m., with the Director of Nursing (DON), the DON stated that an oxygen care plan was needed for Resident 15 so the nurses would know the purpose and the interventions the resident was receiving oxygen therapy. During a review of the facility's P&P titled, Oxygen Administration, revised March 2017, the P&P indicated to verify that there is a physician's order for oxygen administration and review the resident's care plan for any special needs of the resident. The P&P indicated if the resident refuses the administration of oxygen, document the reason(s) and ensure that the risks are explained to the resident and documented. c. During a review of Residents 65 Admission Record (Face Sheet), the Admission Record indicated Resident 65 was initially admitted to the facility on [DATE] with diagnoses that include but not limited to quadriplegia (a form of paralysis that affects all four limbs plus the torso), muscle weakness (lack of muscle strength), osteoarthritis unspecified (degenerative joint disease in which the tissue in the joint break down over time), neuromuscular dysfunction of bladder (lack of bladder control due to brain or spinal cord injury). During a review of Resident 65's Minimum Data Set ([MDS] a specialized resident screening and assessment tool), dated 4/5/2024, the MDS indicated Resident 65 was able to understand and be understood by others. The MDS indicated Resident 65 had impairments (the state of function being weakened or damaged) on both sides of his upper extremities (upper part of the body that includes the shoulder, elbow, wrist, and hand) and on both sides of the lower extremities (lower part of the body that includes the hip, knee, ankle, and foot). The MDS indicated that Resident 65 was dependent on staff for toileting, bathing, dressing, and personal hygiene. During a review of Resident 65's History and Physical (H&P), dated 5/7/2024, the H&P indicated Resident 65 had the capacity to understand and can make medical decisions. During a review of Resident 65's Comprehensive Assessment, dated 5/10/2024, the comprehensive assessment indicated Resident 65 required total assistance with ADL's related to quadriplegia. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of resident 65's active physician orders and order summery dated 7/18/24 and 7/20/24 indicated an order for ADL's (physical therapy appts, occupational therapy appts, non-pharmacological interventions), and non-pharmacologic interventions (any assistance offered without the use of traditional medicine). During an observation on 7/22/2024 at 10:21 a.m. and on 7/23/2024 at 9:30 a.m. in Resident 65's room. Resident 65 was sitting on his wheelchair watching television. During a concurrent interview and record review on 7/23/2024 at 3:00 p.m. with License Vocational Nurse (LVN) 1, Resident 65's Care Plans were reviewed. LVN 1 stated, there were no Care Plans that directly addressed Resident 's total care needs, or the increased need of non-pharmacologic interventions related to Resident 65's limitations. LVN 1 stated that resident care plans are used to familiarize the staff with each individual plan of care. LVN 1 stated that specific details of care about Resident 65's limitations should have been included in care plan. During an interview on 7/24/2024 at 10:45 a.m. Registered Nurse Supervisor (RNS), the RNS stated any new or old information obtained about the residents should always be placed in the care plan. The RNS stated this was the best way to communicate with the team about care. The RNS stated every person on a care team were responsible to help and update care records. During an Interview with the Director of Nursing (DON) on 7/24/24 at 2.00 p.m., the DON stated for any patient that has limitation non-pharmacologic interventions are a must. The DON stated staff works as a group to keep medical records updated. A review of the facility's policy and procedure (P&P) titled, Comprehensive care planning, revised 10/2017, the P&P indicated, A Comprehensive Care Plan will be developed for each resident. The Care Plan will include measurable objectives and timetables to meet a resident's medical, nursing, mental, and psychosocial needs. Cross Reference F695.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48131 Based on observation, interview, and record review, the facility failed to ensure two of 12 sampled residents (Resident 15 and 77) were provided care and services to maintain good grooming and personal hygiene by failing to provide fingernail care for Residents 15 and 77 who were unable to carry out activities of daily living to maintain good personal hygiene. This deficient practice caused Resident 15's long fingernails to dig into the palm of his right hand and had the potential to cause an open wound which could lead to infection. This deficient practice also had the potential to negatively impact Residents 15's and 77's quality of care and self-esteem. Findings: a. During a telephone interview on 7/24/2024 at 9:48 a.m. with Resident 15's Family Member (FM 1), FM 1 stated when they visited Resident 15, Resident 15 frequently had fingernails that were uncut. FM 1 stated that the fingernails on Resident 15's right hand would pinch his skin and cause a cut to the middle of his palm. FM 1 stated the nurses were notified of Resident 15's long fingernails several times, but Resident 15 continued to have long fingernail during their next visit to the facility. FM 1 stated the family would have to cut Resident 15's nails whenever they visited to prevent the nails from cutting his skin. During an observation on 7/24/2024 at 3:30 p.m., in Resident 15's room, Resident 15's right hand was contracted (a shortening of muscles, tendons, skin, and nearby soft tissues that causes the joints to shorten and become very stiff, preventing normal movement). Resident 15 had long, jagged untrimmed fingernails on both hands. Resident 15's fingernails to the right contracted hand were digging into his palm causing redness to the area. During a concurrent observation and interview on 7/24/2024 at 3:35 p.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 opened up Resident 15's contracted right hand. LVN 3 stated Resident 15's long fingernails were causing redness to the to the palm of his hand which could lead to injury and cause an infection. LVN 5 stated the certified nursing assistants (CNAs) should cut Resident 15's fingernails every week. During an interview on 7/24/2024 at 4:27 p.m. with Registered Nurse (RN) 1, RN 1 stated the CNAs were responsible for cutting the residents' fingernails and shaving the resident every Sunday. RN 1 stated that if Resident 15's fingernails were left to grow long, they could break the skin which could lead to infection. During a review of Resident 15's Admission Record, the Admission Record indicated Resident 15 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident 15's diagnoses included cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area), dysarthria (a speech disorder where damage to the nervous system causes the muscles that produce speech to become paralyzed or weakened), anarthria (a complete loss of speech), dysphagia (difficulty swallowing), lack of coordination, muscle weakness, hemiplegia (unable to make voluntary movements on one side of the body), and hemiparesis (muscle weakness on one side of the body). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 15's Minimum Data Set ([MDS] a comprehensive assessment and care-screening tool), dated 6/5/2024, the MDS indicated Resident 15's cognitive skills (ability to learn, reason, remember, understand, and make decisions) were severely impaired (never or rarely able to make decisions regarding tasks of daily life). The MDS indicated Resident 15 was totally dependent and did none of the effort to complete activities such as eating, toileting, bathing, and personal hygiene. During a review of Resident 15's care plan titled, Self-care deficit in personal hygiene/grooming, related to cerebral vascular accident ([CVA] an interruption in the flow of blood to cells in the brain) dated 5/31/2024, the care plan indicated the staff's interventions indicated to monitor skin redness and assist in activities of daily living ([ADLs] skills required to manage basic physical needs, which include personal hygiene or grooming, dressing, toileting, and eating). During a review of Resident 15's care plan titled, Alteration in Skin Integrity Actual Presence of: Skin ulcer/would to right palm related to Contracture dated 6/25/2024, the care plan indicated the staff's interventions included to provide treatment per physician order, provide ongoing assessment, monitor, and report for any signs/symptoms of infection, assess resident for pain manifested by facial grimacing and moaning, keep skin clean and dry, and notify doctor if no noted progress towards healing or any signs and symptoms of decline. 49606 b. During a review of Resident 77's Admission Record (Face Sheet), the Admission Record indicated Resident 77 was admitted to the facility on [DATE] with diagnoses including cerebral infarction (disrupted blood flow to the brain), diabetes (high blood sugar), depression (feeling of sadness and loss of interest), generalized muscle weakness (lack of muscle strength), tachycardia (fast hear rate). During a review of Resident 77's, Care Plan for Activities of Daily Living (ADL's) dated on 6/3/2024 and re-evaluation of ADL's completed on 9/3/2024 indicated Resident 77 had impaired self-care and functional mobility related to cerebral infarction requiring maximum assistance to perform personal hygiene. During a review of Resident 77's History and Physical (H & P), dated 6/2/2024, indicated Resident 77 does not have the capacity to understand and make decisions. During a review of Resident 77's MDS, dated [DATE], the MDS indicated Resident 77 was dependent (helper does all of the effort. Resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity) on staff for eating, oral hygiene, toileting hygiene, shower/bathe self and personal hygiene. During an observation on 7/22/20241:49 a.m. in Resident 77's room, Resident 77 was observed with brown substance underneath all ten fingers with untrimmed fingernails. During an observation on 7/23/2024 8:45 a.m. in Resident 77's room, Resident 77 was observed with brown substance underneath all ten fingers with untrimmed fingernails. During an observation on 7/23/2024 2:45 p.m. in Resident 77's room, Resident 77 was observed with brown substance underneath all ten fingers with untrimmed fingernails. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Pacific Care Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3355 Pacific Place Long Beach, CA 90806	

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/25/2024 at 8:20 a.m. with CNA 3, CNA 3 stated his responsibilities as a CNA included getting the residents up and ready for their activities of daily living. CNA 3 stated resident's fingernails were cleaned every day and whenever staff notices residents with dirty fingernails. CNA 3 stated that if the residents had their fingernails too long, they can injure themselves by scratching themselves or others. During an interview on 7/25/2024 at 8:24 a.m., with LVN 2, LVN 2 stated staff makes sure they provide care with dignity and professionalism, and residents are well kept, by keeping them clean and providing good personal hygiene. LVN 2 stated staff cleans residents' fingernails every day and should be trimmed every Sunday (once a week). LVN 2 stated that if the fingernails become too long the nails may cause skin tears when residents scratch themselves and this can lead to infection. During an interview on 7/25/2024 at 2:17 p.m., with the Director of Nursing (DON), the DON stated CNA's were responsible for performing personal hygiene and residents' fingernails were cleaned as needed and trimmed once a week. During a concurrent interview on 7/25/2024 at 2:17 p.m., with the Assistant Director of Nursing (ADON), the ADON stated that if CNA's were not cleaning the residents' fingernails daily and as needed, it could lead to an infection if he nails were left dirty. The ADON stated if staff were not trimming the residents' fingernails, the residents could scratch themselves and end up with cuts. During a review of the facility's policy and procedure (P&P) titled, Activities of Daily Living, Quality of Care, Routine Resident Monitoring, and Scope of Services, dated June 2022, the P&P indicated, it is the policy of the facility that each resident receive, and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being consistent with the resident's assessment and plan of care. The P&P indicated staff will ensure that ADLs are monitored, assisted with, and provided for those residents who are unable to perform ADLs. The P&P indicated if a resident is unable to carry out ADLs, they are to be provided services to maintain the food nutrition, grooming and personal and oral hygiene. The P&P indicated the facility will provide care consistent with progressional standards for residents to prevent pressure injuries and not develop pressure injures unless they are unavoidable.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48131 Based on observation, interview, and record review, the facility failed to ensure one of two sampled residents (Resident 15) remained on continuous oxygen at 3 liters per minute via nasal cannula (a device that gives additional oxygen through your nose) as ordered by the physician. This deficient practice had the potential to result in complications from lack of sufficient oxygen for Resident 15. Findings: During a review of Resident 15's Admission Record, dated 5/31/2024, the admission record indicated Resident 15 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 15's diagnoses included cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area), dysphagia (difficulty swallowing), gastroparesis (a disorder that slows or stops the movement of food from your stomach to the small intestine), hyperlipidemia (an excess of fats in the blood), and hypertension (high blood pressure). During a review of Resident 15's Minimum Data Set ([MDS] a comprehensive assessment and care-screening tool), dated 6/5/2024, the MDS indicated Resident 15's cognitive skills (ability to learn, reason, remember, understand, and make decisions) were severely impaired (never or rarely able to make decisions regarding tasks of daily life). The MDS indicated Resident 15 required assistance of two or more helpers to complete activities such as eating, toileting, bathing, and personal hygiene. The MDS indicated Resident 15 received oxygen therapy while in the facility. During a review of Resident 15's Order Summary Report, dated 6/27/2024, the order summary report indicated an active order dated 5/30/2024 for oxygen at 3 liters per minute via nasal cannula continuously to keep the oxygen saturation (the amount of oxygen circulating in the blood) above 92 percent (%) for diagnosis of chronic respiratory failure (condition in which blood does not have enough oxygen or has too much carbon dioxide and makes it difficult to breath). During a review of Resident 15's medical records, the medical records did not include a care plan or interventions for oxygen administration or a care plan that indicated Resident 15 frequently removed the nasal cannula. During an observation on 7/22/2024 at 10:33 a.m., in Resident 15's room, Resident 15's nasal cannula was positioned under his chin. During an observation on 7/22/2024 at 3:26 p.m., in Resident 15's room, Resident 15's nasal cannula was lying in the bed next to him. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 7/24/2024 at 3:35 p.m. with Licensed Vocational Nurse (LVN) 3, in Resident 15's room, Resident 15's nasal cannula was observed on the floor next to the bed. LVN 3 stated Resident 15 was receiving oxygen continuously but the resident always removed the nasal cannula from his nose. LVN 3 removed the nasal cannula from the floor and stated that she would get Resident 15 a clean one. LVN 3 stated how important it was to monitor Resident 15 closely to ensure he did not remove the nasal cannula from his nose. LVN 3 stated Resident 15 needed to wear his nasal cannula so that he would receive supplemental oxygen at all times. LVN 3 stated that Resident 15's supplemental oxygen was necessary to keep him alive and prevent him from having difficulty breathing. During an interview on 7/24/2024 at 4:27 p.m. with Registered Nurse (RN) 1, RN 1 stated it was important for Resident 15 to wear his oxygen at all times to prevent shortness of breath. During an interview on 7/25/2024 at 12:46 p.m., with the Director of Nursing (DON), the DON stated Resident 15 could develop respiratory problems if the resident was not wearing the oxygen as ordered by the physician. During a review of the facility's policy and procedure (P&P) titled, Oxygen Administration, revised 3/2017, the P&P indicated to verify that there was a physician's order for oxygen administration and review the resident's care plan for any special needs of the resident. The P&P indicated if the resident refused the administration of oxygen, document the reason(s) and ensure that the risks were explained to the resident and documented. During a review of the facility's P&P titled, Activities of Daily Living, Quality of Care, routine Resident Monitoring, and Scope of Services, dated 6/2022, the P&P indicated the facility would provide care for residents who require respiratory care, so they receive care and treatment in accordance with professional standards of practice, the comprehensive resident centered care plan, as well as the resident's goals and preferences.

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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** 48131 Based on observation, interview, and record review, the facility failed to effectively manage resident's pain for one of one resident (Resident 27) by: 1. Failing to identify the resident's pain level after the administration of routine pain medication. 2. Failing to offer additional pain medication as ordered by the physician when Resident 27 continued to have pain 30 minutes after administering routine pain medications. These deficient practices caused Resident 27 to experience pain that interfered with activities of daily living and resulted in Resident 27 experiencing unrelieved pain. Findings: During a review of Resident 27's Admission Record, dated 7/2/2024, the admission record indicated Resident 27 was initially admitted to the facility on [DATE] with the following diagnoses which included type 2 diabetes (condition that results in too much sugar circulating in the blood, muscle wasting (deterioration of muscle tissue), atrophy (a condition where a body part or tissue shrinks due to lack of use or stimulation), fibromyalgia (a chronic [long-lasting] disorder that causes pain and tenderness throughout the body, as well as fatigue and trouble sleeping), and bilateral (affecting both sides) osteoarthritis (inflammation and swelling that occurs in the joints when the flexible tissue at the ends of bones begin to wear down over time) of the knee. During a review of Resident 27's Minimum Data Set (MDS - a standardized resident assessment care screening tool), dated 6/6/2024, the MDS indicated Resident 27 was cognitively intact (ability to think, remember and reason) and was able to understand and make decisions. The MDS indicated Resident 27 was dependent (resident does none of the effort to complete the activity) related to toileting, bathing, and personal hygiene. During a review of Resident 27's Care Plan, titled Alteration in Comfort - Pain, dated 6/22/2022 and last re-evaluated 7/6/2024, the care plan indicated Resident 27's pain would be relieved within one half hour after pain medication was given. The care plan indicated the following staff's interventions: 1. Instruct resident to report pain as soon as it begins. 2. Assess intensity of pain using a pain scale 1-10. 3. Assess non-verbal resident for possible signs and symptoms of pain such as yelling, irritability, grimaces, and sweating. 4. Administer pain medication per physician's order. 5. Provide nursing measure that will lessen intensity of pain. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. Reassess pain 30 minutes and notify physician for possible need for increased pain medication as needed. During a review of Resident 27's Order Summary Report, dated 6/27/2024, the order summary report indicated an active order dated 2/23/2023 to monitor Resident 27's pain from 0 to 10 on a pain scale (0 -indicated no pain, 1-3 indicated mild pain, 4-6 indicated moderate pain, 7-9 indicated severe pain, and 10 - very severe or horrible pain) every shift. During a review of Resident 27's Order Summary Report, dated 6/27/2024, the order summary report indicated an active order dated 3/27/2024, for non-pharmacologic interventions, such as repositioning, dim light, quiet environment, hot/cold applications, relaxation techniques, distraction, music, and massage every shift. During review of Resident 27's Order Summary Report, dated 6/27/2024, the order summary report indicated an active order dated 3/27/2024, to administer Acetaminophen (Tylenol - a medication to relieve mild to moderate pain) 325 milligrams (MG, unit of measurement), 1 tablet by mouth as needed for mild pain. During review of Resident 27's Order Summary Report, dated 6/27/2024, the order summary report indicated an active order dated 3/27/2024, to administer Tramadol (a medication to relieve moderate to moderately severe pain) 50 MG, 0.5 tablet by mouth as needed for moderate pain. During review of Resident 27's Order Summary Report, dated 6/27/2024, the order summary report indicated an active order dated 3/27/2024, to administer Tramadol 50 MG, 1 tablet by mouth as needed for severe pain. During a review of Resident 27's Order Summary Report, dated 6/27/2024, the orders summary report indicated an active order dated 3/27/2024 for Lidoderm Patch 5% (Lidocaine - a mediation used to relieve nerve pain). Apply to right shoulder topically one time a day for pain management related to right shoulder pain. Apply 1 patch and remove per schedule. During a review of Resident 27's Order Summary Report, dated 6/27/2024, the order summary report indicated an active order dated 2/19/2024 for Lyrica (Pregabalin - a medication used to treat nerve pain) Oral Capsule 50 MG. Give 1 capsule by mouth two times a day for pain management (when available). During a review of Resident 27's Order Summary Report, dated 6/27/2024, the order summary report indicated an active order dated 3/27/2024 to administer Tramadol HCL 50 MG, give 0.5 tablet by mouth, every 4 hours as needed for moderate pain. During a review of Resident 27's Order Summary Report, dated 6/27/2024, the order summary report indicated an active order dated 3/27/2024 to administer Tramadol HCL 50 MG, give 1 tablet by mouth, every 6 hours as needed for severe pain. During a review of Resident 27's Order Summary Report, dated 6/27/2024, the order summary report indicated an active order dated 3/27/2024 to administer Tramadol HCL 25 MG by mouth, at bedtime for pain management related to right shoulder pain. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 27's Order Summary Report, dated 6/27/2024, the order summary report indicated an active order dated 12/28/2023 to administer Tylenol oral tablet 325 MG, give 1 tablet by mouth, every 4 hours as needed for mild pain. During a review of Resident 27's Medication Administration Record (MAR), for the month July 2024, the MAR indicated Resident 27 received Tramadol 50 MG one time for severe pain on 7/6/2024 at 9:16 a.m. During a review of Resident 27's MAR, for the month of July 2024, the MAR indicated on 7/22/2024, Resident 27 received Tramadol 25 MG at 9 p.m. The MAR indicated Resident 27 had a pain level of 7/10 on the 3 p.m. to 11 p.m. (evening) shift and on the 11 p.m. to 7 a.m. (night) shift. During a review of Resident 27's Initial Pain assessment dated [DATE], the initial pain assessment indicated Resident 27's pain threshold (acceptable level of pain) was 5/10 on a pain scale and to administer pain medications as ordered, monitor effectiveness, pain scale, and notify physician for significant changes. During a concurrent observation and interview on 7/22/2024 at 10:54 a.m., with Resident 27, in Resident 27's room, Resident 27 was observed lying in bed, awake and alert. Resident 27 was observed grimacing and pointing to her left upper arm. Observed a Lidocaine patch to Resident 27's left upper arm. Resident 27 stated that she received the patch for pain in the morning along with pain medications, but she continued to have pain. Resident 27 stated the pain in her left upper arm was a 7-8/10 on the pain scale. During a concurrent observation and interview on 7/23/2024 at 9:30 a.m., with Resident 27, in Resident 27's room, observed a Lidocaine patch to the left upper arm dated 7/23/2024. Resident 27 stated she continued to have 7-8/10 pain in her left upper arm. Resident 27 shook her head, grimaced, and rubbed her left upper arm. Resident 27 stated that she received her morning pain medication, but she continued to have pain. During an interview on 7/23/2024 at 3:53 p.m., with Resident 27, in Resident 27's room, Resident 27 stated she continued to have 7-8/10 pain in her left upper arm. Resident 27 shook her head, grimaced, and rubbed her left upper arm. During a concurrent interview and record review on 7/23/2024 at 3:56 p.m., with Licensed Vocational Nurses (LVN) 4, Resident 27's Nursing Progress Notes, for the month of July 2024, Resident 27's care plan titled, Alteration in Comfort - Pain, was reviewed. LVN 4 stated she last assessed Resident 27 for pain on 7/22/2024 at 9 p.m. LVN 4 stated she also gave Resident 27 routine pain medications at that time. LVN 4 stated Resident 27's pain was a 7/10. LVN 4 stated she reassessed Resident 27 one to two hours after giving the pain medication and Resident 27's pain was relieved. LVN 4 stated she did not document the pain reassessment. LVN 4 admitted she should have documented Resident 27's pain reassessment and comfort measures in the nursing progress notes. LVN 4 stated according to the pain care plan, Resident 27's pain should have been reassessed 30 minutes after administering pain medication. LVN 4 stated she should have reassessed Resident 27's pain after assessing a pain level of 7/10. LVN 4 stated that if she had reassessed Resident 27's pain, she could have offered additional pain medications or called the physician if her pain was not relieved. LVN 4 stated that the resident could become distressed from having continuous unrelieved pain. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 7/23/2024 at 4:34 p.m., with LVN 3 and Resident 27, in Resident 27's room, Resident 27 was observed lying in bed awake and alert. LVN 3 stated she worked the morning shift and Resident 27 never stated she was in pain. LVN 3 stated that she administered Resident 27's routine pain medications of Lyrica and applied the Lidocaine patch to her left arm at 9 a.m. (7/23/2024). Resident 27 pointed to her left arm and stated that she was having 8/10 pain. Resident 27 stated she had 7-8/10 pain in her left arm every day. LVN 3 stated she was not aware of Resident 27's pain. LVN 3 stated she would pay closer attention to Resident 27's pain, by making sure she reassessed the resident's pain and additional pain medications as needed if she continued to have pain. LVN 3 stated if she had reassessed Resident 27's pain, she would have known the routine pain medications were not working and offered more medication or called the physician. During an interview on 7/24/2024 at 9:48 a.m., with Resident 27, Resident 27 stated her left upper arm pain was a little better than yesterday, but she continued to have 7/10 pain. During an interview on 7/25/2024 at 12:49 p.m., with the Director of Nursing (DON), the DON stated when a routine pain medication was given, the pain must be reassessed to see if the pain medication was affective or if the physician needed to be notified. The DON stated when residents were experiencing pain, they did not want to participate in activities, the residents cannot sleep or move around. The DON stated pain could affect a resident's whole life. During a review of the facility's policy and procedure (P&P) titled, Pain Management Protocol, dated 10/2017, the P&P indicated pain will be considered as the 5th vital sign and the absence or presence of pain will be documented at each nursing note entry that requires full vital signs. The P&P indicated reassessments will be conducted whenever there is a change in the dose, or the type of medications being utilized. The P&P indicated to assess effectiveness of pain medication with routine and as needed pain medication approximately 30 minutes after administration.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47679 Based on observation, interview, and record review, the facility failed to ensure a dialysis (the process of removing waste products and excess fluid from the body) emergency kit ([e-kit], contains supplies such as tape, clamp, and gauze to use in case the resident experienced bleeding from their dialysis access site) was readily available at the bedside for one of three sampled residents (Resident 192). This deficient practice had the potential for Resident 192 to receive delayed intervention during accidental bleeding and could lead to hypotension and shock. Findings: During a review of Resident 192's Admission Record (Face Sheet), indicated Resident 192 was admitted to the facility on [DATE] with diagnoses that include but not limited to urinary tract infection ([UTI], an infection in any part of the urinary system), end stage renal disease ([ESRD], a stage where the kidneys can no longer support the body's needs for waste removal and fluid balance), and atrial fibrillation (an irregular, often rapid heart rate that can cause poor blood flow). During a review of Resident 192's History and Physical (H&P), dated 7/23/2024, the H&P indicated Resident 192 had fluctuating (changing) capacity to understand and make decisions. During a review of Resident 192's Order Summary Report, dated 7/20/2024, the Order Summary Report indicated Resident 192 was to receive hemodialysis (type of dialysis) every Tuesday, Thursday, and Saturday. During a concurrent observation and interview on 7/22/2024 at 10:17 a.m. with Resident 192, in Resident 192's room, there was not a dialysis e-kit pinned to the wall nor inside the nightstand. Resident 192 stated he had not seen a dialysis e-kit anywhere in his room. During a concurrent observation and interview on 7/23/2024 at 11:15 a.m. with Resident 192, in Resident 192's room, there was not a dialysis e-kit pinned to the wall nor inside the nightstand. Resident 192 stated he was waiting to be picked up by the transport so he could go to the dialysis center. Resident 192 stated he had not seen a dialysis e-kit inside his room. During a concurrent observation and interview on 7/24/2024 at 11:13 a.m. with Licensed Vocational Nurse (LVN) 1, inside Resident 192's room, there was not a dialysis e-kit pinned to the wall nor inside the nightstand. LVN 1 stated there was no dialysis e-kit readily available inside Resident 192's room. LVN 1 stated every resident that received dialysis needed to have a dialysis e-kit inside their room in case the resident experienced bleeding from their access site. LVN 1 stated residents were most at risk for bleeding after their dialysis. LVN 1 stated Resident 192 had dialysis on 7/23/2024 and could have experienced excessive bleeding when he arrived back to the facility. LVN 1 stated without the dialysis e-kit at the bedside, if Resident 192 were to have bleeding from his dialysis access site, the nurses would not have the supplies to stop the bleeding. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/24/2024 at 11:19 a.m., with Registered Nurse (RN) 1, RN 1 stated every dialysis resident needed a e-kit at the bedside in the event they experienced bleeding. RN 1 stated Resident 192 was a dialysis resident and received anticoagulant (blood thinner), which made him a higher risk for bleeding from his dialysis site. RN 1 stated if Resident 192 were to have bleeding from his dialysis access site and did not have a dialysis e-kit readily available, he could have excessive blood loss. During an interview on 7/25/2024 at 11:11 a.m., with the Director of Nursing (DON), the DON stated every dialysis resident was supposed to have a dialysis e-kit readily available. The DON stated there were no reasons why an e-kit would not be inside the room. The DON stated without an e-kit in the room, if Resident 192 were to bleed from his dialysis access site, there may be a delay in stopping the bleeding. The DON stated excessive bleeding could cause a number of complications such as hypotension (low blood pressure) and hypovolemic shock (an emergency situation in which severe blood loss makes the heart unable to pump enough blood to the body). During a review of the facility's policy and procedure (P&P) titled, Dialysis Care, revised on 9/2020, the P&P indicated, In case of an emergency, at the bedside of a dialysis resident, there should be a clamp, tape, [gauze], and Kerlix.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 47092 Based on observation, interview, and record review, the facility failed to document the medication administration of controlled substances (drugs with accepted medical use but with an abuse potential) for one out of three residents (Resident 27). This deficient practice had the potential to harm Resident 27 by the likelihood of medication errors resulting from an inaccurate medical record, and also had the potential to cause Resident 27 harm by potentially not receiving the medication due to the loss of accountability which affects the control against drug loss (any loss of a controlled substance), diversion (transfer of a legally prescribed controlled substance from the individual for whom it was prescribed to another person for any illicit use), or theft. Findings: During a review of Resident 27's Admission Record, the admission record indicated Resident 27 was admitted to the facility on [DATE]. Resident 27's admitting diagnosis included fibromyalgia (a disorder characterized by widespread musculoskeletal pain accompanied by fatigue, sleep, memory, and mood issues) and osteoarthritis (a type of arthritis that occurs when flexible tissue at the end of bones wears down) of both knees. During a review of Resident 27's Minimum Data Set ([MDS] a standardized assessment and care screening tool) dated 6/6/2024, the MDS indicated Resident 27 was mildly cognitively impaired (ability to think and reason). The MDS indicated Resident 27 required total assistance (helper does all the effort) with toileting hygiene, showering/bathing, dressing the lower body, and personal hygiene. During a review of Resident 27's Physician Orders dated 3/27/2024, the order indicated Resident 27 was to receive Lyrica (a brand name for Pregablin) 50 milligram (mg, unit of measurement) capsule by mouth, twice a day for pain management. During a review of Resident 27's Physician Orders dated 3/27/2024, the order indicated Resident 27 was to receive 0.5 tablet ([1/2] one half of a tablet) of Tramadol HCL (a pain medication and controlled substance) 50 mg every four (4) hours as needed for moderate pain. During a review of Resident 27's Medication Administration Record (MAR) dated 7/2024, the MAR indicated Resident 27 last received Pregablin 50 mg capsule on 7/25/2024 at 9:00 a.m. by Licensed Vocational Nurse (LVN) 3. During a review of Resident 27's MAR dated 7/2024, the MAR indicated Resident 27 last received Tramadol 25 mg on 7/25/2024 at 9:07 a.m. by LVN 3. During an observation on 7/25/2024 at 11:03 a.m., Resident 27's Pregablin 50 mg capsule blister pack (medication individually packed in a compartment to ease management and dosing) had 49 pills remaining. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Pacific Care Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 3355 Pacific Place, Long Beach, CA 90806	

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 7/25/2024 at 11:04 a.m., with LVN 3, the Antibiotic or Controlled Substance Drug Record dated 7/2024, was reviewed. The record indicated Resident 27 last received Pregablin 50 mg on 7/24/2024 at 5:00 p.m. and had 50 pills remaining. LVN 3 stated she gave Resident 27 Pregablin 50 mg capsule on 7/25/2024 at 9:00 a.m. but did not document. During an observation on 7/25/2024 at 11:05 a.m., Resident 27's Tramadol 50 mg tablet blister pack had 48 pills remaining. During a concurrent interview and record review on 7/25/2024 at 11:06 a.m., with LVN 3, the Antibiotic or Controlled Substance Drug Record dated 7/2024, was reviewed. The record indicated Resident 27 last received Tramadol 25 mg on 7/24/2024 at 9:00 p.m., with 49 doses remaining. LVN 3 stated she gave Resident 27's Tramadol 25 mg tablet on 7/25/2024 at 9:07 a.m. but did not document. During an interview on 7/25/2024 at 11:10 a.m., with LVN 3, LVN 3 stated when administering controlled substances, it should be signed and documented as soon as possible to prevent medication errors. During an interview on 7/25/2025 at 1:27 p.m., with the Assistant Director of Nursing (ADON), the ADON stated administered controlled substances should be documented right away before it was forgotten to monitor drug effectiveness and to prevent discrepancies. During a review of the facility's policy and procedure (P&P) titled, Controlled Medications 8/2014, the P&P indicated when a controlled medication was administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and the medication record MAR: a. Date and time of administration. b. Amount administered. c. Signature of the nurse administering the dose on the accountability record at the time the medicine is removed from the supply.

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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** 47092 Based on observation, interview, and record review, the facility failed to maintain a medication error rate of five percent or less by failing to: 1. Check for gastrostomy ([g-tube] a surgical opening into the stomach for food and medication administration) tube placement (inserting air via a syringe into the g-tube and listening with a stethoscope to ensure the g-tube has not dislodged) for Resident 50 per policy and procedures (P&P). 2. Verify Resident 50 received the correct dose of Ferrous Sulfate (an iron supplement) 330 milligrams ([mg] a unit of weight measurement) per 7.5 milliliters ([ml] a unit of liquid measurement). 3. Ensure Resident 50's head of bed was greater than 30 degrees per P&P prior to administering medication via g-tube. 4. Disinfect an open vial of insulin (hormone medication used to aid the body in lowering the blood sugar) prior to preparing and administering to Resident 75. These deficient practices had the potential to result in an overdose of medication, infection, and aspiration (choking) of stomach contents for Resident 50, and infection for Resident 75. Findings: During a concurrent observation and interview on 7/24/2024 at 8:18 a.m., with Licensed Vocational Nurse (LVN) 5, LVN 5 prepared Ferrous Sulfate (supplement for a low blood count) from a liquid bottle with the dose on hand 220mg/5ml. LVN 5 prepared in error 11ml (484 mg) in a medicine cup to be administered to Resident 50. LVN 5 stated she had trouble seeing. During an observation on 7/24/2024, at 8:40 a.m., with LVN 5 and Resident 50, Resident 50's head of bed was elevated 15 degrees. LVN 5 administered Resident 50's medication via g-tube without repositioning, and without checking the g-tube for placement. During an interview on 7/24/2024, at 8:58 a.m., with LVN 5, LVN 5 stated she should have repositioned Resident 50's head of bed to at least 35 degrees and should have checked for g-tube placement prior to administering medications via g-tube to prevent aspiration. During an observation on 7/24/2024, at 11:02 a.m., with LVN 6, LVN 6 was observed drawing 3 units of regular insulin (medicine for diabetes) from an opened insulin vial without disinfecting the vial with alcohol wipes/swabs. LVN 6 then administered the 3 units of regular insulin to Resident 75. (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 7/25/2024 at 1:19 p.m., with the Assistant Director of Nursing (ADON), the ADON stated Resident 50's head of bed should have been elevated at least 35 degrees because stomach contents could backflow and potentially cause aspiration. The ADON stated g-tube placement should be checked prior to each use to ensure g-tube was in place and Resident 50 does not get an infection such as cellulitis (deep tissue infection). The ADON stated nursing staff should verify resident's correct dose of medication according to the physician's order to prevent overmedicating which could have harmful consequences. The ADON stated staff must disinfect medication vials with alcohol prior to use, to prevent exposing residents to bacteria which could cause an infection. During a review of Resident 50's Admission Record, the Admission Record indicated Resident 50 was a [AGE] year-old female, admitted to the facility on [DATE]. Resident 50's admitting diagnosis included gastrostomy status and gastro-esophageal reflux disease ([GERD] a digestive disorder in which stomach acid repeatedly flows back up into the tube connecting the mouth and stomach causing erosion). During a review of Resident 50's Minimum Data Set ([MDS] a standardized assessment and care screening tool) dated 5/10/2024, the MDS indicated Resident 50 had severe cognitive impairment (ability to think and reason). The MDS indicated Resident 50 required total assistance (helper does all the effort) with all activities of daily living (ADLs) such as oral hygiene, toileting hygiene, showering/bathing, dressing, and personal hygiene. During a review of Resident 50's Physician's Order dated 2/12/2024, the order indicated Resident 50 was to receive Ferrous Sulfate liquid 330 mg/7.5 ml via g-tube one time daily as a supplement. During a review of Resident 75's Admission Record, the Admission Record indicated Resident 75 was a [AGE] year-old male, originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 75's admitting diagnosis included sepsis (infection of the blood) and type 2 diabetes mellitus (a chronic metabolic disease that occurs when your body cannot regulate your blood sugar causing it to be too high). During a review of Resident 75's MDS dated [DATE], the MDS indicated Resident 50 had severe cognitive impairment. The MDS indicated Resident 75 required total assistance with all ADLs such as oral hygiene, toileting hygiene, showering/bathing, dressing, and personal hygiene. During a review of Resident 75's Physician Orders dated 4/27/2024, the order indicated Resident 75 was to receive Insulin Regular Human Injection Solution 100 units/ml per sliding scale (a pre-defined medication protocol which determines the dose based on blood sugar ranges). The order indicated if Resident 75's blood sugar was 151-200 mg/deciliter ([dL] a unit of liquid measurement) to administer 3 units of Regular Insulin. During a review of the facility's policy and procedure (P&P) titled, Medication Administration dated 5/2019, the P&P indicated The licensed nurse administering the medication must check the label three times to verify the right resident, the right medication, the right dosage, the right time, and route of the administration before giving the medication. During a review of the facility's P&P Medication Administration via Enteral Tube dated 4/2017, the P&P indicated the purpose of the policy was to safely and accurately administer oral medications through an enteral tube (g-tube). As part of the P&P procedure staff are to: (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Elevate the head of bed more than 30 degrees or as directed by the physician. b. Verify tube placement by forcefully injecting 10-30 ml of air into the tube while listening with a stethoscope to the abdomen for a loud bubbling sound. During a review of the facility's P&P Specific Medication Administration Procedures dated 12/2015, the P&P indicated the purpose of the policy was to administer a parenteral [non-oral] medication into the subcutaneous tissue in order to promote slow medication absorption and prolong medication action and the procedure included wiping the rubber cap of a vial with an alcohol swab.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47092 Based on observation, interview, and record review, the facility failed to accurately label and discard expired medications and supplies, to ensure safe medication administration and diagnostic testing by failing to: 1. Ensure 69 packets of expired (2/9/2023) Banatrol Plus ([Banatrol] an antidiarrhea prebiotic supplement) and four (4) bottles of expired (11/2023) ultrasound gel was discarded from the medication storage room. 2. Label Artificial Tears (hydrating solution for dry eyes) eyedrops and Procure Miconazole Nitrate 2% (antifungal powder) with resident name and instructions. These deficient practices had the potential to administer expired medications with substandard therapeutic (producing a favorable result or effect) effects, administer medications not ordered, and to cross contaminate/ spread infection when medications were shared with other residents. Findings: During an observation on 7/25/2024 at 9:01 a.m., 4 bottles of expired (11/2023) ultrasound gel was discovered inside the bottom left cabinet in the medication storage room. During an observation on 7/25/2024 at 9:05 a.m., one box with 69 packets of expired (2/9/2023) Banatrol was discovered inside the bottom left cabinet in the medication storage room. During an interview on 7/25/2024, at 9:15 a.m., with Registered Nurse (RN) 1, RN 1 stated the ultrasound gel and Banatrol in the medication storage room should have been discarded to prevent potential use by staff to residents. During an observation on 7/25/2024, at 11:02 a.m., the north medication cart was observed with Artificial Tears eye drops and Procure Miconazole Nitrate 2% that was unlabeled with a resident name or instructions. During an interview on 7/25/2024 at 11:07 a.m., Licensed Vocational Nurse (LVN) 3 stated the Artificial Tears eyedrops belonged to Resident 15 because it had Resident 15's room number on it. LVN 3 stated all medications should be labeled with the resident's name to ensure it is not given to the wrong resident. LVN 3 states a room number label on the artificial tears eyedops is not sufficient because residents could be moved to different rooms. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/25/2024, at 1:20 p.m., with the Assistant Director of Nursing (ADON), the ADON stated anything that were expired should be taken out the medication storage room or medication cart and should be discarded because expired medications when administered, will not have any therapeutic effect. The ADON stated if expired ultrasound gel is used during a bladder scan (a diagnostic device used to determine how much urine is in the bladder) for a resident, the results could be inaccurate. The ADON stated the Artificial Tears eyedrops and Miconazole Nitrite 2% should be labeled with a resident name to prevent sharing medications which could cause infection or administration of the wrong dose. During an interview on 7/25/2024, at 3:07 p.m., with the Assistant Director of Nursing (ADON), the ADON stated the RN Supervisor should check the medication storage room every 24 hours for expired medications, foods, cleanliness, room temperature, refrigerator temperatures, and e-kits (a kit containing emergency medications). The ADON stated the LVNs (medication nurses) should check their cart every shift for expired medications, cleanliness, and unclaimed medications every shift. The ADON stated the pharmacy also comes once a month or as needed to replace inventory and discard expired medications. The ADON stated she is not sure why there were expired medications in the medication storage room and the north medication cart since staffs were supposed to check the medication storage room and the medication carts daily. During a review of Resident 15's Admission Record, the Admission Record indicated Resident 15 was a [AGE] year-old female originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 15's admitting diagnosis included a cerebral infarction (tissue death of the brain from a clot or other obstruction of blood flow) and hypertension (high blood pressure). During a review of Resident 15's Minimum Data Set ([MDS] a standardized assessment and care screening tool), dated 6/5/2024, the MDS indicated Resident 15 was severely cognitively impaired (ability to think and reason). The MDS indicated Resident 15 required total assistance (helper does all the effort) with all activities of daily living (ADLs) such as oral hygiene, toileting hygiene, showering/bathing, dressing, and personal hygiene. During a review of Resident 15's Physician Orders dated 5/30/2024, the orders indicated Resident 15 was to receive Artificial Tears Solution, one drop in both eyes two time a day for eye dryness. During a review of the facility's P&P titled Medication Storage in the Facility dated 4/2008, the P&P indicated Outdated, contaminated, or deteriorated medications and those in containers that were cracked, soiled, or without secure closures should be immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy if a current order exists. The P&P indicated Medication storage conditions are monitored on a routine basis, and corrective action taken if problems are identified. During a review of the facility's P&P titled Medication Administration dated 5/2019, the P&P indicated The licensed nurse administering the medication must check the label three times to verify the right resident, the right medication, the right dosage, the right time, and route of the administration before giving the medication and medications ordered for a specific resident may not be administered to another resident.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47679 Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and preparation practices for 89 of 89 residents when: 1. The inside compartment of the ice machine was observed with black residue. 2. A dented can of applesauce was not separated from the ready to use cans in the dry storage area. These deficient practices had the potential to result in harmful bacteria growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illnesses in all residents who received food and ice from the kitchen. Findings: a. During a concurrent observation and interview on 7/22/2024 at 8:40 a.m., with Certified Nursing Assistant (CNA) 2, in the dining room, a clean paper towel was used to swipe the ice storage bin ceiling and behind the plastic covering the ice dispensing area and brown and black residue was observed on the paper towel. CNA 2 stated a black and brown residue was on the paper towel after the inside of the ice machine was wiped. CNA 2 stated that kind of residue should not be inside the ice machine if it was cleaned daily. CNA 2 stated it was important to keep the ice machine clean because mold and bacteria could develop and contaminate the ice that was served to the residents. CNA 2 stated this put the residents at risk of illness. During an interview on 7/24/2024 at 9:21 a.m. with the Maintenance Assistant (MA), the MA stated the outside of the ice machine was wiped off daily and an in-depth cleaning was done once a month where the ice was removed, and the inside was thoroughly cleaned. The MA stated black residue should not be found on the inside of the ice machine because it could indicate bacteria or mold was growing. The MA stated the bacteria could contaminate the ice, which was served to the residents in the facility, and it could make them sick. b. During a concurrent observation and interview on 7/23/2024 at 12:15 p.m., with the Dietary Supervisor (DS), in the dry storage area, one dented can of applesauce was not separated from the ready to use cans. The DS stated the dented can of applesauce should not have been on the shelf and should have been placed in the crate designated for dented cans. The DS stated the canned foods were checked upon delivery and once a week to ensure the dented cans were placed in its designated place so it could be disposed of. The DS stated separating the dented cans was important to ensure the canned food was not prepared and served to the residents. The DS stated dented cans put that food item at risk for the growth of botulism (poisoning caused by improper sterilized canned foods), which could be transmitted to the residents and had the potential to make them very ill. During a review of the facility's policy and procedure (P&P) titled, Cleaning the Ice Machine, revised on 4/2017, the P&P indicated, The ice machine shall be cleaned for maintenance of sanitary conditions in order to prevent food contamination and the growth of disease-producing organisms and toxins. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the facility's P&P titled, Dietary- Labeling and Dating Foods, revised on 9/2016, the P&P indicated, Damaged cans are to be set aside in a designated area for return to the vendor or disposed of. According to 2022 Food Code: U.S. Food and Drug Administration, dated 1/18/2023, indicated, Food shall be safe, unadulterated (completely pure and has nothing added to it) . Food packages shall be in a good condition and protect the integrity of the contents so that the food is not exposed to adulteration or potential contaminants.

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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 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 48131 Based on interview and record review, the facility failed to ensure the Infection Preventionist (a person designated by the facility to be responsible for the infection prevention and control program) nurse (IPN) attended, participated, and gave findings on a regular basis to the Quality Assurance and Performance Improvement ([QAPI] a systematic, comprehensive, and data-driven approach to maintaining and improving safety and quality in nursing homes while involving all nursing home caregivers in practical and creative problem solving) committee during monthly meetings. This deficient practice prevented the QAPI Committee from receiving updated information regarding the facility's infection prevention program which had the potential to negatively impact residents' safety regarding infection control practices and outcomes in the facility. Findings: During a concurrent interview and record review on 7/23/2024 at 2:30 p.m. with the Administrator (ADM) and IPN 2, the QAPI committee meeting minutes and sign in sheets on 4/8/2024, 5/16/2024 and 6/20/2024 were reviewed. The QAPI committee sign in sheets and minutes indicated the IPN did not sign and did not present any infection control reports or findings to the QAPI committee. The ADM stated the QAPI committee meets every 30 days. The ADM stated that she was a new administrator in the facility and the IPN was also new to the facility. IPN 2 stated that she had not attended any QAPI meetings since she was promoted as the IPN. The ADM agreed that it was mandatory to have an IPN to attend and participate in all QAPI committee meetings and discuss the current infection rate and infection control practices in the facility. The ADM explained that the previous IPN resigned before a new IPN could be hired. The ADM stated she received the infection control summary for the month of May 2024, but it was never presented at the QAPI committee meeting. The ADM stated she was working on improving the QAPI process. The ADM stated the facility did not have a policy and procedure for their QAPI Program. During a review of the facility's QAPI Plan, (no date), the QAPI Plan indicated all department heads, the administrator, the director of nursing, infection control and prevention officer, medical director, consulting pharmacist, resident and/or family representatives (if appropriate), and three additional staff will provide QAPI leadership by being on the QAPI Committee.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47092 Based on observation, interview, and record review the facility failed to implement infection control practices by failing to: 1. Date Resident 29's peripheral intravenous catheter ([PIV] a small catheter placed into a vein to administer medication or fluids). 2. Change Resident 57's ventilator (a machine or device used medically to support or replace the breathing of a person who is ill, injured, or anesthetized) tubing per the facility policy. These deficient practices had the potential to result in phlebitis (infection/inflammation of the vein) for Resident 29 and pneumonia (infection of the lungs) for Resident 57. 3. Ensure Resident 26's nebulizer (a device used to administer medication in the form of a mist inhaled into the lungs) mask and tubing was properly stored or changed as indicated in the facility's policy and procedure (P&P). This deficient practice had the potential to increase the risk for infection for Resident 26. 4. The incorrect isolation precaution (used to reduce the transmission of microorganisms in healthcare settings) signage was placed outside of Resident 192's room. 5. Improper hand hygiene (action of hand cleansing either with soap and water or with alcohol-based hand rub) was observed during Resident 37's wound care treatment. 6. Expired food was stored in the resident designated fridge for Resident 46. 7. Two open ice coffee bottles were not labeled and were stored in the resident designated fridge. These deficient practices had the potential for the spread of bacteria and had the potential to cause illness. Findings: a. During a review of Resident 29's Admission Record, the admission record indicated Resident 29 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 29's admitting diagnoses included cerebral infarction (tissue death of the brain from a clot or other obstruction of blood flow), dependence on a ventilator, and respiratory failure (a condition in which your blood doesn't have enough oxygen or has too much carbon dioxide). During a review of Resident 29's Minimum Data Set ([MDS] a standardized assessment and care screening tool), dated [DATE], the MDS indicated Resident 29 was severely cognitively impaired (ability to think and reason). The MDS indicated Resident 29 required total assistance (helper does all the effort) with all activities of daily living (ADLs) such as eating, oral hygiene, toileting hygiene, showering/bathing, dressing, and personal hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of Resident 29's Physician's Orders dated [DATE], the orders indicated to restart Resident 29's PIV every 72 hours and as needed if without complications but may extend IV site to 7 days if no complications. During an observation on [DATE] at 9:48 a.m., Resident 29 was observed lying in bed, asleep with an undated and uninitialed peripheral intravenous catheter ([PIV] a small catheter placed into a vein to administer medication or fluids) on her left medial (inner) thigh. During an interview on [DATE] at 11:14 a.m., with Registered Nurse (RN) 2, RN 2 stated she did not know how old Resident 29's PIV was or who inserted it because there was no date or staff's initials on it. RN 2 stated if a PIV is undated nursing staff will not know when to change it. RN 2 stated if a PIV is not initialed by the nurse who inserted it questions or concerns cannot be addressed. During an interview on [DATE] at 3:05 p.m., with the Assistant Director of Nursing (ADON), the ADON stated all PIVs should be dated for nursing staff to know when to change it because PIVs must be changed periodically to prevent phlebitis. The ADON stated nursing staff should date all inserted PIVs for accountability. b. During a review of Resident 57's Admission Record, the admission record indicated Resident 57 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 57's admitting diagnoses included cerebral infarction, dependence on a ventilator, and tracheostomy status (a procedure to help oxygen reach the lungs by creating an opening from outside of the neck and into the airway). During a review of Resident 57's MDS dated [DATE], the MDS indicated Resident 57 was severely cognitively impaired. The MDS indicated Resident 57 required total assistance all ADLs such as eating, oral hygiene, toileting hygiene, showering/bathing, dressing, and personal hygiene. During a review of Resident 57's Physician's Orders dated [DATE], the orders indicated to change the circuit vent (tubing that connects the ventilator to the tracheostomy) once a month and as needed to prevent infection. During an observation on [DATE] at 10:01 a.m., Resident 57 was observed lying in bed, asleep with a tracheostomy hooked up to a ventilator. Resident 57's circuit vent was dated [DATE]. During an interview on [DATE] at 3:33 p.m., with Respiratory Therapist (RT) 1, RT 1 stated Resident 57's circuit vent should be changed once a month or as needed to prevent infection. During a review of the facility's policy and procedure (P&P) titled, Tracheostomy Tube Change dated , d+[DATE], the P&P indicated tracheostomy tubes will be changed monthly or as ordered by the attending physician. During a review of the facility's P&P titled, Peripheral Venous Catheter Insertion dated ,d+[DATE], the P&P indicated PIVs must be dated, timed, and initialized by the one who inserted the PIV. 48343 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE] at 11:16 a.m., with the Director of Nursing (DON), the DON stated EBP, and contact precautions were used to prevent the spread of microorganisms, however, both precautions had their differences in when they were used. The DON stated EBP was used to prevent the spread of microorganisms from the staff member to the resident, whereas contact precaution was used to prevent the spread of microorganisms from the resident to the staff member. The DON stated EBP was more lenient with the use of PPE and because the incorrect signage was used for Resident 192, there could have been individuals who entered the room without donning (put on) PPE and could have been exposed to CRE. The DON stated Resident 192's physician order indicated for Resident 192 to be placed on contact precaution and that order should have been followed. The DON stated the use of the incorrect isolation precaution could increase the spread of microorganisms and infection to the staff and to other residents. During a review of the facility's P&P titled, Infection Control Transmission-Based Precautions, revised on , d+[DATE], the P&P indicated, When a resident is placed on transmission-based precautions, the following should be implemented: identify the type of precautions and the appropriate PPE to be used [and] place a sign outside the resident's room on the wall next to the doorway identifying the [Centers of Disease Control and Prevention] CDC category of transmission-based precautions, instructions for the use of PPE, and/or instructions to see the nurse before entering. e. During review of Resident 37's Admission Record (Face Sheet), the admission record indicated Resident 37 was admitted to the facility on [DATE] with diagnoses that include but not limited to type 2 diabetes mellitus (a condition that results in too much sugar circulating in the blood), osteomyelitis (one infection), and peripheral vascular disease ([PVD],(a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs). During a review of Resident 37's MDS, dated [DATE], the MDS indicated Resident 37's cognition was intact. The MDS indicated Resident 37 required setup assistance with eating and oral hygiene. The MDS indicated Resident 37 required maximal assistance (helper does more than half the effort) with toileting, showering, and dressing. The MDS indicated Resident 37 had diabetic foot ulcers (open wound on the foot that is associated to diabetes) and surgical wounds. During a review of Resident 37's H&P dated [DATE], the H&P indicated Resident 37 had the capacity to understand and make decisions During a review of Resident 37's Order Summary Report, dated [DATE], the Order Summary Report indicated the following daily wound care orders: Cleanse the right foot surgical wound with normal saline ([NS], saltwater solution) and pat dry. Apply the Aquacel Ag Advantage External Pad (type of medicated dressing) to the wound. Cover with dry dressing and secure with rolled dressing and tubular dressing. Cleanse the right heel arterial ulcer (wound caused by decrease in blood flow) with NS and pat dry. Apply the Aquacel Extra Hydrofiber External Pad (type of medicated dressing) to the wound bed followed by a dry dressing and secure with rolled dressing. Apply Betadine External Solution (used to prevent and treat mild skin infections) to the right foot wound and allow to dry. Cover with dry dressing and secure with tubular dressing. (continued on next page)

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F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

During an observation on [DATE] at 8:20 a.m., with the Treatment Nurse (TN) in Resident 37's room, the TN explained that she would be doing Resident 37's wound treatment. The TN prepared her supplies, performed hand hygiene, donned a disposable gown, and applied gloves. Resident 37 was laying on his back and had his right foot dressing exposed. The TN removed the tubular dressing and wrapped dressing from Resident 37's right foot. The TN removed her right glove and applied a new glove. The TN cleansed the heel with NS, removed her gloves, and applied new gloves. The TN cleansed the wound on the plantar (bottom) part of the foot, removed her gloves, washed her hands in the restroom, and applied new gloves. The TN applied the betadine to the plantar wound, removed her gloves, and applied new gloves. The TN cleansed the heel with NS, removed her gloves, and applied new gloves. The TN applied medicated gauze to the plantar wound, removed her right glove, and applied a new glove. The TN applied medicated gauze to the heel, removed her gloves, and applied new gloves. The TN applied padded gauze to the heel and plantar foot and applied lotion to Resident 37's leg. The TN removed her gloves and applied new gloves. The TN adjusted Resident 37's linen and adjusted the bed for Resident 37's comfort. The TN cleaned her area, removed her gloves, and washed her hands in the restroom.

During an interview on [DATE] at 8:50 a.m., with the TN, the TN stated the purpose of hand hygiene was to prevent the spread of infection. The TN stated she was supposed to perform hand hygiene prior to applying new gloves and when she removed old gloves. The TN stated she did not perform hand hygiene every time she took off her gloves and prior to applying new gloves. The TN stated improper hand hygiene had the potential to spread infection to Resident 37's wounds.

During an interview on [DATE] at 10:25 a.m., with the IPN, the IPN stated hand hygiene was the best way to ensure the hands were free of bacteria that could be transmitted to others. The IPN stated hand hygiene was supposed to be done prior to putting on gloves and after taking them off. The IPN stated throughout a wound treatment, the TN would be removing and applying new gloves and each time, she would have to perform hand hygiene. The IPN stated performing hand hygiene was especially important throughout a wound treatment because the resident had open wounds and was prone to infection.

During an interview on [DATE] at 11:19 a.m., with the DON, the DON stated hand hygiene was done to ensure the individual's hands were clean before touching the resident. The DON stated hand hygiene was done before and after glove use and done again if new gloves were applied. The DON stated new gloves were not supposed to be put on until hand hygiene was performed. The DON stated this could cause the spread of bacteria and could cause infection in the wound.

During a review of the facility's P&P titled, Enhanced Standard Precautions, revised on ,d+[DATE], the P&P indicated, Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces, and before going to another resident and wash hands immediately to avoid transfer of microorganisms to other residents or environments.

f. During a review of Resident 46's Admission Record (Face Sheet), the admission record indicated Resident 46 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that include but not limited to chronic obstructive pulmonary disease (COPD, a lung disease characterized by long-term poor airflow), end stage renal disease, and heart failure.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE] at 8:53 a.m., with the Dietary Supervisor (DS), the DS stated expired food should not be stored and should be disposed of right away. The DS stated labeling and dating food items was a way to ensure accountability of the expiration dates and to be aware whose food was whose. The DS stated the residents in the facility were very fragile and many had low immunity, so they were at high risk of food borne illness if the staff were not careful. During an interview on [DATE] at 11:13 a.m. with the DON, the DON stated the nursing department was responsible for maintaining the resident fridge. The DON stated when food items were stored in the fridge, the item had to be labeled with the resident's name, the date, and check the expiration date. The DON stated if a food item was expired, it would need to be discarded. The DON stated removing expired food was essential in preventing foodborne illnesses that could cause diarrhea and upset stomach. During a review of the facility's P&P titled, Dietary- Refrigerator for Resident Storage of Food, revised on , d+[DATE], the P&P indicated, Food will be labeled with the resident's name and the date the food is placed in the refrigerator. Leftover food will be kept for 72 hours after the date on the container and will be discarded after 72 hours or discarded based on the expiration date if unopened.