STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056007	A. Building B. Wing	07/18/2025

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. (continued on next page)

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

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

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of two sampled residents (Resident 75) was free of unnecessary physical restraints (any object or device that an individual cannot remove easily which restricts freedom of movement) by failing to:1.Ensure physician order for the use of restraint was obtained before initiating a physical restraint in the form of a sock which covered the right arm and right hand with tape wrapping the fingers.2. Ensure an assessment and monitoring of the use of physical restraint for the right arm and hand were implemented and documented.This failure had the potential to place Resident 75 at risk for unnecessary prolonged use of restraints, and could lead to decline in physical functioning, impaired blood circulation, and skin injuries. Findings:During a concurrent observation and interview on 7/15/2025, at 10:35 a.m. in the room of Resident 75 with a family member (FM1), Resident 75's right arm and right hand were covered with a blue sock with white tape wrapped around the portion of the fingers. During a review of Resident 75's admission Record, the admission Record indicated the resident was initially admitted on [DATE] and was readmitted on [DATE] to the facility with diagnoses including anoxic brain damage(occurs when the brain was completely deprived of oxygen causing brain cells to die leading permanent problems like memory loss, or trouble speaking) , diabetes mellitus(DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), gastrostomy(a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) dysphagia (difficulty of swallowing) and encephalopathy(disturbance of brain function).During a review of Resident 75's Minimum Data Set (a resident assessment tool) dated 6/7/2025, the MDS indicated Resident 75 had unclear speech and was rarely or never understood. The MDS indicated the resident was dependent (helper does all the effort to complete the activity) on the staff with bathing, dressing, dressing, toileting hygiene, bed mobility and oral hygiene.During a review of Resident 75's History and Physical (H&P) dated 3/5/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 75's Order Summary Report on 7/15/2025 at 12:00 p.m., the Order Summary Report did not indicate any order for physical restraint for resident's right arm or right hand.During a review of Resident 75' medical chart on 7/15/2025 at 4:30 p.m., the medical chart did not indicate a consent for the use of a restraint for the right arm.During an interview on 7/15/2025 at 1:43 p.m. with Certified Nursing Assistant (CNA) 3 in Resident 75's , CNA 3 stated the blue sock that was applied on the right arm and hand of Resident 75 was a mitten to protect the gastrostomy tube (GT- tube inserted through the abdomen directly into the stomach for feeding and medication administration) from being pulled out by the resident.During an interview on 7/16/2025 at 1:50 p.m. with CNA 1, CNA1 stated the blue sock on his hand was a form of restraint and could cause impairment of Resident 75's skin circulation and restrict the movement of his right arm and hand. During an interview on 7/16/2025 at 2:05 p.m. with Licensed Vocational Nurse (LVN) 1, LVN1 stated the blue sock on the right arm and hand should have been removed by the staff and obtained a physician order for a physical restraint because the blue sock could cause skin problems and poor circulation. During an interview on 7/17/2025, at 4:50 p.m. with RN Supervisor (RNS) 1, RNS 1 stated the family of Resident 75 requested the sock on the right arm of the resident. RNS1 agreed it was the responsibility of the facility to monitor and assess the use of the restraint on Resident 75. RNS 1 stated Resident 75 could develop impaired skin and poor circulation because of the skin being covered and not being checked by staff. RNS 1 stated prior to initiating a form of physical restraint on a resident, the facility should use the least restrictive measure by redirecting the behavior, checking the resident more often or utilizing the family member to watch the resident. RNS 1 stated monitoring and assessment of the use of restraints should be documented on the residents' chart.During an interview on 7/18/2025, at 10:43 a.m. with the Director of Nursing (DON), the DON stated there should be a physician order, consent for the placement of restraint, assessment and monitoring for the use of restraint and quarterly restraint assessment to ensure if the resident still requires the use of restraint. The DON stated the blue sock used a restraint was not acceptable form of restraint because the material is not breathable and could make Resident 75's skin prone to breakdown and cause restriction on the movement of his right arm and hand. The DON stated the staff should have removed the sock from Resident 75's right arm, assessed the need for the use of restraint and notified the physician that the resident required a hand mitten or restraint to obtain an order.During a review of facility's policy and procedure (P&P) titled, Physical Restraints, revised 9/2017, the P&P indicated

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, Licensed Vocational Nurse (LVN) 4 failed to ensure Resident 8's Acidophilus ([generic name - lactobacillus] a probiotic supplement used to improve gut health) was completely dissolved before being administered via gastrostomy tube (g-tube - a surgically placed tube used to administer medications or food directly into the stomach). LVN 4 failed to safely administer medications via g-tube by failing to follow infection control practices throughout medications administration, for one of seven sampled residents observed during medication administration. This failure to administer g-tube medications for Resident 8 in accordance with professional standards of care and increased the risk for discomfort, clogging of g-tube, infection and contamination of medications. Findings:During a review of Resident 8's admission Record, dated 7/16/2025, the admission Record indicated, Resident 8 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included but not limited to, sepsis (a life-threatening blood infection), chronic kidney disease (a condition where the kidneys are damaged and cannot filter blood as well as they should), gastrostomy status, personal history of urinary tract infections (infection in any part of the urinary system), pneumonia (an infection/inflammation in the lungs) and history of other infectious and parasitic diseases.During a review of Resident 8's History and Physical (H&P), dated 2/4/2025, the document indicated Resident 8 did not have the capacity to understand and make decisions. During a review of Resident 8's Minimum Data Set (MDS-resident assessment tool), dated 4/21/2025, the MDS indicated Resident 8 was on g-tube feedings, fully dependent on facility staff for Activities of Daily Living (ADLs) such as oral hygiene, toileting hygiene, showering, upper and lower body dressing, putting on or taking off footwear and personal hygiene.During a concurrent observation and interview on 7/16/2025 at 9:00 a.m. with LVN 4, LVN 4 prepared the following six medications and supplements by crushing them individually using a crushing device to be administered to Resident 8 via g-tube. LVN 4 stated he used five to 10 milliliter(ml-unit of measurement) water to dissolve each medication separately.1. One tablet of buspirone (a medication used to treat anxiety [a medical condition described by feeling of fear or uneasiness]) 5 milligrams ([mg] - a unit of measurement for mass)2. One tablet of metformin (a medication used to treat diabetes mellitus [DM]-a disorder characterized by difficulty in blood sugar control and poor wound healing) 500 mg3. One tablet of metoclopramide (a medication used to treat gastroesophageal reflux disease ([GERD - digestive disorder where stomach acid frequently flows back into the esophagus, causing irritation and discomfort], and nausea and vomiting) 5 mg4. One tablet of sucralfate (a medication used to treat and prevent ulcer) 1 gram ([g] a unit of measurement for mass)5. Ferrous sulfate (a medication used to treat low level of iron) 7.5 milliliters ([mL] a unit of measurement for volume) 200 mg/5 mL 6. One capsule of AcidophilusLVN 4 started to use syringe to pull out water from water cup to use it as flush for g-tube, before starting to administer medications. The surveyor prompted LVN 4 to explain his steps, which was when LVN 4 corrected his technique by using the gravity method instead, to flush g-tube by administering 30 mL water into the syringe. The water started flowing out of the g-tube onto Resident 8's bed. LVN 4 stated Oh sorry, I didn't adjust the clamp on the g-tube for medication administration. LVN 4 fixed the issue and continued to administer medications one by one using gravity method followed by water in between each medication. LVN 4 then stepped away from the bedside with the syringe in his hand that was used to administer water and g-tube medications, and walked to the medication cart, which exposed the syringe to other factors in the environment. LVN 4 returned to bedside with the same syringe and resumed medication administration. During the administration of Acidophilus through the syringe into g-tube, the syringe looked cloudy with its powder stuck on the walls of the syringe. LVN 4 stated he will add more water to dissolve the powder. LVN 4 was not able to administer the remaining powdered solution through g-tube. LVN 4 then pushed with the syringe plunger which helped the remaining Acidophilus to be administered via g-tube to Resident 8. During a review of Resident 8's Order Summary Report, dated 7/17/2025, the Order Summary Report indicated but not limited to the following physician orders: Acidophilus oral tablet, give 1 tablet via g-tube one time a day for supplement, order date 1/31/2025, start date 2/1/2025. Buspirone hydrochloride (HCl) tablet 5 mg, give 1 tablet via g-tube every 12 hours for anxiety manifested by (m/b) inability to relax, order date 1/31/2025, start date 2/1/2025. Carafate ([generic name - sucralfate] oral tablet 1 g, give 1 tablet via g-tube four times a day for gastroesophageal reflux disease (GERD - digestive disorder where stomach acid frequently flows back into the esophagus, causing irritation and discomfort)/gastritis, order date 6/22/2025, start date 6/22/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that staff used a communication board (tool used for communicating with residents that speak another language) for one of four sampled residents (Resident 100) as written in her care plan. This deficient practice had a potential for staff to ineffectively communicate with Resident 100's care and had a potential to delay medicating Resident 100 when she complained of being in pain. Findings: During a review of Resident 100's admission Record , the admission Record indicated Resident 100 was originally admitted to the facility on [DATE] with diagnoses including cerebrovascular accident (CVA- stroke, loss of blood flow to part of the brain) and tracheostomy (surgically created opening in the neck that extends into the windpipe) with ventilator (a medical device to help support or replace breathing) dependence. During a review of Resident 100's History and Physical (H&P) dated 7/11/2025, the H&P indicated that Resident 100 was hospitalized on [DATE] for sepsis (life-threatening blood infection) from infected right elbow fracture and infected right knee replacement and was readmitted to the facility on [DATE]. The H&P indicated Resident 100 has a fluctuating capacity to understand and make decisions. During a review of Resident 100's Minimum Data Set (MDS- resident assessment tool) dated 7/17/2025, the MDS indicated Resident 100 was dependent (helper does all the effort or two or more helpers is required for the resident to complete the activity) on staff for bed mobility, moving from sitting on side of bed to lying flat on bed, toileting hygiene, bathing, dressing, personal hygiene, and oral hygiene. The MDS indicated that Resident 100's primary language is Spanish. During review of Resident 100's Care Plan titled Impaired Communication dated 7/13/2025, the Care plan interventions indicated Do not hurry when trying to communicate (with resident). During a concurrent observation and interview on 7/15/2025 at 10:38 a.m. with Resident 100, observed Resident 100 grimacing and uncomfortable in bed. A communication board with Spanish words and phrases hanging on the wall was used to communicate with Resident 100. Resident 100 stated she was in pain and would like pain medication. During an observation on 7/15/2025 at 10:43 a.m. in Resident 100's room, Licensed Vocational Nurse (LVN) 4 instructed Resident 100 that Tylenol was administered at 8:45 a.m. and to wait for the medication to kick in about 45 minutes to an hour in English. Resident 100 shook her head and mouthed, No se (I don't understand). LVN 4 replied, No pain? Okay and left the room. During an interview on 7/15/2025 at 10:50 a.m. with LVN 4, LVN 4 stated that he did not use the communication board to assess Resident 100's uncontrolled pain. During a subsequent observation on 7/15/2025 at 10:52 a.m. with LVN 4 and Resident 100 in Resident 100's room, Resident 100 stated she was in ten-out-of-ten pain in her right leg. LVN 4 asked Resident 100, Are you sure you're in pain? I just gave you medicine at 8:45 (a.m.) Resident 100 was grimacing and nodded her head. During an interview on 7/17/2025 at 2:31 p.m. with Register Nurse Supervisor (RNS) 3, RNS 3 stated that staff should be using the communication board when communicating with Resident 100 because it was important for her to make her needs known. RNS stated that staff was trained in how to use the communication board and what it was part of new hire orientation. RNS 3 stated that LVN 4 did not try to understand Resident 100 and this had the potential for Resident 100 to continue being in pain. During an interview on 7/18/2025 at 12:26 p.m. with the Director of Nursing (DON), the DON stated that staff can neglect residents' needs when they don't use the communication board and that is why all staff should be using it. During a review of Resident 100's Policy and Procedures (P&P) titled, Activities of Daily Living, Quality of Care, Routine Resident Monitoring, and Scope of Services dated 6/2022, the P&P stated, The facility will provide. communication (speech, language and other means such as a communication board) to residents assessed to require these services.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure one of one sample resident (Resident 53) received rehabilitation services or Restorative Nursing Aide ([RNA] nursing aide program that helps residents to maintain their function and joint mobility) services for the right-hand contracture. (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints).This failure had the potential to result in Resident 53 being at risk for further range of motion (ROM - the extent of movement of a joint) decline and contracture.Findings:During a review of Resident 53's admission Record, the admission Record indicated, Resident 53 was admitted to the facility on [DATE] with diagnoses including dysarthria (a speech disorder that occurs when muscles used for speaking become weak or are unable to coordinate properly), muscle weakness, hemiplegia (paralysis of one side of the body) and hemiparesis (weakness of one side of the body) affecting the right dominant side.During a review of Resident 53's History and Physical, dated 6/25/2025, the H&P indicated Resident 53 did not have the capacity to understand and make decisions.During a review of Resident 53's Minimum Data Set (MDS-a resident assessment tool), dated 7/12/2025, the MDS indicated Resident 53 was dependent on nursing staff for toileting, showering, dressing, sitting, lying down and transferring. The MDS indicated Resident 53 needed partial to moderate assistance from nursing staff with personal and oral hygiene.During a concurrent observation and interview on 7/15/2025 at 10:38 am with Resident 53 in Resident 53's room, observed Resident 53's right wrist and right hand were contracted. Resident 53 stated she does not know if she was getting therapy for the contractures on the right wrist and right hand.During a concurrent interview and record review on 7/17/2025 at 9:48 am with Licensed Vocational Nurse (LVN) 2, Resident 53's Care Plan, titled cerebral vascular accident (CVA- lack of adequate blood supply to the brain), dated 6/24/2025 was reviewed. The Care Plan indicated Resident 53 was at risk for development of joint limitation/contracture secondary to decreased mobility related to right side weakness and a right arm contracture. The Care Plan indicated the goal was to minimize the risk of further joint limitation in the next three months. The Care Plan indicated to provide restorative activities as ordered. LVN 2 stated Resident 53 was admitted to the facility with a right upper extremity contracture with moderate to severe limitations. During a concurrent interview and record review on 7/07/17/2025 at 11:52 AM with the Director of Rehabilitation (DOR), Resident 53's Joint Mobility Assessment, dated 6/24/2025, was reviewed. The Joint Mobility Assessment indicated Resident 53 had right shoulder moderate to severe joint mobility limitation. The Joint Mobility assessment indicated Resident 53 had right elbow moderate to severe joint mobility limitation. The Joint Mobility assessment indicated, Resident 53 had right wrist severe joint mobility limitation. The Joint Mobility assessment indicated Resident 53 had right hand and fingers with moderate joint mobility limitation. The DOR stated the PT focus was on bed mobility. The DOR stated the OT focus was on upper body dressing, transferring and personal hygiene. The DOR stated he does not know when Resident 53 developed contractures to the right elbow, right shoulder and right hand. The DOR stated there are no goals for the right-hand contracture. The DOR stated typically a splint should be given to residents with contractures on the hand. The DOR stated interventions for contractures are active ROM, passive range of motion ([PROM] the range of motion that is achieved when an outside force such as a therapist causes movement of a joint and is usually the maximum range of motion that a joint can move) and strengthening and preventative measures. The DOR stated no preventative measures were done for Resident 53. The DOR stated Resident 53 should have received preventive measures for the right-hand contracture to prevent further decline and contractures.During an interview on 7/17/2025 at 3:51 pm with Registered Nurse Supervisor (RNS) 1, RNS 1 stated Resident 53's right hand was contracted, and no nursing services were being provided to maintain or improve mobility on the right hand. RNS 1 stated Resident 53's contracture would worsen and more limitation to hand mobility if Resident 53 was not receiving any preventive services (RNA services).During an interview on 7/18/2025 at 3:36 pm with the Director of Nursing (DON), the DON stated residents admitted to the facility with contractures need rehabilitation services to prevent further decline in function and to maintain function and prevent further contractures.During a review of the facility's policy and procedure (P&P), titled Limitations in Range of Motion and Mobility and Referrals for Therapy, , date revised 10/2017, the P&P indicated, It is the policy of the facility that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one of one sampled resident (Resident 66) was not left un-attendant in bed prior to transfer to a mechanical lift (Hoyer lift- (a device used to assist with transferring and moving individuals who have limited mobility) and bed should be locked.This failure had the potential for Resident 66 to fall out of bed and sustain injuries that require hospitalization. Findings:During a review of Resident 66's admission Record, the admission Record indicated Resident 66 was admitted to the facility on [DATE] with diagnoses including intracranial hemorrhage (brain bleed), cervical osteomyelitis (infection of the bone) , cervical discitis (an infection of the intervertebral discs in the neck), and cervical spondylolisthesis (a condition where one of the vertebrae in your neck (cervical spine) slips forward, backward, or onto the vertebra below it).During a review of Resident 66's Care Plan, titled Risk for Fall, dated 4/27/2025, the Care Plan indicated, Resident 66 had poor safety awareness, episodes of placing the bed up high despite explanations of risk and benefits. During a review of Resident 66's Care Plan, titled High Risk for Injury, dated 4/27/2025, the Care Plan indicated, Resident 66 had generalized muscle weakness. The Care Plan indicated to implement fall precautions with frequent visual checks, call for safety with Hoyer lift transfer. During a review of Resident 66's History and Physical (H&P), dated 4/28/2025, the H&P indicated, Resident 66 had the capacity to understand and make decisions.During a review of Resident 66's Minimum Data Set (MDS- a resident assessment tool), dated 5/3/2025, the MDS indicated, Resident 66 needed substantial to maximal assistance with toileting, showering, dressing, sitting, standing, and transferring.During an observation on 7/15/2025 at 10:40 a.m., in Resident 66's room, observed two wheelchairs were positioned in front of Resident 66's bed blocking the entrance into the room. Resident 66 was lying flat on her back in bed with a Hoyer lift pad underneath. Resident 66's bed was elevated, the side rails were down, the breaks at the foot of the bed were off. Resident 66's foley catheter bag was on top of Resident 66's bed next to Resident 66.During a concurrent observation and interview on 7/15/2025 at 10:44 a.m., with Certified Nursing Assistant (CNA) 4, CNA 4 and another certified nursing assistant (unknown) went to Resident 66 bedside with a Hoyer lift wearing gowns and gloves. CNA 4 connected Resident 66 to the Hoyer lift using the strap from the Hoyer lift pad. CNA 4 stated the breaks at the foot of the bed were not locked and should always be locked. CNA 4 locked Resident 66's brakes on at the foot of the bed. CNA 4 and another CNA transferred Resident 66 off the bed into a wheelchair. During an interview on 7/16/2025 at 1:31 p.m., with CNA 4, CNA 4 stated it was documented in Resident 66's Care Plan that the resident likes to raise her bed. CNA 4 stated Resident 66 was not on any fall precaution measures. CNA 4 stated before the transfer of Resident 66 with the Hoyer lift the brakes at the foot of the bed were not locked. CNA 4 stated the bed should have been in the lowest position before transferring Resident 66 to the wheelchair to prevent Resident 66 from falling.During a concurrent interview and record review on 7/17/2025 at 10:56 a.m., with Licensed Vocational Nurse, (LVN) 5, Resident 66 Care Plan, dated 4/27/2025 was reviewed. The Care Plan indicated on 4/27/2025 Resident 66 had episodes of putting bed up in a high position and the risk and benefits were explained. The Care Plan indicated frequent visual checks and providing a safe environment. LVN 5 stated the brakes should be locked at all times while Resident 66 was in bed as Resident 66 could fall. During an interview on 7/17/2025 at 3:48 p.m., with Registered Nurse Supervisor (RNS) 1, RNS 1 stated Resident 66 was a high risk for falls. RNS 1 stated if Resident 66 was left unattended with the bed in a high position and the brakes were not locked Resident 66 could fall in bed and sustain injury. During an interview on 7/18/2025 at 3:35 p.m., with the Director of Nursing (DON), the DON stated the brakes on Resident 66's bed should be locked. The DON stated the nursing staff were not supposed to leave the residents unattended when the bed was in a high position. The DON stated someone should have stayed with Resident 66 for safety and to prevent risk of falling.During a review of the facility's policy and procedure (P&P), titled Falling Star Program, , date revised 7/2018, the P&P indicated, Purpose: .To attempt to increase supervision for residents assessed to be at high risk for falls. General safety precautions and interventions should be used for residents and may include: Maintaining the bed in the lowest position. Locking brakes on beds, gurneys, or wheelchairs.Keep the resident's environment free of unnecessary obstacles.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure one of one sample resident (Resident 47) was provided with indwelling urinary catheter (a flexible tube inserted into the bladder to drain urine) care based on professional standards of practice and Resident 47's physician order. This failure had the potential for Resident 47 to develop a urinary tract infection (UTI- an infection in any part of the urinary system, the kidneys, bladder or urethra) and unable to assess Resident 47's intake and output.Findings:During a review of Resident 47's admission Record, the admission Record indicated, Resident 47 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including end stage renal disease (the final stage of chronic kidney disease (CKD) where the kidneys have significantly lost their ability to function adequately), hydronephrosis (a condition where one or both kidneys swell due to a backup of urine), retention of urine and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing).During a review of Resident 47's Minimum Data Set (MDS- a resident assessment tool), dated 5/20/2025, the MDS indicated, Resident 47 was dependent on nursing staff for toileting, showering, dressing and transferring. The MDS indicated Resident 47 had an indwelling urinary catheter.During a review of resident 47's Physician Orders, dated 6/26/2025, the Physician Orders indicated, Resident 47 had an order to monitor urinary output every shift.During a review of Resident 47's History and Physical (H&P), dated 6/27/2025, the H&P indicated, Resident 47 had the capacity to understand and make decisions.During a review of Resident 47's Care Plan, dated 6/27/2025, the Care Plan indicated Resident 47 was at risk of developing a UTI. The Care Plan interventions indicated to monitor intake and output (I&O) every shift.During an interview on 7/15/2025 at 1:53 p.m., with Resident 47, Resident 47 stated her urinary indwelling catheter bag was not being emptied every shift. Resident 47 stated his urinary bag was being emptied in the mornings and afternoons.During an interview on 7/16/2025 at 2:49 p.m., with Certified Nursing Assistant (CNA) 5, CNA 5 stated Resident 47 was a dialysis (a treatment that replaces kidney function when kidneys fail, removing waste and excess fluid from the blood) resident. CNA 5 stated Resident 47 has a indwelling urinary catheter and should be emptied one time per shift. CNA 5 stated she documents the urinary output on the TASK section in the residents' health record and informs the licensed vocational nurses (LVN) of the urinary output every shift. CNA 5 stated it was important to empty Resident 47's urinary bag to see if the resident was having urinary retention or if there were any problems. CNA 5 stated the urine needs to be emptied because it can cause backflow and Resident 47 can develop a UTI.During a current interview and record review on 7/17/2025 at 10:14 a.m., with LVN 2, Resident 47's Medication Administration Record (MAR), dated July 2025 was reviewed. The MAR indicated there was no documentation of the licensed nurses to demonstrate the amount of urine output measured in milliliters on the following days:7/2/2025, for night shift (11 p.m. to 7 a.m.)7/4/2025, for night shift7/5/2025, for evening shift (3 p.m. to 11 p.m. shift) and night shift7/6/2025, for night shift 7/7/2025, for night shift7/8/2025, for night shift7/11/2025, for night shift7/12/2025, for night shift7/13/2025, for evening shift and night shift7/14/2025, for night shift7/16/2025, for night shift LVN 2 stated Resident 47 was a dialysis resident and uses a indwelling urinary catheter due to urinary retention. LVN 2 stated Resident 47's urinary output should be monitored, emptied and measured once per shift and as needed to prevent urine backflow. LVN 2 stated Resident 47 could develop a UTI or kidney infection. During a concurrent interview and record review on 7/17/2025 at 3:31 PM with Registered Nurse Supervisor (RNS) 1, Resident 47's Physician Order, dated 6/26/2025, was reviewed. The Physician Order indicated to monitor Resident 47's output every shift. RNS 1 stated every shift the nurses need to empty the indwelling urinary catheter and document the amount of output in milliliters in the resident's health record. RNS 1 stated if the urinary catheter output was not documented we cannot have an accurate monitoring of the urine output for a resident on dialysis, to know if the resident was having retention or any fluid buildup or needs extra dialysis, and to assess renal function.During an interview on 7/18/2025 at 3:12 p.m., with the Director of Nursing (DON), the DON stated the nurses should have documented the measured urine output in milliliters in the resident's health record. DON stated it is important to know the urine output to make sure the resident is not retaining fluid. During a review of facility's policy and procedure (P&P) titled Intake and Output revised 05/2016, the P&P indicated It is the policy of the facility to record fluid and intake and output in accordance with the following: If ordered by the physician; and for each resident admitted with an indwelling catheter

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident with a gastrostomy tube (GT-a tube that is passed through the abdominal wall to the stomach used to provide nutrition) site was not leaking from January 2025 to present for one out of eight residents (Resident 8). This deficient practice resulted in continuous leakage of tube feeding formula around Resident 8's stoma (surgically created opening on the abdomen that allows waste to exit the body) site with Resident 8 being transferred to the General Acute Care Hospital (GACH) and had the potential to cause skin breakdown around the site, lead to malnutrition, infection and Resident 8 not receiving the volume of tube feeding formula ordered by the physician.Findings:During a concurrent observation and interview on 7/16/2025 at 2:46 p.m., with Treatment Nurse (TN 1), Resident's 8 g-tube dressing was observed leaking out through the g-tube dressing. TN1 stated it was observed today that the g-tube was leaking.During a review of Resident 8's admission Record/Face sheet (a document that summaries key information about a person, thing or situation), the admission Record indicated Resident 8 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including, gastrostomy status (the presence of a gastrostomy tube, which is a surgical procedure that creates an opening in the stomach through the abdominal wall.), dysphagia (a medical term for difficulty swallowing.), tracheostomy (a surgical procedure that creates an opening in the trachea [windpipe]to help with breathing).During a review of the care plan (CP) titled, Alteration in skin integrity dated 2/01/25, the CP indicated the interventions included to notify MD for G-tube leakage if no progress was made towards healing or any signs or symptoms of decline. During a review of Resident's 8 Significant Change in Status Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 04/21/2025, the MDS indicated the resident had severely impaired cognitive (process of thinking) skills for daily decision making. The MDS also indicated the Resident's 8 was totally dependent (helper does all the effort) on bed mobility, transfer, locomotion, dressing, tube feeding, toilet use, and personal hygiene.During a record review on 7/17/24 of Resident 8's transfer record, the transfer record indicated to send Resident 8 to the GACH for a G-tube evaluation and management related to the stoma site leaking. During an interview on 7/17/25 at 10:39am with TN1. TN1 stated she called the doctor because the g-tube was leaking excessively. TN1 stated she thinks the stoma was too large, and that is why the g-tube was leaking. During a concurrent interview and record review on 7/17/225 at 2:23 pm with The Assistant Director of Nursing (ADON), the ADON stated Resident 8's was transferred to the GACH today because the G-tube was leaking with excess amounts of caramel colored fluid. The ADON stated the doctor was called and gave an order to transfer Resident 8 to the GACH for a g-tube replacement. The ADON stated Resident 8'medical records indicated the G-tube was leaking since 1/31/25. The ADON stated the evaluation of g-tube should have been done by the doctor and the licensed nurses should have follow up. The ADON stated the leaking of the g-tube can cause skin irritation, redness and could make Resident 8 uncomfortable. During a concurrent interview and record review on 7/17/25 at 3:13 pm with TN2 of Resident 8's weekly skin assessment was reviewed. TN2 stated she should have called and followed up with the doctor that g-tube was still leaking with no progress. TN 2 stated, this was a delay in treatment. During a review of Resident 8's weekly skin assessment, the following measurements of the G-tube were documented: -On 7/6/25 1x1centimeter ([cm] unit of measurement) in size with redness.-On 7/16/25 2x2 cm in size with redness and leaking. During a concurrent interview and record review on 7/17/25 at 3:46 pm with the Director of Nursing (DON), the DON stated Resident 8 should have been evaluated earlier for G-tube leaking because it can cause skin irritation and redness. The DON stated licensed nurses in the facility should report any abnormal changes to the doctor. During a review of the facility's policy and procedure (P&P) titled, Gastrostomy Tube Feeding via Continuous Pump dated 1/2017, the P&P indicated to Report complications promptly to the supervisor and the attending physician.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure resident's pain was managed for one of two sampled residents (Resident 100); who had multiple pressure ulcers (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence), a healing right arm fracture, and right knee surgical site. Specifically, the facility failed to:1. Ensure that staff followed Resident 100's care plan titled, Alteration in Comfort - Pain which indicates to provide nursing measures that will provide comfort and lessen intensity of pain by repositioning, offering pain medication, and reassessing effectiveness of pain medication after 30 minutes.2. Ensure that Treatment Nurse (TN) 1 did not continue providing wound care treatment when Resident 100 had facial grimacing (a facial expression where the mouth and face are twisted, often to indicate disgust, disapproval, or pain) and complained of having severe pain (a pain rating of seven to ten in the numeric pain scale) during the care.3. Ensure Licensed Vocational Nurse (LVN) 6 followed the physician's orders to give two tablets of Norco (pain medication) 5/325 milligrams (mg- a unit of measurement) for severe pain when Resident 100 complained of having a seven-out-of-ten pain. 4. Ensure that staff medicated Resident 100 with Tylenol (pain medication) 500 mg 30 minutes prior to wound care treatment as ordered by the physician.These deficient practices had a potential for Resident 100 experiencing unrelieved and uncontrolled pain manifested by facial grimacing, stiffening, and verbalizing having severe pain when treatment nurses provided wound care treatment. Findings:During a review of Resident 100's admission Record (AR), the AR indicated Resident 100 was originally admitted to the facility on [DATE] with diagnoses including fracture of right humerus (long bone in the upper arm, extending from shoulder to elbow) and right radius (one of two long bones in the forearm, located on the thumb side), infection and inflammatory reaction due to internal right knee prosthesis (artificial internal body part), osteomyelitis (inflammation of bone or bone marrow) of right tibia (the shinbone, the larger of the two bones in the lower leg between the knee and ankle) and right fibula (the calf bone, located on the outer side of the lower leg between the knee and ankle), tracheostomy (surgically created opening in the neck that extends into the windpipe) with ventilator (a medical device to help support or replace breathing) dependence, infection of the skin and subcutaneous tissue (layer of fat and tissue under the skin), and myositis (inflammation of the muscles that causes weakness and pain) of the right thigh. During a review of Resident 100's History and Physical (H&P) dated 7/11/2025, the H&P indicated that Resident 100 was hospitalized on [DATE] for sepsis (life-threatening blood infection) from infected right elbow fracture and infected right knee replacement and was readmitted to the facility on [DATE]. The H&P indicated Resident 100 has a fluctuating capacity to understand and make decisions. During a review of Resident 100's Minimum Data Set ([MDS] resident assessment tool) dated 7/17/2025, the MDS indicated Resident 100 was dependent (helper does all the effort or two or more helpers is required for the resident to complete the activity) on staff for bed mobility, moving from sitting on side of bed to lying flat on bed, toileting hygiene, bathing, dressing, personal hygiene, and oral hygiene. The MDS indicated Resident 100 has a deep tissue injury (pressure ulcer where damage occurs to the underlying soft tissues often beneath intact skin) on the left heel and a stage 2 pressure ulcer (partial-thickness loss of skin, presenting as a shallow open wound) on the right heel. The MDS indicated that Resident 100's primary language is Spanish.During review of Resident 100's Care Plan (CP) titled Impaired Communication dated 7/13/2025, the CP states, Do not hurry when trying to communicate (with resident). 1. During a concurrent observation and interview on 7/15/2025 at 10:38 a.m. with Resident 100, Resident 100 was grimacing in bed. A communication board with Spanish words and phrases hanging on the wall was used to communicate with Resident 100. Resident 100 stated she was in pain and would like pain medication.During an observation on 7/15/2025 at 10:43 a.m. in Resident 100's room, LVN 4 instructed Resident 100 (in English) that Tylenol was administered at 8:45 a.m. and to wait for the medicine to kick in about 45 minutes to an hour. Resident 100 shook her head and mouthed, No se (I don't understand). LVN 4 replied, No pain? Okay and left the room. During an interview on 7/15/2025 at 10:50 a.m. with LVN 4, LVN 4 stated that he did not use the communication board to assess Resident 100's uncontrolled pain. During a subsequent observation on 7/15/2025 at 10:52 a.m. in Resident 100's room with LVN 4 and Resident 100, Resident 100 stated she was in ten-out-of-ten pain in her right leg. LVN 4 asked Resident 100, Are you sure you're in pain? I just gave you medicine at 8:45 (a.m.) Resident 100 was grimacing and nodded her head. During an interview on 7/15/2025 at 11:05 a.m. with LVN 4, LVN 4 stated he was not aware that two hours

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on interview and record review, the facility failed to ensure an annual performance evaluation (a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics in performing that an individual needs to perform work roles or occupational functions successfully) was performed every year for Certified Nursing Assistant (CNA) 2. This deficient practice had the potential for the facility not be able to assess the skills necessary for CNA 2 to provide nursing services to assure resident safety and to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Findings:During a concurrent interview and record review on 7/18/2025 at 12:01 PM with the Director of Staff Development (DSD), Certified Nursing Assistant (CNA) 2's employee file with a date of hire on 10/6/2010 was reviewed. CNA 2's employee file indicated the last performance evaluation was done on 10/15/2021. The DSD stated performance evaluations should be done yearly to talk about improvements and how to exceed expectations and to make sure the employee can perform their job duties or may need a review. The DSD stated if the annual performance evaluation was not done it could jeopardize the care of the residents. During an interview on 7/18/2025 at 3:46 PM with the Director of Nursing (DON), the DON stated the annual performance evaluations need to be done annually to let us know how the certified nurses are doing. DON stated we need to do the annual performance to get feedback on how they are doing and if nurses need room for improvement to grow as an employee.During a review of facility's Certified Nursing Assistant (CNA) Job Description (undated), the Certified Nursing Assistant (CNA) Job Description indicated CNA Must demonstrate the knowledge and skills necessary to provide care appropriate to the age-related needs of the residents served.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain accurate documentation on accountability record or controlled medication count sheet/controlled drug record ([CDR] - a document indicating perpetual inventory and administration of controlled substances affecting three residents (Residents 66, 76 and 90) in one of three inspected medication carts (Middle Medication Cart Skilled Nursing Facility [SNF] side).1.Resident 76's Pregabalin (a controlled medication [medications that the use and possession of are controlled by the federal government] used to treat fibromyalgia [pain in muscles and soft tissues] related pain, neuropathic (nerve related) pain and a subset of seizures [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness]).2.Resident 66's Clonazepam (a controlled medication used to treat panic disorder and seizure [a medical term used to describe sudden, uncontrolled burst of electrical activity in the brain]).3. Resident 90's Pregabalin.These deficient practices of failing to maintain accurate documentation of controlled medications had the potential to result in medication errors, controlled medication loss and/or drug diversion for Residents 66, 76 and 90. Findings:1a. During a review of Resident 76's admission Record, dated 7/17/2025, the admission Record indicated Resident 76 was admitted to the facility on [DATE] with diagnoses including muscle weakness and type 2 diabetes mellitus ([DM]-a disorder characterized by difficulty in blood sugar control and poor wound healing).During a review of Resident 76's History and Physical (H&P), dated 1/30/2025, the H&P indicated Resident 76 had the capacity to understand and make decisions.During a review of Resident 76's Minimum Data Set (MDS -resident assessment tool), dated 5/5/2025, the MDS indicated, Resident 76's cognition (ability to think, understand, learn, and remember) was intact. The MDS indicated Resident 76 was independent in performing activities of daily living (ADLs) such as eating, oral hygiene and personal hygiene, needed clean-up assistance from the facility staff for upper body dressing, supervision or touching assistance for toileting hygiene and showering and moderate assistance for lower body dressing and putting on or taking off footwear.During a concurrent observation, interview and record review on 7/17/2025 at 1:29 p.m. with Licensed Vocational Nurse (LVN) 5 of Middle Medication Cart SNF, Resident 76's medication card / bubble pack (a card that packages doses of medication within small, clear, plastic bubbles), facility's controlled medication count sheet (CDR) and the medication administration details in electronic Medication Administration Record (eMAR) for pregabalin 25 milligrams ([mg] a unit of measurement for mass) and pregabalin 100 mg were reviewed. Resident 76's medication card / bubble pack for pregabalin 25 mg contained a quantity of nine capsules remaining, with instructions as take one capsule (with 100 mg total dose of 125 mg) by mouth two times a day for neuropathic (nerve) pain, fill date 7/7/2025. The facility's CDR indicated a quantity of 10 capsules remaining with the last dose administered on 7/16/2025 at 3:00 p.m. Resident 76's medication card / bubble pack for pregabalin 100 mg contained a quantity of nine capsules remaining, with instructions as take one capsule with 25 mg (total dose of 125 mg) by mouth two times a day for neuropathic pain, fill date 7/7/2025. The facility's CDR indicated a quantity of 10 capsules remaining with the last dose administered on 7/16/2025 at 7/16/2025 at 3:00 p.m. The administration details in eMAR indicated the instructions as Lyrica (pregabalin) capsule 25 mg, give 5 capsules (125 mg) by mouth two times a day for neuropathic pain and the last dose of 5 capsules of pregabalin 25 mg was documented as administered on 7/16/2025 at 5:31 p.m. LVN 5 stated she forgot to document the pregabalin 25 mg and pregabalin 100 mg after they were administered to Resident 76 on 7/17/2025 at morning time in CDR and in eMAR. During a concurrent interview and record review on 7/17/2025 at 2:01 p.m. with Registered Nurse Supervisor (RNS) 2, the order details for Resident 76's pregabalin and physician orders for pregabalin 100 mg and pregabalin 25 mg were reviewed. The order details in Resident 76's medical record indicated only Lyrica oral capsule 25 mg (pregabalin) controlled drug, give 5 capsules by mouth two times a day for neuropathic pain, give 5 capsules of 25 mg (total of 125 mg). The physician order for pregabalin 100 mg, give 1 capsule by mouth two times a day for neuropathic pain was discontinued on 6/16/2025 with the reason indicated as increased to 125 mg two times a day. The document contained a new order for pregabalin oral capsule 25 mg, give 5 capsules by mouth two times a day for neuropathic pain. Give 5 capsules of 25 mg (total of 125 mg). RNS 2 stated he could not speak much of the order because he did not administer the medications for Resident 76. During an interview on 7/17/2025 at 2:06 p.m. with LVN 5, LVN 5 stated she should have informed pharmacy about the changes in

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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. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain a medication error rate of less than 5% (percent) during medication pass for two of seven sampled residents (Residents 40 and 80) by failing to:1. Administer Resident 40's artificial tears eye drops in the correct eye in accordance with physician orders. 2. Administer Resident 80's metformin (a medication used to treat high blood glucose) within one hour of its scheduled time of administration as per facility's policy and procedure (P&P) titled, Medication Administration, dated 4/2025.These deficient practices resulted in a medication administration error rate of 5. 71%, which exceeded the 5% threshold and had the potential to cause eye complications for Resident 40, hyperglycemia (high blood glucose) for Resident 80 and hospitalization for Residents 40 and 80.Findings:1. During a review of Resident 40's admission Record, dated 7/16/2025, the admission Record indicated Resident 40 was originally admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including tracheostomy (a surgical procedure to create an opening in the neck and into the trachea [windpipe] to allow for breathing when the upper airway is blocked or when prolonged breathing assistance is needed) status and unspecified glaucoma (an eye condition that increased eye pressure).During a review of Resident 40's Minimum Data Set (MDS -resident assessment tool), dated 6/13/2025, the MDS indicated Resident 40's cognition (ability to think, understand, learn, and remember) was intact. The MDS indicated Resident 40 needed setup or clean-up assistance from the facility staff for activities of daily living (ADLs) such as eating, supervision assistance for oral hygiene, moderate assistance for upper body dressing and personal hygiene, maximal assistance for lower body dressing, putting on or taking off footwear, and dependent for toileting hygiene.During a concurrent observation and interview on 7/16/2025 at 9:45 a.m. with Licensed Vocational Nurse (LVN) 4, LVN 4 prepared the following six medications to be administered to Resident 40:a. A vial of artificial tears eye drops to administer one drop for the right eyeb. One tablet of calcium carbonate (a medication used to treat symptoms of acid reflux) 500 milligrams ([mg] a unit of measurement for mass)c. One tablet of prednisone (a medication used to treat inflammation and pain) 5 mg. d. One tablet of Eliquis (generic name - apixaban] a medication used to treat blood clots) 2.5 mge. One tablet of midodrine 2.5 mgf. 7.5 milliliters ([mL] a unit of measurement for volume) of levetiracetam (a medication used to treat seizures [sudden, uncontrolled electrical disturbances in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness]) 100 mg per mLLVN 4 was not observed washing hands after preparing medications, before wearing gloves and before administering artificial tears eye drops to Resident 40. LVN 4 administered one drop of artificial tears into Resident 40's left eye. Resident 40 had a trach tube so she could not speak. Resident 40 signaled to LVN 4 using hand gestures to inform him that he administered the eye drops in the wrong eye. LVN 4 stated oh I'm sorry, let me administer in your right eye. During a medication reconciliation review on 7/16/2025 at 1:12 p.m., Resident 40's Order Summary Report, dated 6/1/2025 and 7/17/2025 indicated the following physician order: Artificial Tears Ophthalmic (eye) Solution (carboxymethylcellulose sodium) instill 1 drop in right eye four times a day for dry eyes/itchiness, order date 4/4/2023, start date 4/4/2023.During an interview on 7/16/2025 at 2:05 p.m. with LVN 4, LVN 4 stated he made a mistake and administered artificial tears eye drops in Resident 40's left eye instead of right eye. LVN 4 stated it was important to follow physician orders, and this mistake could have caused an eye reaction, redness or itching.During an interview on 7/17/2025 at 11:48 a.m. with the Director of Nursing (DON), the DON stated there was a risk for side effects in the eye such as redness, itching and irritation if the artificial tears eye drops were not administered in the correct eye as indicated on the physician order.2. During a review of Resident 80's admission Record, dated 7/16/2025, the admission Record indicated Resident 80 was originally admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included but not limited to, type 2 diabetes mellitus ([DM]-a disorder characterized by difficulty in blood sugar control and poor wound healing) without complications, essential (primary) hypertension (high blood pressure), acute embolism (a blood clot that can travel to other parts of the body) and thrombosis (blood clotting) of unspecified deep veins of unspecified lower extremity.During a review of Resident 80's History and Physical (H&P), dated 4/30/2025, the H&P indicated Resident 80 had the capacity to understand and make decisions.During a review of Resident 80's MDS, dated [DATE], the MDS indicated Resident 80's cognition was intact. The MDS indicated Resident 80 needed supervision or touching assistance from the facility staff for eating, moderate assistance for oral hygiene, maximal assistance for upper body dressing

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to:1. Store, label and/or discard Resident 41 or 42's Epogen ([generic name - epoetin alfa] a medication used to treat anemia [low red blood cell count]) and Resident 100's Retacrit ([generic name - epoetin alfa-epbx] a medication used to treat anemia) in accordance with manufacturer's specifications and facility's policy and procedure (P&P) titled, Vials and Ampules of Injectable Medications, dated 4/2008, affecting one of one inspected medication room (Medication Room).2. Ensure removal of expired docusate sodium (a medication used to relieve constipation), Resident 55's latanoprost (a medication used to treat high eye pressure) eye drops from the medication cart, and ensure Resident 76's Basaglar ([generic name - insulin glargine] a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication), Resident 63's insulin lispro pen and Resident 77's insulin lispro pen were labeled with an open date, in accordance with manufacturer's specifications and facility's policy and procedure (P&P) titled, Storage of Medications, dated 4/2008, affecting two of three inspected medication carts inspected (Middle Medication Cart Skilled Nursing Facility [SNF] side and Medication Cart 2 Subacute).3. Ensure the facility's licensed nursing staff did not leave Resident 40's medications unattended, that included artificial tears eye drops, calcium carbonate (a supplement used to relieve acid reflux), prednisone (a medication used to treat inflammation), Eliquis ([generic name - apixaban] a medication used to prevent blood clots, midodrine (a medication used to treat low blood pressure) and levetiracetam (a medication used to treat seizure [a medical term used to describe sudden, uncontrolled burst of electrical activity in the brain] oral solution, affecting one of seven residents observed during medication administration (Resident 40).4. Maintain a clean and safe environment for medication storage in two out of three inspected medication carts, by failing to remove and dispose of medications, discarded and used vials that were stored in unsealed red biohazard containers in an irretrievable manner (Medication Cart 2 Subacute and Medication Cart 3 Subacute). These deficient practices resulted in an unclean and unsecure environment for medication storage, had the potential to result in medication errors, and Residents 40, 41 or 42, 55, 63, 76 and 77 receiving medications that were discontinued, expired, ineffective, or toxic due to improper storage and labeling possibly leading to adverse health consequences such as anemia, eye complications, abnormal blood glucose levels and hospitalization. Findings:1. During a concurrent observation and interview on [DATE] at 4:43 p.m. with Registered Nurse Supervisor (RNS) 3, in Medication Room Refrigerator Subacute, the medication refrigerator contained the following medications that were found stored in a manner contrary to manufacturer requirements:a. One open multidose vial of Epogen 20,000 units per milliliters ([mL] a unit of measurement for volume) with no opened date label for Resident 41 or 42.b. Two unopened multidose vials of Epogen 20, 000 units/mL for Resident 41 or 42.According to the manufacturer's product labeling, a multidose vial would be stable for up to 21 days when stored at 2-to-8 degrees Celsius ([C] is a unit of temperature [36-to-46 degrees Fahrenheit ([F] is a unit of temperature) after it was opened.c. One open single dose vial of Retacrit 10,000 units/mL for Resident 100.d. One unopened single-use or single dose vial of Retacrit 10,000 units/mL for Resident 100.According to the manufacturer's product labeling, unopened single-use vials should be stored between 2 and 8 C (36 and 46 F) and unused portions of single-use should be discarded and not reused.RNS 3 stated the licensed nurse staff should have discarded the partial dose from the single use vial because the single dose vials should not be reused because it would increase the risk for infection. RNS 3 stated the single dose vial would not be safe or effective for residents to treat anemia.2a. During a concurrent observation and interview on [DATE] at 12:39 p.m. with Licensed Vocational Nurse (LVN) 5 of Middle Medication Cart SNF, the medication cart contained the following medications either expired, or stored and labeled in a manner contrary to the facility's P&P titled, Storage of Medications and manufacturer requirements:a. One opened bottle of docusate sodium 100 milligrams ([mg] a unit of measurement for mass) with an expiration date of 7/2025.LVN 5 stated it would not be safe for facility residents to receive an expired medication, and docusate sodium should have been removed from the medication cart three months before its expiration date.b. One bottle of opened latanoprost eye drops with an opened date of [DATE] for Resident 55.According to the pharmacy label on latanoprost eye drops, the unused portion of the medication was supposed to be discarded after 28 days.LVN 5 stated Resident 55's latanoprost eye drops should have been removed from the medication cart after 28 days, on [DATE], for the resident's safety. LVN 5 stated

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview and record review, the facility's Quality Assessment and Assurance Committee (QAA) failed to ensure effective oversight and implementation of the facility's plan of correction (POC) of the deficient practices identified during the last recertification survey in 2024.This failure resulted in the facility to have repeat deficiencies in pharmacy services, quality of care and infection control.Findings:During a review of the facility's Statement of Deficiencies for the 2024 Recertification survey indicated the following repeat deficiencies in pharmacy services, quality of care and infection control.During a concurrent interview and record review on 7/18/2025 at 3:27 pm with the Administrator (ADM), the Quality Assurance Performance Improvement (QAPI- a data driven proactive approach to improvement used to ensure services are meeting quality standards) was reviewed. The ADM stated that QAPI was an ongoing program in the facility where the QAPI team analysis data and statistics to evaluate and identify concerns in the building to improve the quality of care for the residents. The ADM stated she was not sure what happened, she only started working at the facility two months ago.During a review of the facility's policy and procedure (P&P), titled Quality Assurance and Performance Improvement (QAPI) Program, dated, 12/2024, the P&P indicated, It is the policy of this facility to provide a process to evaluate and monitor the ongoing quality of services and care provided to residents through the facility's quality assessment and assurance committee, which will be referred to by the facility as the Quality Assurance Performance Improvement (QAPI) committee. The QAPI committee identifies and addresses specific care, and quality issues and implements an action plan to resolve these issues. The goal of the QAPI committee is to promote excellence in quality of care, quality of life, resident choice, person directed care and resident transitions. All systems that affect resident and family satisfaction, quality of care and services provided, and all areas that affect the quality of life for residents and employees will be addressed.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow infection control precautions for three of four sampled residents (Resident 100, Resident 8 and Resident 40) when:1a.Certified Nursing Assistant (CNA) 2 picked up a pillow and bed linen from the floor and placed it on Resident 100's lower extremities (lower legs, feet).1b.CNA 2 did not follow the standard of practice of wiping front to back when cleaning Resident 100's rectum. 1c.CNA 2 did not perform hand hygiene after providing perineal (the area of the body between the anus and the external genitalia) care on Resident 100.1d.CNA 2 failed to doff (remove) personal protective equipment (PPE) before leaving Resident 100's room.2. Infection control precautions were not observed while administering Resident 8's medications via gastrostomy tube (g-tube - a surgically placed tube used to administer mediations or food directly into the stomach)3.Licensed Vocational Nurse (LVN) 4 failed to wash hands before administering Resident 40's eye drops, during medication administration. These deficient practices placed Resident 100, 8 and 40 at risk of infection, cross contamination (process by which bacteria or other microorganisms are unintentionally transferred from one substance or object to another) and contamination of medications. Findings: 1.During a review of Resident 100’s admission Record, the admission Record indicated Resident 100 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including fracture (broken bone) of right humerus (long bone in the upper arm, extending from shoulder to elbow) and right radius (one of two long bones in the forearm, located on the thumb side), infection and inflammatory reaction due to internal right knee prosthesis (artificial internal body part), osteomyelitis (inflammation of bone or bone marrow, usually due to infection) of right tibia (the shinbone, the larger of the two bones in the lower leg between the knee and ankle) and right fibula (the calf bone, located on the outer side of the lower leg between the knee and ankle), infection of the skin and subcutaneous tissue (layer of fat and tissue under the skin). During a review of Resident 100’s Minimum Data Set ([MDS] resident assessment tool) dated 7/17/2025, the MDS indicated Resident 100’s cognition was severely impaired. The MDS also indicated Resident 100 was dependent (helper does all the work) with activities of daily living (ADLs- activities such as toileting and personal hygiene a person performs daily).The MDS also indicated Resident 100 had a multi-drug -resistant organism (MDRO- microorganisms that are resistant to at least one class of antibiotics). During a review of Resident 100’s History and Physical (H&P) dated 7/11/2025, the H&P indicated that Resident 100 had fluctuating capacity to understand and make decisions for herself. During a review of Resident 100’s Order Summary Report dated 7/18/25, the Order Summary Report indicated Resident 100 was on enhanced barrier precautions (EBP- an infection control strategy primarily used in nursing homes, to reduce the spread of MDRO’s) for Candida Auris (C-Auris type of yeast that can cause severe illness and spreads easily among patients in healthcare facilities), Carbapenem-Resistant Acinetobacter baumanni (CRAB- a type of antibiotic resistant bacteria that causes serious infections in healthcare facilities). The Order Summary Report also indicated Resident100 was taking Cephalexin (antibiotic used to treat bacteria) 250 milligrams (mg- unit of measure) every 12 hours one capsule through a gastrostomy tube (g-tube- tube inserted through the abdominal wall directly into the stomach) for right elbow infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 100’s Care plan titled on Enhanced Barrier Precaution related to (r/t) C-auris and CRAB dated 7/10/25, the care plan interventions indicated staff were to use personal protective equipment (PPE-gloves, gown, mask) when providing care to Resident 100, to keep PPE cart outside resident’s room with proper disposable materials and staff need to do frequent hand washing. During an observation on 7/16/25 at 11:11am in Resident 100’s room , CNA2 was assisting Treatment Nurse 1 (TXN1) with wound care on Resident 100. CNA 2 was observed placing a wet towel on Resident 100’s bed on a dirty chux (absorbent pads used to protect bedding from bodily fluids like urine and blood). CNA 2 was also observed cleaning Resident 100’s rectum using the same towel that was on the dirty chux and wiping from back to front. CNA 2 was also observed picking up a pillow and bed linen off the floor and placing it back on Resident 100’s bed touching her lower extremities. CNA 2 was also observed taking dirty linen out of Resident 100’s room and failing to doff his PPE (gown, gloves). CNA 2 proceeded to grab a pillowcase and returned to Resident 100’s room wearing the same gown. CNA 2 was then observed putting on gloves and completed Resident100 care. CNA 2 did not do hand hygiene when providing Resident 100’s personal care. During an interview on 7/16/25 at 1:32 pm with CNA 2,CNA 2 stated that he was aware he should have used a basin with soap and water when providing care for Resident 100, but he did not see one in her bedside drawer. CNA 2 also stated that when he was cleaning Resident 100’s bottom he should have cleaned from front to back not back to front and changed his gloves and washed his hands after cleaning Resident 100’s bottom, because there was a potential for Resident 100 to have cross contamination from feces causing her to have an infection. CNA 2 stated when the pillow and bed linen touched the floor he should not have put it back on Resident 100’s bed because the pillow and bed linen were contaminated. CNA 2 also stated that Resident 100 was on EBP for her infections and that he should have taken off his PPE before exiting Resident 100’s room to prevent cross contamination. During an interview on 7/16/25 at 4:04 pm with TXN 1, TXN 1 stated Resident 100 was on EBP because of her infected wounds. TXN 1 stated she did see CNA 2 place the wet towel on Resident 100’s dirty chux and that he did clean Resident 100’s bottom from back to front and that she did not see CNA 2 wash his hands or change his gloves after cleaning Resident 100’s bottom. TXN 1 stated she saw CNA 2 pick up the pillow and bedlinen off the floor and place it back on Resident 100’s bed and that the linen was contaminated and should not have been put back on Resident 100’s bed. TXN 1 the reason she did not correct CNA 2 was because she was focusing on Resident 100’s wound treatment. During an interview with the Director of Staff Development (DSD) on 7/17/25 at 4:18 pm, the DSD stated when providing any kind of perineal care on the residents the CNA needs to get two basins, one for clean and one for dirty water and six towels, they need to wipe and dump meaning, that you should wipe from front to back then toss the towel and get a new one. The DSD stated CNA needs to change their gloves and wash their hands after cleaning residents bottoms, to prevent the spread of infection from cross contaminations. The DSD also stated that any time a pillow or bedlinen touches the floor the CNA was to get a clean set of bedlinens and place the linen that fell on the ground in the dirty linen barrel to prevent the spread of infection. The DSD stated that anytime the CNAs wear PPE they need to take it off before leaving the residents’ room and they need to wash their hands and put on new PPE before reentering residents’ room when providing the residents with care to protect the residents from infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/18/25 at 12:26 pm with the Director of Nursing (DON), the DON stated Resident 100 was on EBP and the staff need to wear PPE when providing direct care to Resident 100. The DON stated she was made aware of CNA 2 failure to follow infection control practices. The DON stated Resident 100 was at risk for worsening infection and rehospitalization. During a review of the facility’s policy and procedures (P&P) titled Hand Hygiene, dated 7/2019 the P&P indicated “It is the policy of the facility that all staff members perform hand hygiene before and after direct resident care and after contact with potentially contaminated substances to prevent, to the extent possible, the spread of infection. Hand hygiene will be performed by staff as follows, before taking care of susceptible residents such as those who are severely immunosuppressed. During care when moving from a contaminated activity to a clean activity (for example after assisting a resident with toileting, before assisting with clean clothing). Immediately after glove removal, After taking care of an infected resident or one who is likely to be colonized with micro-organisms of special clinical or epidemiologic significance (e.g., multiple resistant bacteria, MRSA); and before and after giving personal care to residents and/or self. If gloves are worn for a procedure, hand hygiene is to be performed before putting gloves on and after removal and disposal of gloves. During a review of the facility’s policy and procedures (P&P) titled Perineal Care dated 10/2018, the P&P indicated, “Wash perineal area with the washcloth or personal cleansing cloths, wiping from front to back. Wash the rectal area thoroughly, wiping from the base of the labia towards and extending over the buttocks. Do not reuse the same washcloth or water to clean the labia or use the same personal cleansing cloth.” 2.During a review of Resident 8’s admission Record, dated 7/16/2025, the admission Record indicated, Resident 8 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included but not limited to, sepsis (a life-threatening blood infection), chronic kidney disease (a condition where the kidneys are damaged and cannot filter blood as well as they should), gastrostomy status, personal history of urinary tract infections (infection in any part of the urinary system), pneumonia (an infection/inflammation in the lungs) and history of other infectious and parasitic diseases. During a review of Resident 8’s History and Physical (H&P), dated 2/4/2025, the document indicated Resident 8 did not have the capacity to understand and make decisions. During a review of Resident 8’s Minimum Data Set (MDS-resident assessment tool), dated 4/21/2025, the MDS indicated Resident 8 was on g-tube feedings, fully dependent on facility staff for Activities of Daily Living (ADLs) such as oral hygiene, toileting hygiene, showering, upper and lower body dressing, putting on or taking off footwear and personal hygiene. During a concurrent observation and interview on 7/16/2025 at 9:00 a.m. with Licensed Vocational Nurse (LVN) 4, LVN 4 prepared six medications and supplements by crushing them individually using a crushing device to be administered to Resident 8 via g-tube. LVN 4 stated he used five to 10 mL water to dissolve each medication separately. LVN 4 started to administer medications one by one using gravity method followed by water in between each medication. LVN 4 then stepped away from the bedside with the syringe in his hand that was used to administer water and g-tube medications, and walked to the medication cart, which exposed the syringe to other factors in the environment. LVN 4 returned to bedside with the same syringe and resumed medication administration. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/16/2025 at 2:47 p.m. with LVN 4, LVN 4 stated he should not have taken the syringe used for g-tube medication administration with him to the medication cart. LVN 4 stated he should have changed gloves and sanitized hands if he needed to move away from the resident. LVN 4 stated there was a risk of contamination when he removed the syringe away from the resident's area. LVN 4 could not say that it was important to take precautions to prevent infection but stated to prevent any bacteria and prevent contamination. During an interview on 7/17/2025 at 11:48 a.m. with the Director of Nursing (DON), the DON stated nurses should not have brought the syringe that was used to administer g-tube medications away from the resident care area to medication cart because that would increase the risk for contamination and infection when the syringe was reintroduced to administer g-tube medications. 3. During a review of Resident 40’s admission Record, dated 7/16/2025, the admission Record indicated Resident 40 was originally admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including tracheostomy (a surgical procedure to create an opening in the neck and into the trachea [windpipe] to allow for breathing when the upper airway is blocked or when prolonged breathing assistance is needed) status and unspecified glaucoma (an eye condition that increased eye pressure). During a review of Resident 40’s MDS, dated [DATE], the MDS indicated Resident 40’s cognition (ability to think, understand, learn, and remember) was intact. The MDS indicated Resident 40 needed setup or clean-up assistance from the facility staff for activities of daily living (ADLs) such as eating, supervision assistance for oral hygiene, moderate assistance for upper body dressing and personal hygiene, maximal assistance for lower body dressing, putting on or taking off footwear, and dependent for toileting hygiene. During a concurrent observation and interview on 7/16/2025 at 9:45 a.m. with LVN 4, LVN 4 prepared six medications to be administered to Resident 40 which included artificial tears eye drops. LVN 4 stated Resident 40 was supposed to receive one drop of artificial tears into the right eye four times a day for dryness. LVN 4 was not observed washing hands after preparing medications, before wearing gloves and before administering artificial tears eye drops to Resident 40. During a medication reconciliation review on 7/16/2025 at 1:12 p.m., Resident 40’s Order Summary Report, dated 6/1/2025 and 7/17/2025 indicated the following physician order: “Artificial Tears Ophthalmic (eye) Solution (carboxymethylcellulose sodium) instill 1 drop in right eye four times a day for dry eyes/itchiness, order date 4/4/2023, start date 4/4/2023.” During an interview on 7/16/2025 at 2:05 p.m. with LVN 4, LVN 4 stated he should have washed his hands before administering artificial tears eye drops to Resident 40 to prevent contamination and infection. During an interview on 7/17/2025 at 11:48 a.m. with the DON, the DON stated it was very important for nurses to wash their hands before putting on gloves and before administering eye drops to prevent infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility’s policy and procedure (P&P) titled, “Hand Hygiene,” dated 7/2019, the P&P indicated, “It is the policy of the facility that all staff members perform hand hygiene before and after direct resident care and after contact with potentially contaminated substances to prevent, to the extent possible, the spread of infection. Hand hygiene will be performed by staff as follows: during care when moving from a contaminated activity to a clean activity (for example .clothing).” During a review of the facility’s P&P titled, “Medication Administration,” dated 4/2025, the P&P indicated, “Staff shall follow facility infection control procedures, i.e., handwashing, antiseptic techniques, gloves, isolation precautions, etc. as applicable.”

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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. (continued on next page)

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 07/18/2025

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement and follow its protocol for antibiotic (medicine used to kill bacteria and treat infections) use on one of four sampled residents (Resident 55).This failure had the potential for Resident 55 to receive an inappropriate antibiotic which could lead to antibiotic resistance (occurs when bacteria evolve and develop the ability to withstand the effects of antibiotics, rendering these drugs ineffective).Findings:During a review of Resident 55's admission Record, the admission Record indicated the resident was admitted on [DATE] to the facility with diagnoses including methicillin resistant staphylococcus aureus infection (MRSA- caused by a type of staph bacteria that's become resistant to many of the antibiotics used for staph infections), obstructive and reflux uropathy(blockage in the urinary tract that prevents normal urine flow and backward flow of urine from the bladder towards the kidneys), chronic kidney disease(long term decline in kidney function) and benign prostatic hyperplasia (BPH-common condition in older men where the prostate gland gets bigger and the enlargement can put pressure on the urethra [tube that carries urine from the bladder] causing problems with urination).During a review of Resident 55's Minimum Data Set (MDS- a resident assessment tool) dated 6/30/2025, the MDS indicated the resident had intact cognition (thought process) and required partial/moderate assistance (helper does less than half the effort) with personal hygiene, bed mobility and upper body dressing. The MDS indicated the resident was on an antibiotic.During a review of Resident 55's urine culture (laboratory test that checks a urine sample for bacteria, yeast or other microorganisms and helps determine what type of germ is causing the infection) collected on 6/25/2025 , the urine culture indicated the resident had greater than 100,000 cfu (colony forming units-refers to estimated number of viable bacteria or fungi in a urine sample)/milliliter(ml.-a unit of volume) of Escherichia coli (bacteria). The urine culture indicated Escherichia Coli is sensitive (effective in inhibiting the growth of bacteria)to Macrobid. During a review of Resident 55's Physician's Order dated 7/3/2025, the Physician Order indicated an order of Macrobid (antibiotic that treats urinary tract infection [UTI-infection in the bladder/urinary tract) oral capsule 100 milligrams (mgs- unit of measurement) two times a day for UTI for 5 days.During a review of Resident 55's Licensed Personnel Progress Notes dated 7/3/2025 at 10:30 p.m., the Licensed Personnel Progress Notes indicated the resident was being monitored for adverse reaction related to Macrobid administration. During a review of Resident 55's SBAR (a structured communication tool that stands for situation, background, recommendation, assessment used for relaying information in a resident's condition) dated 7/2/2025 timed at 6:30 p.m. , the SBAR indicated the resident had an ESBL (Extended -Spectrum Beta Lactamase - bacteria that produces enzyme which makes them resistant to certain antibiotics and can be harder to treat) in the urine and had no pain. The SBAR indicated that the physician and family representative were notified, and the facility was awaiting orders from the physician.During a concurrent interview and record review on 7/18/2025 at 11:50 a.m. with Infection Preventionist Nurse (IPN), Resident 55's Surveillance Data Collection form (data collection that helps healthcare facilities monitor antibiotic usage, identify areas where stewardship efforts can be improved and track the development of antibiotic resistance) and Progress Notes were reviewed. The IPN stated Resident 55 had cloudy urine with sediments and the urine culture had E. coli. The IPN stated the facility used McGeer criteria (a set of guidelines used to ensure consistent surveillance, reporting of infections and as well appropriate treatment and antibiotic use) for their antibiotic use and the use of Macrobid for the UTI did not meet the criteria of Mcgeer. The IPN stated Resident 55 had an indwelling catheter (flexible tube inserted into the bladder to drain urine) and was not showing any symptoms of infection, just sediments in the urine. The IPN stated the physician should have been notified if the resident was not meeting the McGeer's Criteria. The IPN verified through record review of Progress Notes, there was no documentation the physician was notified about the use of Macrobid not meeting the McGeer Criteria. The IPN stated the licensed nurses and IPN are responsible in making sure the usage of antibiotics is meeting the McGeer criteria. The IPN stated, the licensed nurses should have followed up with the physician if the resident still need the antibiotic because it did not meet the Mcgeer. The IPN stated Resident 55 can be at risk for antibiotic resistance and development of MDRO (multi-drug-resistant organisms- a germ that is resistant to many antibiotics).During an interview on 7/18/2025, at 3:10 p.m. with the Director of Nursing (DON), the DON stated her responsibility in antibiotic stewardship (coordinated interventions designed to improve and optimize antibiotic use, ensuring they are used appropriately, safely and effectively) is to ensure the antibiotic prescribed by the physician

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056007	A. Building B. Wing	07/18/2025

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

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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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview and record review the facility failed to ensure five of five sampled employees Certified Nursing Assistant (CNA) 2, CNA 5, , CNA 6, Licensed Vocational Nurse (LVN) 4, Director of Rehabilitation (DOR) and CNA 4 were offered the Covid-19 (an infectious disease caused by the SARS-CoV-2 virus) vaccine (a substance that is put into the body of a person to protect them from a disease) .This failure had the potential to place all residents and staff at risk for infection of Covid 19.Findings:During an interview on 7/18/2025 at 10:17 a.m., with the Infection Preventionist Nurse, (IPN), the IPN stated upon hire she makes sure employees have their Covid 19 immunization (the process of making a person resistant to a disease, typically through the administration of a vaccine) and any other immunizations. The IPN stated she offers employees the flu vaccine, Covid 19 vaccine, hepatitis vaccine and TDAP (a vaccine that protects against three diseases: tetanus, diphtheria, and pertussis). The IPN stated if the employee declines a vaccine the employee will sign the employee declination form. The IPN stated she provides education about the vaccine and re-offers the vaccine to staff. The IPN stated if the employee wants the vaccine facility will administer the vaccine to the employee. The IPN stated she had a Covid 19 clinic in June and July 2025 and offered the Covid-19 vaccine to employees. The IPN stated she does not have documentation of employees declining the COVID 19 vaccine. The IPN stated she should have documented if the employees were offered the Covid 19 vaccine. The IPN stated it was important to offer the vaccines for the prevention of flu, Covid 19, and pneumonia. The IPN stated it was important to offer vaccines to staff to protect residents, lessen the severity of illness, and prevent potential outbreaks. During an interview on 7/18/2025 at 3:44 p.m., with the Director of Nursing (DON), the DON stated the IPN needs to document if staff was offered the Covid-19 vaccine and should be offered upon hire. The DON stated vaccination was to protect staff and resident and prevent them from getting sick from Covid 19.During a review of facility's policy and procedure (P&P) titled Coronavirus Vaccine Policy dated 02/2025, the P&P indicated COVID 19 vaccinations will be offered to all staff and residents.unless such immunizations are medically contraindicated, the individual has already been immunized during this time period or the individual refuses to receive the vaccine. The facility will maintain documentation for all residents and staff on COVID 19 vaccinations status.