STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056010	A. Building B. Wing	04/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seal Beach Health and Rehabilitation Center	3000 N Gate Road Seal Beach, CA 90740

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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 0550 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453 Based on observation, interview, and medical record review, the facility failed to ensure the resident care was provided in a manner to promote dignity and respect for two of 32 final sampled residents (Residents 20 and 59). * The facility failed to ensure the staff sat next to Residents 20 and 59 while assisting the residents to eat. This failure had the potential to negatively impact the resident's feelings of self-worth and well-being. Findings: 1. On 4/15/25 at 1256 and 1300 hours, Resident 20 was observed being assisted to eat by RNA 1. RNA 1 was observed standing over Resident 20 who was seated in bed. On 4/15/25 at 1306 hours, an interview was conducted with RNA 1. RNA 1 acknowledged he was standing over Resident 20 when assisting the resident with eating. When asked about the facility's policy for assisting the residents with meals, RNA 1 stated he was supposed to be sitting down when assisting a resident with meals, however, he could not find any available chair. Medical record review for Resident 20 was initiated on 4/15/25. Resident 20 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of the MDS assessment dated [DATE], showed Resident 20 had a severe cognitive impairment and was dependent on the staff's assistance for eating. 2. On 4/17/25 at 0823 hours, Resident 59 was observed being assisted to eat by CNA 10. CNA 10 was observed standing over Resident 59 who was seated in bed. On 4/17/25 at 1439 hours, an interview was conducted with CNA 10. CNA 10 acknowledged she was standing over Resident 59 when assisting the resident with eating. When asked about the facility's policy for assisting the residents with meals, CNA 10 stated she was supposed to be sitting down when assisting a resident with meals to keep an eye level with the resident to ensure dignity for the resident, but she could not find any available chair. (continued on next page)

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

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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 0550 Level of Harm - Potential for minimal harm Residents Affected - Some	Medical record review for Resident 59 was initiated on 4/15/25. Resident 59 was admittted to the facility on [DATE], and readmitted on [DATE]. Review of the MDS assessment dated [DATE], showed Resident 59 had a severe impairment and required substantial/maximal assistance from the staff for eating. On 4/21/25 at 1313 hours, an interview was conducted with the DSD. When asked about the facility's policy for assisting the residents with meals, the DSD stated the staff should be seated beside the resident or at the resident's eye level when assisting the residents to eat to promote the residents' dignity.

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49258 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of 32 final sampled residents (Resident 730) and one nonsampled resident (Resident 780) were thoroughly assessed to self-administer their medications. * The facility failed to assess and develop a care plan problem to address the self-administration of medications when Resident 730 had bottles of refresh liquigel lubricant eye gel (medication use for dry eyes) and refresh tears lubricant eye drops (medication use for dry eyes) at the bedside and self-administered these medications. * Resident 780 was observed to have the miconazole nitrate 2% (an antifungal powder) medication at the bedside cabinet and had self-administered the medication. These failures had the potential for the residents to inaccurately self-administer their medications and negatively affect their well-being. Findings: Review of the facility's P&P titled Self-Administration of Medications revised 2/2021 showed the residents have the right to self-administer medications if the IDT has determined that it is clinically appropriate and safe for the resident to do so. The Policy Interpretation and Implementation section showed: - As part of the evaluation comprehensive assessment, the IDT assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident; - If it is safe and appropriated for the resident to self-administer medications, this is documented in the medical record and the care plan. The decision that the resident can safely-administer medications is reassessed periodically based on changes in the resident's medical and/or decision-making status; and - Any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party. Review of the facility's P&P titled Administering Medications revised April 2023 showed the residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that the residents have the decision-making capacity to do so. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. On 4/15/25 at 0848 hours, during the initial tour of the facility, an observation and concurrent interview was conducted with Resident 730. Resident 730 was observed awake and sitting in the wheelchair inside her room. Three unlabeled, small, green plastic bottles were observed inside Resident 730's personal transparent bag. Resident 730 showed one of three small green plastic bottles labeled as refresh liquigel lubricant eye gel 0.5 fl oz with an expiration date of 4/2025 and the other two bottles labeled as refresh tears lubricant eye drops 0.5 fl oz with expiration dates of 6/2026 and 7/2027. Resident 730 stated the bottle with an expiration date of 7/2027 was a new bottle given to her by the nurse couple of days ago and could not recall the nurse's name. Resident 730 stated she applied the refresh liquigel one to two drops to her eyes every night. Resident 730 stated she applied the refresh tears one to two drops to her eyes three to four times every day. Resident 730 stated she did not know how long she should close her eyes after the application of the eye drops. The resident was asked if she knew she should close her eyes after applying the eye drops. Resident 730 stated most of the time, she would just open her eyes right away after she applied the eye drops. Medical record review for Resident 730 was initiated on 4/15/25. Resident 730 was admitted to the facility on [DATE]. Review of Resident 730's H&P examination dated 3/31/25, showed Resident 730 had the capacity to make medical decisions. Review of Resident 730's Order Summary Report showed a physician's order dated 3/29/25, to instill refresh plus ophthalmic solution 0.5% two drops in both eyes five times a day for dry eyes. Further review of the Order Summary Report failed to show a physician's order to allow Resident 730 to self-administer the medications. Review of Resident 730's Plan of Care failed to show a care plan problem was developed to address Resident 730's self-administration of the refresh liquigel and refresh tears eye drops. On 4/15/25 at 0946 hours, a concurrent observation of Resident 730, interview, and medical record review for Resident 730 was conducted with LVN 3. LVN 3 verified the three eye drop medications in the room of Resident 730. LVN 3 stated Resident 730 should be assessed if Resident 730 had the capacity to self-administer the medications. LVN 3 stated Resident 730 should have the order and plan of care for self-administration of medications. LVN 3 further stated Resident 730 should have been taught how to properly administer the eye drops to get the full benefit of the medication. LVN 3 checked the medication cart and did not find any refresh plus ophthalmic solution 0.5% medication for Resident 730. LVN 3 verified Resident 730 was not assessed for self-administration of medication and did not have a physician's order and plan of care to address for self-administration of the eye drops. On 4/22/25 at 1010 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 49644 2. On 4/15/25 at 1115 hours, an observation and concurrent interview was conducted with Resident 780. The miconazole nitrate 2% medication was observed on top of Resident 780's bedside cabinet. Resident 780 stated she might have used the miconazole nitrate 2% medication once but could not remember who brought the medication. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medical record review for Resident 780 was initiated on 4/15/25. Resident 780 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 780's MDS assessment dated [DATE], showed the resident's cognition was moderately impaired. Review of Resident 780's Order Summary Report dated 4/16/25, did not show a physician's order for the use of the miconazole nitrate 2% medication. Further review of the medical record failed to show Resident 780 was assessed for self-administration of miconazole nitrate 2% medication. In addition, the medical record did not show a care plan for the use of miconazole nitrate 2% medication. On 4/15/25 at 1125 hours, an observation and concurrent interview was conducted with LVN 1. LVN 1 verified Resident 780 had miconazole nitrate 2% medication on top of the bedside cabinet. LVN 1 stated she did not know Resident 780 had the medication in her room. On 4/17/25 at 1329 hours, an interview and concurrent medical record review was conducted with LVN 3. LVN 3 acknowledged the above findings. LVN 3 stated Resident 780 and the resident's family member should have been educated on the facility's protocol regarding keeping the medication at the bedside including the risks and benefits. On 4/18//25 at 1021 hours, an interview was conducted with the DON. The DON acknowledged the above findings. The DON stated the facility's staff educated Resident 780's family member to inform them when they brought in the medication because it would need a physician's order to use the medication.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453 Based on interview, medical record review, and facility's P&P review, the facility failed to ensure the resident's wishes and instructions for healthcare were followed for two of 13 final residents (Residents 19 and 141) reviewed for the advance directives * The facility failed to follow Resident 141's advance health care directive's designating Family Member 2 as her agent, and the resident's choice not to prolong her life. * The facility failed to maintain a copy of Resident 19's advance healthcare directive in the resident's medical record and readily retrievable. These failures had the potential for the residents' decisions regarding their healthcare and treatment options not being honored. Findings: 1. Review of the facility's P&P titled Advance Directives dated ,d+[DATE] showed the following if the resident has an advance directive: - If the resident or the resident's representative has executed one or more advance directive(s), or executes one upon admission, copies of these documents are obtained and maintained in the same section of the resident's medical record and are readily retrievable by any facility staff; - The resident's wishes are communicated to the resident's direct care staff and the physician by placing the advance directive in a prominent, accessible location in the medical record and discussing the resident's wishes in care plan meetings; and - The plan of care for each resident is consistent with his or her documented treatment preferences and/or advance directive. The facility staff are not required to provide care that conflicts with an advance directive. Medical record review for Resident 141 was initiated on [DATE]. Resident 141 was admitted to the facility on [DATE]. Review of Resident 141's MDS assessment dated [DATE], showed Resident 141 had a severe cognitive impairment. Review of Resident 141's Advance Health Care Directive Form dated [DATE], under Part 1 Power of Attorney for Healthcare section, showed Family Member 2 was designated as Resident 141's agent to make health care decision for the resident, and the agent's authority was to take effect immediately. Further review of the form, under Part 2 Instructions for Healthcare section, showed Resident 141's choice not to prolong life. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 141's Order Summary Report dated [DATE], showed a physician's order dated [DATE], for CPR/to attempt resuscitation according to the POLST issued. Review of Resident 141's electronic health record did not show a copy of the POLST dated [DATE], was uploaded. On [DATE] at 0914 hours, an interview and concurrent medical record review for Resident 141 was conducted with RN 1. RN 1 verified there was no POLST form uploaded to Resident 141's electronic health record. RN 1 was observed looking into a binder, and to which he showed Resident 141's POLST form. Review of Resident 141's POLST dated [DATE], showed to attempt resuscitation/CPR and allow a trial period of artificial nutrition including feeding tubes. Further review of the POLST form, under the Information and Signatures section, showed Resident 141 had no advance directive and the box for legally recognized decisionmaker was checked. In addition, the POLST form was signed by Family Member 1. RN 1 verified the above findings. RN 1 verified Resident 141's CPR code status and Family Member 1 marked as her legally decisionmaker in the POLST form did not matched Resident 141's choice not to prolong her life and Family Member 2 as her power of attorney for healthcare as stated in her advance healthcare directive. RN 1 stated the social services department in collaboration with the nursing and medical records departments had to ensure the POLST was accurate, and the resident's advance healthcare directive was followed. On [DATE] at 1337 hours, an interview and concurrent medical record review for Resident 141 was conducted with the SSD. The SSD verified Resident 141's CPR code status and Family Member 1 marked as her legally decisionmaker in the POLST form did not match Resident 141's choice not to prolong her life and Family Member 2 as her power of attorney for healthcare as stated in her advance healthcare directive. The SSD stated the social services department was responsible for checking and verifying the assigned healthcare agent as stated in the resident's advance healthcare directive to be followed, and the resident's electronic health record profile should be updated to reflect her power of attorney for healthcare. 2. Medical record review for Resident 19 was initiated on [DATE]. Resident 19 was initially admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 19's MDS assessment dated [DATE], showed Resident 19 was cognitively intact. Review of Resident 19's POLST dated [DATE], under Section D Information and Signatures, showed the resident's advance directive was not available. Review of Resident 19's Progress Notes showed a social services note dated [DATE], showing the copy of resident's advance healthcare directive was provided by his family member and was provided to the Medical Records Director. Further review of Resident 19's medical record failed to show a copy of Resident 19's advance directive. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 0906 hours, an interview and concurrent medical record review for Resident 19 was conducted with RN 1. RN 1 verified Resident 19's POLST form dated [DATE], showed the resident's advance directive was not available. RN 1 was also observed checking Resident 19's hospice binder and showed another POLST form dated [DATE], for Resident 19. Review of Resident 19's POLST form dated [DATE], under Section D Information and Signatures, showed the resident's advance directive was available and reviewed. RN 1 verified Resident 19's POLST form dated [DATE], showed the resident's advance directive was available and reviewed; however, a copy of Resident 19's advance directive was not available or uploaded to the resident's electronic health record. On [DATE] at 1328 hours, an interview and concurrent medical record review for Resident 19 was conducted with the SSD. The SSD verified Resident 19's POLST form dated [DATE], showed the resident's advance healthcare directive was available and reviewed, and a copy of Resident 19's advance directive was not available or uploaded to the resident's electronic health record. The SSD stated an advance healthcare directive was provided by the resident's family member, but it may not have been uploaded to the resident's electronic health record by the medical records department. On [DATE] at 1355 hours, an interview and concurrent medical record review for Resident 19 was conducted with the Medical Records Director. The Medical Records Director stated if a copy of the advance directive was provided, it should be uploaded as soon as it was given to the medical records department. The Medical Records Director verified Resident 19's POLST form dated [DATE], showed the resident's advance healthcare directive was available and reviewed; however, a copy of Resident 19's advance directive was not available or uploaded to the resident's electronic health record. On [DATE] at 1430 hours, a follow-up interview for Resident 19 was conducted with the Medical Records Director. The Medical Record Director stated Resident 19's family member provided a copy of the resident's advance healthcare directive on [DATE]; however, it was not uploaded because it was not a good copy. The Medical Record Director stated Resident 19's family member was sending the facility a better copy per the SSD on [DATE]; however, this was not followed up. The Medical Record Director verified a copy of Resident 19's advance healthcare directive was not obtained and maintained in Resident 19's health records.

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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 0583 Level of Harm - Potential for minimal harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453 Based on observation, interview, and medical record review, the facility failed to ensure the resident's personal health information was maintained in a confidential manner for one nonsampled resident (Resident 431). * The facility failed to ensure the laptop displaying Resident 431's personal health information was safeguarded when left unattended. This failure had the potential for unauthorized access to Resident 431's medical record information. Findings: Medical record review for Resident 431 was initiated on 4/15/25. Resident 431 was admitted to the facility on [DATE]. On 4/18/25 at 1023 hours, Medication Cart A was observed parked in the hallway near the nurses' station. The laptop on top of the medication cart was open with the screen displayed Resident 431's personal health information, including the resident's name and scheduled medications. The facility staff and another resident were observed passing by the hallway. On 4/18/25 at 1025 hours, an observation and concurrent interview was conducted with LVN 11. LVN 11 verified the staff laptop on top of Medication Cart 1 located in the hallway was unattended and displayed Resident 431's personal health information. LVN 11 acknowledged she left the laptop open and unattended. LVN 11 stated she should have either logged out or closed the laptop to ensure Resident 431's personal health information confidentiality.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 48332 Based on observation, interview, and facility P&P review, the facility failed to provide a safe, clean and homelike environment for three of 32 final sampled residents (Residents 65 and 123). * Resident 65's room (Room B) wall had multiple vertical scratches and chipped paint extending down to the base board, with non-penetrating holes. * Resident 123's room (Room C) wall had chipped wood and paint and multiple scratches extending down to the baseboard, with non-penetrating holes. These failures had the potential to negatively impact the resident's quality of life Findings: Review of the facility's P&P titled Homelike Environment revised 2/2021 showed the residents are provide with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. The staff provides person-centered care that emphasizes the resident's comfort, independence and personal needs and preferences. The facility staff and management maximizes to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include clean, sanitary and orderly environment, inviting colors and decor. Review of the facility's P&P titled Maintenance Service revised 12/2009 showed the maintenance service shall be provided to all the areas of the building, grounds, and equipment. The maintenance department is responsible for maintaining the building, grounds, and equipment in a safe and operable manner at all times. The functions of the maintenance personnel include but are not limited to: maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines. Maintaining the building in good repair and free from hazards. Providing routinely scheduled maintenance service to all areas, and others that may become necessary or appropriate. The maintenance director is responsible for developing and maintaining a schedule of maintenance service to assure that the buildings, grounds, and equipment are maintained in a safe and operable manner. 1. On 4/15/25 at 0854 hours, during an observation of Room B, Resident 65 was lying on her bed. The wall along the head of the bed was observed with multiple vertical scratches and chipped paint extending down to the base board, with non-penetrating holes. On 4/17/25 at 1115 hours, a concurrent observation of Room B, interview and facility document review was conducted with the Maintenance Director. The Maintenance Director verified the findings on the wall at the back of the bed. The Maintenance Director stated the paint would be fixed and the hole would be retouched. When asked about the process when there was a need for repair, the Maintenance Director stated the staff let him know through the blue book/maintenance logbook at the stations which was checked daily. The nurse would write the location and equipment for the repair. Review of the Maintenance Logbook failed to show a report for repair for Room B. The Maintenance Director verified there was no report for the repair of Room B. (continued on next page)

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F 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	2. On 4/15/25 at 0941 hours, an observation and concurrent interview was conducted with Resident 123. Resident 123 was sitting on her bed watching television in Room C. The wall at the left side of bed near the headboard and bedside table was observed with chipped wood and paint, multiple scratches extending down to the baseboard and non-penetrating holes. Resident 123 was asked if she noticed the condition of the wall on her side, Resident 123 confirmed seeing it. On 4/17/25 at 1130 hours, a concurrent observation of Room C, interview, and facility document review was conducted with the Maintenance Director. The Maintenance Director verified the findings on the walls. Review of the Maintenance Logbook failed to show a report for repair for Room C. The Maintenance Director verified there was no report for repair of Room C.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49644 Based on observation, interview, medical record review, and facility P&P review, the facility failed to develop the comprehensive plans of care to reflect the individual care needs for two of 32 final sampled residents (Residents 48 and 171). * The facility failed to develop a care plan to address Resident 48's use of the apixaban (anticoagulant) medication. * The facility failed to develop a care plan to address Resident 171's weight loss of 6.5% in one month. These failures had the potential risk of not providing appropriate, consistent, and individualized care to these residents. Findings: 1. Review of the facility's P&P titled Care Plans, Comprehensive Person-Centered revised 3/2022 showed a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The Policy Interpretation and Implementation section showed the IDT, in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. Medical record review for Resident 48 was initiated on 4/16/25. Resident 48 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 48's Medical Provider Note dated 1/27/25, showed Resident 48 was diagnosed with paroxysmal atrial fibrillation. Review of Resident 48's MDS dated [DATE], showed the resident was cognitively intact. Review of Resident 48's Order Summary Report for April 2025 showed a physician's order dated 4/11/25, to administer apixaban oral tablet 5 mg one tablet by mouth two times a day for atrial fibrillation. Review of Resident 48's plan of care failed to show a care plan was developed to address the use of the apixaban medication. On 4/18/25 at 1117 hours, an interview and concurrent medical record review was conducted with LVN 2. LVN 2 verified there was no care plan for Resident 48's use of the apixaban medication. LVN 2 stated the licensed nurse should have updated Resident 48's care plan when the apixaban medication was ordered. On 4/18/25 at 1643 hours, the DON and ADON were informed and acknowledged the above findings. (continued on next page)

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Seal Beach Health and Rehabilitation Center	3000 N Gate Road Seal Beach, CA 90740

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	48332 2. Medical record review for Resident 171 was initiated on 4/15/25. Resident 171 was admitted to facility on 3/19/25, with diagnoses including malignant neoplasm of esophagus (presence of cancer cells with ability to spread to other sites of the body and destroy tissues from the throat to the stomach), dysphagia (difficulty swallowing), and muscle wasting (condition where muscle tissue shrinks and decrease in size leading to loss of strength and mass). Review of Resident 171's weekly weights from 3/20/25 to 4/13/25 showed the following: - 180 lbs on 3/20/25 - 175 lbs on 3/29/25 - 174 lbs on 4/5/25 - 169 lbs on 4/13/25 Resident 171 had significant weight loss of 11 lbs equivalent to 6.5% in one month. Review of Resident 171's plan of care failed to show documented evidence a care plan problem was developed addressing Resident 171's significant weight loss of 6.5% in one month. On 4/17/25 at 0847 hours, an interview and concurrent medical record review for Resident 171 was conducted with the ADON. The ADON verified the findings.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39856 Based on interview, medical record review and facility document review, the facility failed to ensure the professional standards of quality were met when the facility diet manual was not followed for diabetic diets. This failure had the potential to adversely affect the quality of life for the 51 residents who received an RCS diet. Findings: A professional review titled Management of Diabetes in Long-term Care and Skilled Nursing Facilities: A Position Statement of the America Diabetes Association, Diabetes Care 2016 showed liberal diets have been associated with improvement in food and beverage intake in the LTC population to better meet caloric and nutrient requirements (27). While carbohydrate intake should be taken into consideration, no concentrated sweets or no sugar diet orders are ineffective for glycemic management and should not be recommended. Instead, a consistent carbohydrate meal plan that allows for a wide variety of food choices (e.g., general diet) may be more beneficial for both nutritional needs and glycemic control in patients with Type 1 diabetes or Type 2 diabetes on mealtime insulin. According to the Academy of Nutrition and Dietetics Nutrition Care Manual (NCM) 2025, the name of the diet used in your facility should no longer emphasize the restriction of sugar or sweets but rather emphasize consistent carbohydrates or carbohydrate controlled. Review of the Academy of Nutrition and Dietetics Nutrition Care Manual Process for Annual Diet Manual Review and Implementation 2025 showed in part, 2. Identify all diet orders used at your facility, diet names used in all areas should match; medical record documentation, printed menus or tray tickets, diet manual, documents used by kitchen staff (i.e. menu spreadsheets), diet guide sheets and policies and procedures. 3. Make changes to facility diets as needed, identify current diet names used at your facility that may require a change and/or diet names that require clarification of foods served. Discuss modifications to existing diet order names with health care team and agree on final names for all diets. Document and date this discussion. Change existing diet terminology to match new, updated diet names. Review of the facility's Diet Manual revised April 2024 showed the following diabetic diets: - A Controlled-Carbohydrate (CC Diet)*, *CC Diet may also be referenced as CC/RCS, RCS, or CCHO. The breakfast and noon meal contain approximately 60 gms carbohydrate (+/- 15 gms), and the evening meal contain 75 gms of carbohydrate (+/- 15 gms). - A Consistent-Carbohydrate Diet (Diabetic Diet). - A Controlled-Carbohydrate-Renal diet (CC/Renal Diet)*, *CC/Renal diet may also be referenced as CC/RCS/Renal, RCS/Renal or CCHO/Renal. The breakfast and noon meal contain approximately 60 gms carbohydrate (+/- 15 gms), and the evening meal contain 75 gms of carbohydrate (+/- 15 gms). (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- A Fortified Controlled-Carbohydrate Diet (Fortified/CC Diet)*, * Fortified/CC diet may also be referenced as Fortified/CC/RCS, Fortified/RCS or Fortified/CCHO. The breakfast and noon meal contain approximately 60 gms carbohydrate (+/- 15 gms), and the evening meal contain 75 gms of carbohydrate (+/- 15 gms). - A CC/Low Fat/Cholesterol Diet (CC/Fat/Chol)*, *CC/Fat Cholesterol diet may also be called CC/RCS/Fat Cholesterol, RCS/Fat Cholesterol, CCHO/Fat Cholesterol. All diets except the Fortified Controlled-Carbohydrate Diet included the following statement: The ADA states the terms reduced concentrated sweet, no sugar added, and ADA diets are inappropriate because these terms do not reflect current nutrition recommendations. Review of the facility's document titled Therapeutic Spreadsheets dated Spring 2025 showed the following diets: Fortified/High Protein/RCS diet, RCS Liberal Renal diet, RCS Low Fat/Low Cholesterol diet, and RCS diet. Review of the facility's document titled Diet Type Report dated 4/17/25, showed 51 of 164 residents received an RCS diet at the facility. The document further showed three residents were on a Fortified/High Protein/RCS diet, five residents were on a RCS Liberal Renal diet, no residents were on a RCS Low Fat/Low Cholesterol diet, 13 residents were on a RCS diet, and 30 residents were on a RCS NAS diet. On 4/16/24 at 0845 hours, a review of the facility diet manual and concurrent interview was conducted with the RD. The RD was asked about the RCS diet used at the facility. The RD stated the RCS diet was the same diet as the CC diet. The RD stated the facility called the CC diet as RCS. The RD was asked if she felt the RCS diet was interchangeable with the CC diet. The RD stated she was not happy with the nomenclature of RCS diet but stated the Diet Manual had a statement which said the CC diet and the RCS diet were the same diets, so she thought that was ok. The RD further stated the facility's menus were approved by the Corporate RD, and she did not have control over it. The RD was asked if she had voiced her concern to the Corporate RD regarding the RCS nomenclature. The RD stated she had not mentioned the RCS nomenclature to the Corporate RD. On 4/18/25 at 0750 hours, an interview was conducted with the RD. The RD stated the RCS meant reduced concentrated sweet and was similar to the CC diet. The RD quoted a blog from Therapeutic diets in Long Term Care which stated the RCS diet was similar to the CC diet. The RD agreed the RCS diet was not a recognized diet with the Academy of Nutrition and Dietetics or the ADA but the RCS diet worked for the facility. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/18/25 at 1030 hours, a concurrent interview, medical record review for Resident 134, and facility document review was conducted with the RD. Resident 134 was admitted to the facility on [DATE], with a diagnosis of a fractured fibula (a lower leg bone) and Diabetes Mellitus. On 3/21/25, a RCS NAS regular consistency diet was ordered by the physician for Resident 134. The care plan for Resident 134 was reviewed with the RD. The RD confirmed she was responsible for all the resident's nutrition care plans. The RD confirmed she always selected the terminology diet as ordered for all the resident's care plans. The RD further confirmed the terminology diet as ordered referred to the RCS NAS regular consistency diet which was ordered for Resident 134. The Diet Type Report dated 4/17/25, was reviewed with the RD. The RD confirmed there were 51 residents in the facility who received an RCS diet, and she was responsible for all the nutrition care plans for the 51 residents of the facility. The facility dietary documents (therapeutic spread sheets, tray cards and diet orders) were reviewed with the RD. The RD confirmed all the dietary documents read RCS for the diabetic diets. During the exit conference with the facility on 4/18/25 1338 hours, the DON stated the RCS nomenclature was used at the facility because they have always used RCS terminology for diabetic diets and when the PCC was implemented several years ago . The DON verified RCS was the name they used for the diabetic diet.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49258 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of 32 final sampled residents (Resident 43) reviewed for ADL care received the adequate personal hygiene care. * The facility failed to provide the nail care for Resident 43 which caused self-inflicted excoriations (scratches on skin). This failure had the potential to not meet the personal care needs of the residents in the facility. Findings: Review of the facility's P&P titled Activities of Daily Living (ADL), Supporting revised 3/2018 showed the residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. On 4/18/25 at 1036 hours, a concurrent initial tour observation and interview was conducted with Resident 43. Resident 43 was observed awake, lying in bed, and watching TV. Resident 43 was observed scratching her face, neck and arms with her fingernails. Resident 43 was observed with multiple small red lesions in the face, neck, and arms. Resident 43 stated she felt itchy, but the CNA had just assisted the resident in cleaning her face, neck, and arms. Resident 43's fingernails in the right hand were observed long and in addition, all the fingernails on both hands were observed with black stain underneath the fingernails. Medical record review for Resident 43 was initiated on 4/18/25. Resident 43 was readmitted to the facility on [DATE]. Review of Resident 43's MDS assessment dated [DATE], showed Resident 43 was cognitively intact and needed staff supervision with the personal hygiene and grooming. Review of Resident 43's Care Plan initiated on 12/30/24, showed a care plan problem addressing Resident 43's scattered self-inflicted excoriations in the face and bilateral upper extremities. The interventions included to keep the fingernails short. On 4/21/25 at 1122 hours, a concurrent observation of Resident 43 and interview for Resident 43 was conducted with CNA 4. CNA 4 stated Resident 43 had the habit of picking and scratching her face. CNA 4 verified Resident 43's fingernails were long and with black stain underneath the fingernails. Resident 43's fingernails were also observed with yellow sauce and food residue. CNA 4 stated one of the CNA's responsibilities was to provide assistance to the residents in trimming the nails. CNA 4 stated the shower team used the skin observation form which included if the nails of the resident were clipped. CNA 4 stated she would clean and clip Resident 43's fingernails. Review of Resident 43's Skin Observation form showed the last time Resident 43's fingernails were clipped was on 3/18/25. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/21/25 at 1325 hours, a concurrent observation of Resident 43 and interview and medical record review for Resident 43 was conducted with LVN 3. LVN 3 stated the care plan for each of the resident was individualized to meet the personal care needs and should be followed. LVN 3 verified Resident 43's fingernails were long and dirty which caused skin impairment to the resident due to her self-inflicted excoriations. LVN 3 verified the last time Resident 43's fingernails were clipped was on 3/18/25, and Resident 43's medical record did not show any documentation Resident 43 was offered to clip her nails thereafter. LVN 3 stated Resident 43's fingernails should be kept short to prevent harm and infection to the resident. On 4/21/25 at 1425 hours, an interview was conducted with the ADON. The ADON stated providing personal hygiene and grooming which included nail care to the resident were the responsibilities of the CNA. The ADON stated if the resident was not assisted with his/her personal hygiene and grooming, it could affect the resident's dignity because the resident was left untidy or unkept and could also potentially develop bacterial growth. The ADON was informed and acknowledged the above findings for Resident 43.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32179 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the necessary care and services were provided to prevent the development and worsening of the pressure injuries for one of the six final sampled residents (Resident 163) reviewed for pressure injury as evidenced by: * The facility failed to provide a low air loss mattress for Resident 163 who had an unstageable pressure injury on the sacrum. * The facility failed to ensure the accurate skin assessment of Resident 163's blisters. * The facility failed to follow the physician's order for a wound consult for Resident 163. These failures had the potential for deterioration of Resident 163's pressure injuries as well as the development of new pressure injuries. Findings: Review of the facility's P&P titled Support Surface Guidelines dated 2/2024 showed guidelines for selecting appropriate pressure relieving devices include individuals at risk for developing pressure ulcers should be placed on a redistribution support surface such as foam, gel, static air, alternating air or air loss or gel when lying in bed. Review of the facility's P&P titled Pressure Injuries Overview dated 2/2024 showed Stage 2 pressure injury: partial thickness skin loss with exposed dermis. The wound bed is viable, pink, red, moist and may also present as an intact or ruptured serum intact blister. Medical record review for Resident 163 was initiated on 4/14/25. Resident 163 was admitted to the facility on [DATE]. Review of Resident 163's Braden Scale for Predicting Pressure Sore Risk forms dated 3/17 and 3/26/25, showed Resident 163 was at high risk for pressure injury. Review of Resident 163's Skin and Wound Evaluation dated 3/18/25, showed the resident was admitted with a Stage 3 pressure injury on the sacrum, measuring 6 cm (length) x 2.6 cm (width). Review of Resident 163's care plan dated 4/10/25, showed a care plan problem addressing the pressure injury and altered skin integrity related to the pressure injury on the sacrum. The care plan showed the contributing factors for further skin breakdown or slow healing included incontinence and decreased mobility. The interventions included for a pressure-relieving device for the wheelchair; however, it did not include a pressure-relieving device for the bed. Review of Resident 163's Skin and Wound Evaluation dated 4/14/25, showed the resident had the following wounds: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- a Sage 3 pressure injury on the sacrum, measuring 6.7 cm x 2.3 cm; - a left heel blister, measuring 6.6 cm x 3.7 cm; and - a right heel blister, measuring 5.3 cm x 2.8 cm. Review of Resident 163's Order Summary report dated 4/16/25, showed a physician's order dated 4/9/25, for a physician wound consult due to the Stage 3 pressure injury on the sacrum. On 4/15/25 at 0730 hours, a concurrent observation and interview was conducted with Resident 163. Resident 163 was resting in bed without a low air loss mattress. Resident 163 stated he had an open wound with a dressing on his buttock area. On 4/15/25 at 1000 hours, during an observation, Resident 163 was sleeping in bed without a low air loss mattress. On 4/15/25 at 1210 hours, during an observation, Resident 163 was observed sitting upright in bed without a low air loss mattress. On 4/17/25 at 0920 hours, an interview was conducted with an LVN 7. LVN 7 stated Resident 163 had no low air loss mattress. On 4/17/25 at 0945 hours, an interview and concurrent medical record review was conducted with LVN 10. LVN 10 stated Resident 163 was admitted with a Stage 3 pressure injury on the sacrum, and all the residents admitted with a Stage 3 pressure injury or higher should be placed on a low air loss mattress. Resident 163 had not yet received a low air loss mattress even though an order for one was made upon admission and communicated to the case manager, it was not approved due to insurance issues. When asked if she had followed up on this matter, LVN 10 mentioned since Resident 163 was recently admitted to the hospice services, she had communicated with the hospice nurse; however, she was not sure if the hospice nurse had visited Resident 163 to follow up regarding the air loss mattress. LVN 10 verified these findings and also stated on 4/14/25, she observed blisters on the left and right heels. When asked about these blisters, she explained an intact blister on the heel was not considered a Stage 2 pressure injury. On 4/17/25 at 1410 hours, an interview and concurrent medical record review was conducted with the Case Manager. The Case Manager stated she was not aware Resident 163 required a low air loss mattress and had not been informed of any request for it. On 4/17/25 at 1600 hours, an interview and concurrent medical record review was conducted with the ADON. When asked about the nursing intervention for a resident admitted with a Stage 3 pressure injury, the ADON stated Resident 163 should have been provided with a low air loss mattress. The ADON stated due to insurance issues, it might have taken a week to obtain the mattress. The ADON verified it had been a month since the resident's admission and Resident 163 should have already been provided with one. The ADON also stated an intact blister on a bony prominence should be considered a Stage 2 pressure injury and verified these findings. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/21/25 at 1400 hours, an interview and concurrent medical record review was conducted with LVN 5. LVN 5 was asked if there was a wound consult for Resident 163. LVN 5 stated the attending physician had ordered a wound consult on 4/9/25, and the order was still active but had not been followed up. LVN 5 was not aware of the physician's order for the wound consult and stated a wound physician had been making rounds with her, but LVN 5 did not know that Resident 163 needed a wound consult. LVN 5 acknowledged the wound consult should have been followed up and completed. LVN 5 verified the findings.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49644 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure two of 32 final sampled residents (Residents 15 and 20) and one nonsampled resident (Resident 83) were free from the accident hazards. * The facility failed to ensure no resident's belongings were placed on top of Resident 15's overhead light fixture. * The facility failed to ensure no items were placed on top of Residents 20 and 83's overbed light fixtures. These failures had the potential for increased risk of accidents or injuries to the residents. Findings: Review of the facility's P&P titled Safety and Supervision of Residents revised 7/2023 showed the facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. The Systems Approach to Safety section showed the facility-oriented approaches to safety are used together to implement a systems approach to safety, which considers the hazards identified in the environment and individual resident risk factors, and then adjusts interventions accordingly. 1. On 4/15/25 at 1115 hours, during the initial tour of the facility, two picture frames, a hat, and two stuffed toys were observed on top of Resident 15's overhead light fixture. Medical record review for Resident 15 was initiated on 4/15/25. Resident 15 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 15's MDS assessment dated [DATE], showed the resident was moderately impaired. On 4/15/25 at 1119 hours, an observation and concurrent interview was conducted with LVN 1. LVN 1 verified the two picture frames, a hat, and two stuffed toys were on top of Resident 15's overhead light fixture. LVN 1 stated Resident 15's belongings could weaken the overhead light fixture and fall. LVN 1 stated the belongings could fall and injure Resident 15 if there was an earthquake. On 4/17/25 at 0915 hours, an observation and concurrent interview was conducted with the Maintenance Director. The Maintenance Director acknowledged the above findings. The Maintenance Director stated Resident 15 was just transferred to her room not too long ago and he checked the residents' room monthly. The Maintenance Director further stated the facility's staff should have written a request in the maintenance logbook if a resident's belongings needed to be removed. The Maintenance Director stated if the belongings were heavy, the belongings could fall and the resident could get hurt. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/17/25 at 1102 hours, a concurrent interview and review of the facility's Maintenance Request logbook was conducted with LVN 3. LVN 3 verified there was no request in the logbook to check the overhead light fixture in Resident 15's room. LVN 3 stated the CNA or licensed nurse should have written their request in the Maintenance Request logbook when they needed help. On 4/18/25 at 1016 hours, an interview was conducted with the DON. The DON stated the CNA and nurses should have checked the resident's room. The DON stated the residents' safety was everyone's responsibility and the facility's staff should have tried to fix the problem or put the request in the Maintenance Request logbook. 39453 2. On 4/17/25 at 0818 hours, an observation for Resident 20 and concurrent interview was conducted with CNA 11. Resident 20 was observed in bed and CNA 11 was observed inside the room. Two pop-up flower cards were observed on top of Resident 20's overbed light fixture. CNA 11 verified the findings. CNA 11 stated he did not really pay attention to those or any items on top of the resident's overbed light fixture and did not know who had placed the items there. On 4/18/25 at 0803 hours, the two pop-up flower cards were observed on top of Resident 20's overbed light fixture. Medical record review for Resident 20 was initiated on 4/15/25. Resident 20 was readmitted to the facility on [DATE]. Review of Resident 20's MDS assessment dated [DATE], showed Resident 20 had a severe cognitive impairment. 3. On 4/18/25 at 0825 hours, a piece of wood was observed on top of Resident 83's overbed light fixture. Medical record review for Resident 83 was initiated on 4/15/25. Resident 83 was admitted to the facility on [DATE]. Review of Resident 83's MDS assessment dated [DATE], showed Resident 83 had a severe cognitive impairment. On 4/18/25 at 0830 hours, an observation and concurrent interview was conducted with the Maintenance Director. Resident 20 was observed in bed, and two pop-up flower cards were observed on top of Resident 20's overbed light fixture. Resident 83 was observed in bed, and a piece of wood was also observed on top of Resident 83's overbed light fixture. The Maintenance Director verified the above findings. The Maintenance Director was observed taking the piece of wood and was also observed taking out a metal drawer slide bracket from the top of Resident 83's overbed light fixture. The Maintenance Director stated the piece of wood and metal bracket might have been from Resident 83's nightstand. The Maintenance Director stated there should be no items on top of the overbed light fixture as these items could fall on to the residents.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49258 Based on interview, medical record review, and facility P&P review, the facility failed to monitor the new onset of weight loss for one of five final sampled residents (Resident 103) reviewed for nutrition. * The facility failed to monitor Resident 103 after the resident had a significant weight loss of 6.71% for one month. This failure had the potential for not providing the necessary care and services if the resident had a change in condition. Findings: Review of the facility's P&P titled Change in a Resident's Condition or Status revised 2/2021 showed a significant change of condition is a major decline or improvement in the resident's status. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. Review of the facility's P&P titled Nutrition (Impaired)/Unplanned Weight Loss - Clinical Protocol revised 9/2017 showed under the Monitoring section, the physician and staff will monitor status, an individual's response to interventions, and possible complications of such interventions (for example, additional weight gain or loss, nausea, or vomiting). Medical record review for Resident 103 was initiated on 4/15/25. Resident 103 was admitted to the facility on [DATE]. Review of Resident 103's MDS assessment dated [DATE], showed Resident 103 had severe cognitive impairment and had a weight loss of 5% or more in the last month. Review of Resident 103's weight record showed the following: - dated 3/3/25, weight of 149 lbs - dated 3/27/25, weight of 135 lbs - dated 3/29/25, weight of 135 lbs - dated 4/5/25, weight of 139 lbs Review of Resident 103's IDT Weight Management assessment dated [DATE], showed the RD noted the sign of weight loss most likely secondary to the acute care hospitalization and recommended adding eight ounces of milk three times a day with meals for weight/intake support. The RD would monitor the weights weekly, oral intake, laboratory tests, and skin. Further review of Resident 103's medical record did not show documented evidence Resident 103 was being assessed or monitored for the change of condition of significant weight loss. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/15/23 at 1336 hours, a concurrent meal observation and interview was conducted with Resident 103. Resident 103 was observed consuming only 20% of the lunch meal. Resident 103 stated the food was good but he did not want to eat anymore. On 4/16/25 at 0938 hours, a concurrent observation and interview for Resident 103 was conducted with CNA 5. CNA 5 stated Resident 103 consumed 80% of the breakfast meal. CNA 5 stated she encouraged Resident 103 to eat and was constantly checking if Resident 103 wanted something else. On 4/21/25 at 1407 hours, a concurrent interview and medical record review for Resident 103 was conducted with the ADON. The ADON stated the weight loss of 5% or more in one month was considered a change of condition. The ADON stated for any change of condition, the resident should be assessed or monitored relative to the changes in the resident's medical condition every shift for 72 hours. The ADON verified Resident 103 was not monitored following the resident's change of condition related to significant weight loss. The ADON stated it was important to assess or monitored the resident to identify other causes so the facility could provide immediate intervention and to prevent worsening condition or to evaluate if the interventions initiated were helping the resident. On 4/22/25 at 1010 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary GT care and services for one of one final sampled resident (Resident 37) reviewed for enteral feeding care. * The facility failed to ensure Resident 37 was positioned safely at 30 to 45 degrees during the enteral feeding via GT. In addition, the facility failed to ensure Resident 37's GT feeding bag was labeled with the date when it was hung. These failures posed the risk for developing complications related to the residents' GT. Findings: According to Taylor's Fundamentals of Nursing seventh edition, Nursing Considerations with Tube Feeding, make sure the resident is as upright as possible during feeding. If the resident is in bed during feedings, elevate the head of the bed at least 30 degrees during feeding and for one hour afterward to prevent reflux and aspiration. Review of the facility's P&P titled Enteral Feedings - Safety Precautions revised 11/2018 showed the following: - To prevent errors in administration, check the enteral nutrition label against the order before administration. Check the information including date and time the formula was prepared. On the formula label, document initials, date and time the formula was hung, and initial that the label was checked against the order; and - To prevent aspiration, elevate the head of the bed at least 30 degrees during tube feeding and at least one hour after feeding. Medical record review for Resident 37 was initiated on 4/15/24. Resident 37 was readmitted to the facility on [DATE]. Review of Resident 37's Order Summary Report showed the following physician's orders: - dated 6/7/24, to administer Fibersource 1.2 (enteral feeding formula) via GT for a total of 900 ml/1080 kcal at a rate of 45 ml per hour for 20 hours; and - dated 7/8/20, to elevate the head of the bed between 30 to 45 degrees during feeding. On 4/18/25 at 1340 and 1345 hours, Resident 37 was observed in bed with the head of bed slightly elevated. Resident 37's GT feeding of Fibersource 1.2 was observed infusing via a feeding pump at 45 ml per hour. The bag of the enteral feeding Fibersource 1.2 was not labeled with the date to show when the formula was hung. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/18/25 at 1347 hours, an observation and concurrent interview for Resident 37 was conducted with LVN 11. LVN 11 verified Resident 37's head of the bed was not elevated at 30-45 degrees while on GT feeding. LVN 11 also verified the GT enteral feeding of Fibersource 1.2 was not labeled with the date when the formula was hung.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services for four of four final sampled residents reviewed for respiratory care (Residents 32, 37, 39, and 136) and three nonsampled residents (Residents 24, 55, and 118) reviewed for respiratory care. * The facility failed to ensure a physician's order was obtained and a care plan was developed to address Resident 37's use of oxygen. In addition, the facility failed to obtain a physician's order was obtained to suction the resident. * The facility failed to administer Resident 136 was receiving the correct rate of oxygen as per the physician's order. In addition, the nasal cannula tubing was undated and the set-up bag was dated 3/13/25. * The facility failed to ensure the nebulizer mask was dated and the set-up bag was changed weekly for Resident 32. * The facility failed to ensure the oxygen tubing was dated and the set-up bag was provided for Resident 39. * The facility failed to ensure the suction tubing was dated and the suction canister was changed weekly for Resident 55. * The facility failed to ensure the oxygen tubing was dated and the set-up bag was provided for Resident 118. * The facility failed to ensure the nebulizer mask was dated and the set-up bag was changed weekly. These failures had the potential to affect the respiratory health and well-being of the residents in the facility. Findings: 1. Review of the facility's P&P titled Oxygen Administration revised 10/2010 showed to verify there is a physician's order for this procedure; review the physician's order or facility protocol for oxygen administration; and review the resident's care plan to assess for any special need of the resident. Review of the facility's P&P titled Suctioning the Upper Airway (Nasopharyngeal or Oropharyngeal Suctioning) revised 10/2023 showed to verify there is a physician's order for this procedure and review the physician's orders or facility protocol for suctioning. a. On 4/15/25 at 0918 hours, during the initial tour of the facility, Resident 37 was observed lying in bed and receiving oxygen at two liters per minute via nasal cannula. An unlabeled/undated suction canister and a Yankauer suction catheter were also observed at bedside. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medical record review for Resident 37 was initiated on 4/15/25. Resident 37 was readmitted to the facility on [DATE]. Review of Resident 37's Order Summary Report did not show a physician's order to administer the oxygen. Review of Resident 37's plan of care did not show a care plan was developed to address the use of oxygen. On 4/15/25 at 1008 hours, an observation for Resident 37 and concurrent interview and medical review was conducted with the IP. The IP verified Resident 37 was lying in bed and receiving oxygen at two liters per minute via nasal cannula. The IP verified a physician's order was not obtained prior to administering the oxygen to Resident 37 and verified a care plan was not developed to address Resident 37's use of oxygen. b. On 4/16/25 at 0916 hours, 4/17/25 at 0816 and 1450 hours, and 4/18/25 at 0753 hours, Resident 37 was observed lying in bed. An undated and unlabeled Yankauer (plastic tool used to suction secretions from mouth in order to prevent aspiration) suction catheter connected to an undated an unlabeled suction canister was observed on top of Resident 37's nightstand. There was no set-up bag observed for the Yankauer suction catheter. On 4/18/25 at 0814 hours, an observation and concurrent interview and medical record review for Resident 37 was conducted with LVN 11. LVN 11 verified an undated and unlabeled Yankauer suction catheter connected to an undated and unlabeled suction canister was on top of Resident 37's nightstand. LVN 11 also verified there was no set-up bag for the Yankauer suction catheter. LVN 11 stated Resident 37 needed to be suction for her oral secretions. LVN 11 stated she had to call the physician to obtain a physician's order to suction Resident 37. 2. On 4/15/25 at 1106 hours, during the initial tour of the facility, Resident 136 was observed lying in bed and receiving oxygen at three liters per minute via nasal cannula. The nasal cannula tubing was undated, and the set-up bag was dated 3/13/25. Medical record review for Resident 136 was initiated on 4/15/25. Resident 136 was readmitted to the facility on [DATE]. Review of Resident 136's Order Summary Report showed a physician's order dated 2/19/25, to administer oxygen at two liters per minute via nasal cannula as needed for SOB. On 4/15/25 at 1115 hours, an observation and concurrent interview and medical record review for Resident 136 was conducted with the IP. The IP verified Resident 136 was receiving three liters per minute of oxygen. The IP also verified the nasal cannula tubing was undated and the set-up bag was dated 3/13/25. The IP stated Resident 136 should only receive two liters of oxygen per the physician's order, and the nasal cannula tubing should be changed weekly. 48332 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of the facility's P&P titled Departmental (Respiratory Therapy) - Prevention of Infection revised 11/2011 showed the purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment, including ventilators, among residents and staff. The Procedure section showed infection control considerations related to medication nebulizers/continuous aerosol: - Obtain equipment (i.e., administration set-up, plastic bag, gauze sponges). - Wash hands. - After completion of therapy: remove the nebulizer container, rinse the container with fresh tap water; and dry on a clean paper towel or gauze sponge. - Take care not to contaminate internal nebulizer tubes - Store the circuit in plastic bag, marked with date and resident's name, between uses - Discard the administration set-up every seven (7) days. During the initial tour of the facility on 4/15/25 at 0941 hours, Resident 32 was observed awake, alert, lying in bed with the head of bed up and nebulizer machine at the bedside. The nebulizer machine was connected to the tube with empty nebulizer container inside the plastic bag dated 2/16/25. Medical record review for Resident 32 was initiated on 4/15/25. Resident 32 was initially admitted to the facility on [DATE], and was readmitted on [DATE]. Review of Resident 32's Order Summary Report dated 4/17/25, showed an order dated 1/23/25, for Ipratropium-Albuterol (bronchodliator) inhalation solution 0.5-2.5 (3 mg/3 ml) 3 ml inhale orally every four hours as needed for COPD via nebulizer. On 4/15/24 at 1058 hours, an observation of Resident 32's nebulizer and concurrent interview was conducted with LVN 6. LVN 6 verified the nebulizer was dated 2/16/25, and should have been changed weekly. 4. Review of the facility's P&P titled Departmental (Respiratory Therapy) - Prevention of Infection, revised 11/2011 showed the purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment, including ventilators, among residents and staff. Under Steps in the Procedure, showed Infection Control Considerations Related to Oxygen Administration: - Obtain equipment (i.e., oxygen tubing, reservoir, and distilled water). - Change the oxygen cannula and tubing every seven (7) days , or as needed. - Keep the oxygen cannula and tubing used PRN in a plastic bag when not in use. - Wash filters from oxygen concentrators every seven days with soap and water. Rinse and squeeze dry. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Wash hands after manipulation. On 4/15/25 at 1054 hours, a concurrent observation of Resident 39 and interview was conducted with LVN 6. Resident 39 was observed sitting in her wheelchair at the side of her bed with oxygen on at 2-3 liters per minute per nasal cannula with tubing connected to the oxygen concentrator. There was no date on the oxygen tubing and no plastic bag to store the nasal cannula when it was not in use. LVN 6 verified the findings. Medical record review for Resident 39 was initiated on 4/15/25. Resident 39 was admitted to the facility on [DATE]. Review of Resident 39's Order Summary Report dated 4/17/25, showed an order dated 1/15/25, for oxygen at 2 liters per minute via nasal cannula continuously every shift. 5. Review of the facility's P&P titled Suctioning the Upper Airway (Nasopharyngeal or Oropharyngeal Suctioning) revised 10/2023 showed the purpose of this procedure is to clear the upper airway of mucous secretions and prevent the development of respiratory distress. Nasopharyngeal suctioning is performed using sterile technique. Catheters should not be reused. Oropharyngeal suctioning is performed using aseptic technique. Review of the facility's P&P titled Cleaning and Disinfection of Resident-Care Items and Equipment revised 9/2022 showed the semi-critical items consist of items that may come in contact with mucous membranes or non-intact skin, (e.g., respiratory therapy equipment). Such devices shall be free from all microorganisms, although small numbers of bacterial spores are permissible. Critical and semi-critical items are sterilized/ disinfected in a central processing location and stored appropriately until use. The equipment will be labeled with at least the following information: the date and time the label was affixed to the equipment. On 4/15/25 at 1124 hours, a concurrent observation of Resident 55 and interview was conducted with CNA 12. Resident 55 was observed lying in bed, asleep, with a GT connected to an enteral feeding formula and water via enteral pump. There was a suction machine at the bedside connected to a suction canister dated 2/10/25. The suction tubing was undated and the Yankauer suction tip hanging on the enteral pump, not kept inside the plastic bag. CNA 12 verified the findings. On 4/15/25 at 1145 hours, a follow-up observation of Resident 55's room and concurrent interview was conducted with LVN 6. LVN 6 verified the findings and stated it should have been replaced weekly. 6. On 4/15/25 at 1032 hours, a concurrent observation of Resident 118 and interview was conducted with LVN 6. Resident 118 was sitting in her wheelchair at the side of her bed. The oxygen concentrator was on but not in use by Resident 118. Resident 118 stated she just moved from the bed to wheelchair, so she removed the oxygen. The nasal cannula was observed hanging at the left side of the bed. There was no plastic bag to keep the cannula when not in use, and the oxygen tubing was not dated. LVN 6 verified the findings. Medical record review for Resident 118 was initiated on 4/15/25. Resident 118 was initially admitted to facility on 11/5/24, and was readmitted on [DATE]. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 118's Order Summary Report dated 4/17/25, showed a physician's order dated 4/6/25, for oxygen at 2 liters per minute via nasal cannula continuously every shift for SOB. 49644 7. Review of the facility's P&P titled Departmental (Respiratory Therapy) - Prevention of Infection revised 11/2011 showed the purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment, including ventilators, among residents and staff. The Infection Control Considerations Related to Medication Nebulizers/Continuous Aerosol section showed to discard the administration set-up every seven days. On 4/15/25 at 0858 hours, during the initial tour of the facility, an undated mask nebulizer inside a set up bag dated 4/6/25, was observed on top of Resident 24's bedside cabinet. Medical record review for Resident 24 was initiated on 4/15/25. Resident 24 was admitted to the facility on [DATE]. Review of Resident 24's MDS assessment dated [DATE], showed Resident 24's cognition was moderately impaired. Review of Resident 24's Order Summary Report dated 4/6/25, showed an order dated 4/6/25, to administer albuterol sulfate (medication to treat and prevent breathing difficulties caused by lung disease) 2.5 mg/3 ml solution, 3 ml inhale orally via nebulizer four times a day for COPD. On 4/15/25 at 1110 hours, an observation and interview was conducted with LVN 1. LVN 1 verified Resident 24's nebulizer mask was undated and the set-up bag was dated 4/6/25. LVN 1 stated the respiratory supplies should have been changed by the central supply staff every week. On 4/17/25 at 0902 hours, an interview was conducted with the Central Supply Manager. The Central Supply Manager stated the respiratory supplies were all in the utility room. The Central Supply Manager further stated he checked the respiratory supplies in the utility room every day and every nursing station has a utility room. The Central Supply Manager stated the nurse should have labeled the set-up bag and respiratory supplies before giving to the residents. On 4/17/25 at 1402 hours, an interview was conducted with LVN 3. LVN 3 stated the licensed nurses were responsible for changing the respiratory supplies including the bag, tubing and the nebulizer. LVN 3 further stated the respiratory supplies should have been changed weekly and as needed if it was soiled. LVN 3 stated the licensed nurse should label the respiratory supplies with the resident's name, room number, and date. On 4/18/25 at 1026 hours, an interview was conducted with the DON. The DON stated the night shift charge nurse should change the respiratory supplies every Sunday. The DON acknowledged the above findings. The DON stated Resident 24's nebulizer mask should have been labeled and changed per schedule.

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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. 49644 Based on interview, facility document review, and facility P&P review, the facility failed to ensure the performance evaluations were completed every 12 months for one of two CNAs' employee files (CNA 1) reviewed. This failure had the potential for the staff to not maintain competencies to provide the residents with needed and appropriate care and services. Findings: Review of the facility's P&P titled Performance Evaluations revised 9/2020 showed the job performance of each employee shall be reviewed and evaluated at least annually. The Policy Interpretation and Implementation section showed the performance evaluations will be completed by the employees' department directors and supervisors and reviewed by the director of human resources. Each employee will be given the opportunity to review his/her evaluation with his/her department director and the director of human services. On 4/17/25 at 1520 hours, an interview and concurrent facility document review was conducted with the DSD. The DSD stated the DSD and QA nurse were supposed to do the performance evaluation yearly so they could recognize areas of improvement of the employees. The DSD verified CNA 1's last performance evaluation was on 11/16/22. The DSD stated the employee's file should have been reviewed frequently based on the date of hire. On 4/18/25 at 1006 hours, an interview was conducted with the DON. The DON acknowledged the above findings. The DON stated the policy on performance evaluation should have been followed.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49258 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure dementia (a decline in mental ability severe enough to interfere with daily life) care interventions were being implemented for one of two final sampled residents (Resident 135) reviewed for dementia care. This failure had the potential for Resident 135 to not receive the appropriate treatment and services needed for her dementia. Findings: Review of the facility's P&P titled Dementia - Clinical Protocol (undated) showed the following: - The staff and physician will evaluate individuals with new or worsening cognitive impairment and behavior and differentiated dementia from other causes; - The staff and physician will review current physical, functional, and psychosocial status of individuals with dementia, and will summarize the individual's condition, related complications, and functional abilities and impairments; and - The staff will monitor the individual with dementia for changes in condition and decline in function and will report these findings to the physician. On 4/15/25 at 0837 hours, during the initial tour of the facility, Resident 135 was observed lying and sleeping in bed. The breakfast tray was observed at the bedside of Resident 135. On 4/15/25 at 0840 hours, an interview for Resident 135 was conducted with CNA 6. CNA 6 stated Resident 135 was confused, sometimes agitated, and would refuse to eat at times so she would try several times to offer the food. CNA 6 stated she believed Resident 135 had dementia. CNA 6 stated she would try to wake up the Resident 135 and assist her with meal. CNA 6 stated Resident 135 could eat by herself but would need reminding to eat. CNA 6 stated she would always report to the charge nurse any unusual behavior of Resident 135 like agitation, aggressiveness, or increased in confusion. Medical record review for Resident 135 was initiated on 4/15/25. Resident 135 was admitted to the facility on [DATE]. Review of Resident 135's H&P examination dated 3/8/25, showed Resident 135 had no capacity to understand and make medical decisions and had a medical history of dementia. Review of Resident 135's plan of care revised on 1/13/25, showed a care plan problem addressing Resident 135's altered thought process related to dementia. The interventions included to monitor for change in condition and decline in function, reduction in alertness, appetite, attention span and responsiveness, confusion, agitation, lethargy, fluctuation in level of consciousness, hallucinations, and delusion; and would report these findings to the physician. (continued on next page)

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Seal Beach Health and Rehabilitation Center	3000 N Gate Road Seal Beach, CA 90740

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident 135's medical record did not show documented evidence Resident 135 was being observed/monitored for the signs and symptoms of altered thought process related to her dementia. On 4/21/25 at 1045 hours, a concurrent observation of Resident 135 and interview was conducted with CNA 7. Resident 135 was observed awake and lying bed. Resident 135 did not respond to questions. CNA 7 stated Resident 135 was confused, not cooperative when the CNA was doing care, sometimes would hit the staff when being repositioned, and needed total assistance with hygiene. CNA 7 stated they did not document any altered behavior of Resident 135 related to dementia but would report it to the charge nurse. On 4/21/25 at 1335 hours, a concurrent interview nd medical record review for Resident 135 was conducted with LVN 3. LVN 3 stated Resident 135 was confused but able to make simple needs known. LVN 3 stated Resident 135 had episodes of agitation, screaming, and yelling when being clean. LVN 3 verified there was no documented evidence Resident 135 was being assessed or monitored for altered thought process and behaviors related to dementia as stated in the resident's plan of care. LVN 3 stated it was important to monitor those behaviors to know if Resdient 135's dementia condition was getting worse and if the interventions needed to be changed. On 4/21/25 at 1539 hours, an interview was conducted with the ADON. The ADON stated the plan of care to address Resident 135's dementia allowed proper treatment of the resident. The ADON stated increased behavior related to dementia as stated in the plan of care of Resident 135 could be indicative of the progression of dementia and even infection. The ADON stated knowing and monitoring those behaviors related to dementia would provide the facility an effective intervention and safety for the resident, and for the physician to adjust the treatment as needed related to the dementia problem. The ADON was informed and acknowledged the above findings.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 51352 Based on interview and facility document review, the facility failed to ensure the proper accounting and safeguarding of the controlled medications to prevent loss, diversion, or accidental exposure. * The facility failed to ensure complete and accurate documentation of the Narcotic Card/Bottle Count Sheets on Medication Cart C for February and March 2025 and Medication Cart D for February and April 2025. This failure had the potential for controlled substance diversion. Findings: a. Review of the facility document titled Narcotic Card/Bottle Count Sheet for February and March 2025 for Medication Cart C showed the following: - dated 2/29, 3/1 and 3/29/25 for the 1500-2300 hours shift, there were no staff signatures for the incoming and outgoing shifts. - dated 2/29 and 3/1/25 for the 2300-0700 hours shifts, there were no signatures for the on duty staff. - dated 3/1 and 3/8/25 for the 0700-1500 hours shifts, there were no signatures for the on duty and off duty staff. - dated 2/29, 3/1, 3/7 and 3/29/25 for the 1500-2300 hours shifts, there were no signatures for the on duty staff. - dated 2/29, 3/1, 3/6, 3/7, 3/10 and 3/29/25 for the 1500-2300 hours shifts, there were no signatures for the off duty staff. - dated 3/1/25 for the 2300-0700 hours shift, there was no documentation of the total number of narcotic cards/bottles by the off duty staff. - dated 3/1 and 3/8/25 for the 0700-1500 hours shift, there was no documentation of the total number of narcotic cards/bottles by the on duty staff. - dated 3/1 and 3/8/25 for the 0700-1500 hours shift, there was no documentation of the total number of narcotic cards/bottles by the off duty staff. - dated 3/1, 3/7, and 3/29/25 for the 1500-2300 hours shift, there was no documentation of the total number of narcotic cards/bottles by the on duty staff. - dated 3/1, 3/6, 3/7, 3/11, and 3/29/25 for the 1500-2300 hours shift, there was no documentation of the total number of narcotic cards/bottles by the off duty staff. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/21/25 at 1036 hours, an interview and concurrent facility document review was conducted with LVN 6. LVN 6 verified the above findings. LVN 6 stated it was the responsibility of license nurses to count the total number of the narcotic cards and bottles and sign the Narcotic Card/Bottle Count Sheet when they reported to the facility for their oncoming shift to prevent diversion of controlled substances. b. Review of the facility document titled Narcotic Card/Bottle Count Sheet for February and April 2025 for Medication Cart D showed the following: - dated 2/22/25 for the 0700-1500 hours shift, there were no signatures for the on and off duty staff. - dated 4/1/25 for the 2300-0700 hours shift, there were no signatures for the on duty staff. - dated 2/22/25 for the 0700-1500 hours shift, there was no documentation of the total number of narcotic cards/bottles by the on and off duty staff. - dated 2/28/25 for the 1500-2300 hours shift, there was no documentation of the total number of narcotic cards/bottles by the on and off duty staff. - dated 4/1/25 for the 2300-0700 hours shift, there was no documentation of the total number of narcotic cards/bottles by the on duty staff. On 4/21/25 at 1100 hours, an interview and concurrent facility document review was conducted with LVN 16. LVN 16 verified the above findings. LVN 16 stated it was the responsibility of the license nurses to count the total number of the narcotic cards and bottles and sign the Narcotic Card/Bottle Count Sheet when they reported to the facility for their oncoming shift.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453 Based on observation, interview, and medical record review, the facility failed to ensure the medication error rate was below 5%. The facility's medication error rate was 23.07%. Three of three licensed nurses (LVNs 3, 7, and 9) who were observed during medication administration were found to have errors. * LVN 3 failed to ensure an unscored tablet was not cut when administering an oral medication to Resident 25. * LVN 3 failed to administer the correct dosages of medications to Resident 46 as per the physician's orders. LVN 3 failed to ensure the medications were not administered together when administering medications via the GT to Resident 46, and to flush the GT in between the medications. LVN 3 failed to check if Resident 46 had loose stools prior to administering the stool softener medication. * For Resident 120, LVN 7 failed to administered calcium with Vitamin D (supplement) medication following the physician's order, did not instruct the resident not to chew for extended release medication, and did not assess/ask if resident any bleeding or bruised prior administration of Apixaban. * For Resident 28, LVN 9 failed to assess the bowel movement before administering the colace (stool softener) medication. These failures created the risk for the residents to have potential side effects or complications related to the medications. Findings: 1. Review of the FDA article titled Tablet Splitting dated 8/23/13, showed if a tablet is FDA- approved to be split, this information will be printed in the How Supplied section of the professional label insert and in the patient package insert. Also, the tablet will be scored with a mark indicating where to split it. According to Taylor's Fundamentals of Nursing seventh edition, under Administering Oral Medications section, unless a tablet is scored, do not break it because doing so could result in an inaccurate dose. On 4/16/25 at 0826 hours, a medication administration observation for Resident 25 was conducted with LVN 3. LVN 3 prepared a tablet of multivitamins with minerals (supplement), and a tablet of vitamin C (supplement) 500 mg. LVN 3 stated she needed to cut the vitamin C tablet and used a pill cutter to cut the unscored tablet of vitamin C 500 mg. LVN 3 administered one tablet of multivitamins with minerals and a half tablet of vitamin C medication to Resident 25. Medical record review for Resident 25 was initiated on 4/15/25. Resident 25 was admitted to the facility on [DATE]. Review of Resident 25's Order Summary Report showed the following physician's orders dated 3/25/25: (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- ascorbic acid (vitamin C) 250 mg one tablet by mouth one time a day; and - multivitamins with minerals one tablet by mouth one time a day. On 4/16/25 at 1453 hours, an interview and concurrent medical record review was conducted with LVN 3. LVN 3 verified she cut an unscored vitamin C tablet in half. LVN 3 stated there should be an order to cut medications and the nurses were allowed to cut unscored tablets as long as they made sure it was really cut in half. 2. Review of the National Institute of Health's peer-reviewed journal titled Preventing Errors When Drugs Are Given via Enteral Feeding Tubes dated 10/13 showed incompatibility between drugs being given together can be a problem. Mixing two or more drugs together, whether in solid or liquid forms, creates a brand-new, unknown entity with an unpredictable mechanism of release and bioavailability. Proper flushing of the GT before, during, and after each drug administration can help prevent problems. Review of the facility's P&P titled Administering Medications Through an Enteral Tube revised 11/2018 showed the following: - Do not add medication directly to the enteral feeding formula; - Administer each medication separately and flush between medications; - When preparing the medications, check the label and confirm the medication name and dose with the MAR. Follow the USP procedures for crushing, diluting and/ or mixing prior to administration; - To dilute the medication, dilute the crushed/ powdered medication with at least 30 ml purified water or prescribed amount. Dilute the liquid medication with 30 ml or more (depending on viscosity) purified water; and - If administering more than one medication, flush with 15 ml warm purified water or prescribed amount between medications. On 4/16/25 at 0847 hours, a medication administration observation for Resident 46 was conducted with LVN 3. LVN 3 prepared the following medications for Resident 46: - One tablet of amlodipine (antihypertensive) 5 mg; - One tablet of baclofen (muscle relaxant) 5 mg; - One tablet of calcium 600 mg with vitamin D 5 mcg (supplement) - One tablet of carvedilol (beta blocker) 12.5 mg; - One capsule of cholecalciferol (supplement) 125 mcg; - 10 ml of docusate sodium (stool softener) 50 mg/5 ml; (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 5 ml of Keppra (antiseizure) 500 mg/5 ml; - 15 ml of multivitamins with minerals and antioxidants (supplement) - 15 ml of potassium 10% (supplement) 20 meq/15 ml; and - 5 ml of vitamin C 500 mg. During the medication administration, the following was observed: - LVN 3 flushed the GT with 30 ml water. Then, LVN 3 poured a liquid medication into the GT syringe. The medication was pouring out of the GT port rather than flowing into the resident's GT. LVN 3 turned the GT valve off. When asked what the medication was, LVN could not identify the medication; - LVN 3 flushed the GT with 30 ml water which went out of the GT port again. LVN 3 turned the GT valve off; - LVN 3 poured a liquid medication into the GT syringe and flushed with 30 ml of water; - LVN 3 poured a liquid medication and added another liquid medication into the GT syringe. LVN 3 waited for a few seconds, added another liquid medication, and added 15 ml of water into the GT syringe. While there were still three medications inside the GT syringe, LVN 3 poured another crushed medication diluted with 15 ml water, and continued to add another crushed medication diluted with 15 ml water, then added another crushed medication diluted with 15 ml water. LVN 3 did not flush the GT in between the medications. When asked what the six medications mixed together that were administered, LVN could not identify the medications; - LVN 3 flushed the GT with 30 ml of water; - LVN 3 poured another crushed medication mixed with 15 ml water. LVN 3 identified it as the amlodipine medication; - LVN 3 poured 30 ml water into the GT syringe. While the water was still in the syringe, LVN 3 was observed pouring an undiluted crushed medication into the GT syringe. LVN 3 identified it as the baclofen medication; - LVN 3 flushed the GT with 30 ml of water; - LVN 3 did not check if Resident 46 had any loose stool prior to administering the docusate sodium medication; and - LVN 3 started stacking the medication cups and stated she was done. A significant amount of residue of powder was observed in one of the medication cups. LVN 3 verified there was a residue in the medication cup, and she identified it as the calcium with vitamin D medication. Medical record review for Resident 46 was initiated on 4/15/25. Resident 46 was admitted to the facility on [DATE]. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 46's Order Summary Report showed the following physician's orders: - dated 6/20/23, to flush tube feeding with 30 ml water before and after medication; - dated 5/9/24, for amlodipine 5 mg via GT one time a day; - dated 3/19/25, for baclofen 5 mg via GT two times a day; - dated 10/24/23, for calcium 600 mg with vitamin D 10 mcg via GT one time a day; - dated 9/3/24, for carvedilol 12.5 mg via GT one time a day; - dated 6/27/23, for docusate liquid 50 mg/5 ml 10 ml via GT two times a day. Hold for loose stool; - dated 6/20/23, for Keppra 500 mg/5 ml 5 ml via GT two times a day; - dated 10/23/23, for multivitamin with minerals 15 ml via GT one time day; - dated 5/20/24, for potassium 10% 20 meq/15 ml 15 ml via GT two times s day; and - dated 6/20/23, for vitamin C 500 mg/5 ml 5 ml via GT one time a day. On 4/16/25 at 1009 hours, an interview and concurrent medical record review for Resident 46 was conducted with LVN 3. LVN 3 verified the above findings as follows: - LVN 3 did not check whether Resident 46 had a loose stool before administering the docusate sodium medication. - LVN 3 administered calcium 600 mg with vitamin D 5 mcg to Resident 46, instead of calcium 600 mg with vitamin D 10 mcg as per the physician's order. - LVN 3 administered multivitamins with minerals and antioxidants to Resident 46, instead of multivitamin with minerals per the physician's order. - LVN 3 did not administer the correct dosage of the liquid medication to Resident 46 when it was spilled during the medication administration, and LVN 3 could not identify the medication. - LVN 3 did not administer the six medications separately, did not flush in between the medications, and LVN 3 could not identify the medications; - LVN 3 added the crushed baclofen medication without diluting it with water. - LVN 3 did not administer the correct dosage of the calcium medication when a residual was observed in the medication cup. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/21/25 at 1333 hours, an interview and concurrent medical record review for Residents 25 and 46 was conducted with the DON. The DON stated the nurses were expected to be competent in administering the oral medications and GT medications. The DON stated the medications administered should be given as per the physician's order and should be the correct dose. The DON also stated the LVN should have checked the resident's bowel movement before administering the docusate sodium medication. The DON stated the LVN should have asked the resident, if interviewable, and if the resident was not interviewable, the LVN should have checked the CNA task documentation for bowel movement. The DON stated the tablet had to be scored to cut it, if not, the LVN should have called the physician to get the appropriate dosage. 32179 3. Medical record review for Resident 120 was initiated on 4/15/25. Resident 120 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 120's Order Summary Report dated 4/16/25, showed the following physician's orders: - dated 11/19/24, to administer Dilantin (anticonvulsant) oral capsule 100 mg one capsule by mouth daily for epilepsy (seizures). - dated 8/16/24, to administer Eliquis oral tablet 5 mg (anticoagulant) one tablet by mouth twice a day for deep vein thrombosis. - dated 8/13/24, to administer Caltrate 600+D oral tablet 600-400 mg-unit (Calcium Carbonate-Vitamin D) one tablet by mouth twice a day as a supplement; give with food. - dated 8/16/24, to monitor for signs and symptoms of bleeding associated with Eliquis (including abnormal or unexplained bruising, petechiae, internal bleeding, nosebleeds, bleeding gums, hematuria, or melena). [NAME] as (+) YES or (-) NO. Notify the physician if (+). Review of Resident 120's bubble pack of Dilantin 100 mg tablet ER medication showed a label indicating do not chew or crush. On 4/16/25, multiple observations of a medication pass administration for Resident 120 was conducted with LVN 7. The following was observed: - At 0815 hours, LVN 7 administered one tablet of Caltrate 600 mg with Vitamin D 5 mcg medication to Resident 120. - At 0830 hours, LVN 7 administered one tablet of Eliquis 5 mg medication to Resident 120. LVN 7 did not assess or inquire whether Resident 120 exhibited any signs or symptoms of bleeding or bruising. - At 0840 hours, Resident 120 broke the calcium tablet to easily swallow the medication. LVN 7 administered one tablet of Dilantin 100 mg tablet ER medication to Resident 120. LVN 7 did not instruct Resident 120 to avoid chewing the medications. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/16/25 at 0955 hours, during an interview, LVN 7 was asked about providing patient education regarding extended-release medications. LVN 7 stated the extended-release medications should not be chewed and acknowledged not instructing Residents 120 to avoid chewing the medicine. LVN 7 was asked if she was aware of vitamin D was in calcium bottle. LVN 7 was not aware it was different dose from the physician's order. LVN 7 stated she would call the pharmacy to get the calcium 600 mg with vitamin D 400 mg medication. LVN 7 also verified he did not assess or asked the questions to the residents for any signs or symptoms of bleeding or bruising before administering Eliquis. LVN 7 verified the above findings. 4. Medical record review for Resident 28 was initiated on 4/15/25. Resident 28 was admitted to the facility on [DATE]. Review of Resident 28's Order Summary Report dated 4/16/25, showed an order dated 9/22/23, to administer dolcusate sodium (stool softener) oral capsule 250 mg one capsule by mouth twice a day for bowel management and to hold administration for loose stools. On 4/16/25 at 0925 hours, during an observation, LVN 9 administered one tablet of docusate sodium medication to Resident 28. However, LVN 9 did not assess whether Resident 28 had any loose bowel movements. On 4/16/25 at 0935 hours, during an interview, LVN 9 was asked whether she should have assessed the resident before administering the docusate sodium medication. LVN 9 stated she should have asked if the resident had any loose bowel movements and when the resident last had a bowel movement. LVN 9 verified the findings.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51352 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the staff implemented the proper storage, labeling, and disposal of medications and supplies in a safe manner. * The facility failed to ensure Treatment Cart 1 was free from expired treatment supplies. * The facility failed to ensure Medication Storage room [ROOM NUMBER] was free from staff's personal belongings. Additionally, Mediation Storage room [ROOM NUMBER] had transdermal (application of medication through the skin, usually via a patch) patches stored with the oral medications. * The facility failed to ensure the medication refrigerator in Medication Storage room [ROOM NUMBER] was maintained at the appropriate temperature. * The facility failed to ensure the artificial tears eyedrops (drops used to lubricate dry eyes) were not stored with the oral medications in Medication Storage room [ROOM NUMBER]. * The facility failed to ensure the antifungal cream was not stored with the oral medication sodium alendronate (medication used to increase bone density) and pantoprozole (used to treat gastroesophageal reflux disease (GERD), a condition where the acid in the stomach washes back up into the esophagus) suspension in Medication Cart A. * The facility failed to ensure the heparin sodium (medication to prevent blood clots) injection 5,000 USP per ml vials were not stored with the inhalant (delivered directly to the lungs via inhalation, offering targeted relief for respiratory conditions) medication in Medication Cart C. * The facility failed to ensure the bottle of fluticasone (used to treat a variety of respiratory conditions such as allergies and asthma) nasal spray was not stored with the inhalant medication in Medication Cart D. * The facility failed to ensure a discontinued antibiotic medication was not stored with the current medication inside Medication Cart B. * The facility failed to ensure Medication Cart A was not left unlocked and unattended. * The facility failed to ensure a white capsule medication was not found on Resident 104's bed. * The facility failed to ensure the desitin with 40% zinc oxide (cream use to treat and help prevent diaper rash and discomfort) cream was not kept at Resident 16's bedside table. * The facility failed to ensure the artificial tears eye drops solution was not kept at Resident 127's bedside. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	These failures had the potential to result in unsafe medication administration and cross-contamination of the medications. Findings: 1. On [DATE] at 1308 hours, an inspection of Treatment Cart 1 and concurrent interview was conducted with LVN 8. Treatment Cart 1 contained two culture swabs with an expiration date of [DATE]. LVN 8 verified the culture swabs were expired and the expired supplies should not be kept in any medication carts. 2. On [DATE] at 0917 hours, an inspection of Medication Storage room [ROOM NUMBER] and concurrent interview was conducted with RN 1. The following was observed: - Staff belongings under the sink which included two jackets and one insulated water bottle. - Transdermal patches stored with oral medications. RN 1 verified the above findings. RN 1 stated the staff should not store their personal belongings in the medication rooms, and he would have the personal belongings removed. RN 1 stated the transdermal medications should not be stored with the oral medications and he would reorganize the cabinet. 3. On [DATE] at 0920 hours, an inspection of Medication Storage room [ROOM NUMBER] and concurrent interview was conducted with LVN 16. The temperature reading for the medication refrigerator was 29 degrees F. LVN 16 verified the above findings and stated the acceptable temperature range for the medication refrigerator was 35 - 40 degrees F as per the temperature log posted on the front of the medication refrigerator. LVN 16 manually adjusted the temperature on the refrigerator and stated he would notify the maintenance of the refrigerator temperature being out of range. 4. On [DATE] at 0955 hours, an inspection of Medication Storage room [ROOM NUMBER] and concurrent interview was conducted with the Central Supply Manager. There were twelve bottles of artificial tears eyedrops were stored next to the oral medications. The Central Supply Manager verified the above findings. On [DATE] at 1000 hours, the DON joined the inspection of Medication Storage room [ROOM NUMBER] and verified the above findings. 5. On [DATE] at 1100 hours, an inspection of Medication Cart A and concurrent interview was conducted with LVN 8. There was one tube of ciclopirox 8% antifungal cream stored with the alendronate sodium tablets 70 mg and pantoprazole suspension liquid medication. LVN 8 verified the findings and stated the antifungal cream should not be stored with the oral medications. 6. On [DATE] at 1036 hours, an inspection of Medication Cart C and concurrent interview was conducted with LVN 6. One box of heparin sodium injection 5,000 USP per ml vials was stored with the inhalant medications. LVN 6 verified the findings and stated the injection medication should not be stored with the inhalant medications. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7. On [DATE] at 1100 hours, an inspection of Medication Cart D and concurrent interview was conducted with LVN 16. One bottle of fluticasone nasal spray was stored with the inhalant medication. LVN 16 verified the above findings. LVN 16 stated the nasal spray and inhalant medications should not be stored together and he would rearrange Medication Cart D. 39453 8. On [DATE] at 1357 hours, an inspection of Medication Cart B and concurrent interview and medical record review for Resident 63 was conducted with RN 1. Resident 63's vial of ceftriaxone (antibiotic) one gm was observed inside Medication Cart B. Medical record review for Resident 63 was initiated on [DATE]. Resident 63 was readmitted to the facility on [DATE]. Review of Resident 63's Order Summary Report showed a physician's order dated [DATE], to administer ceftriazone one gm via IV one time a day for six days, to be completed on [DATE]. RN 1 verified the above findings. RN 1 stated the ceftriaxone medication had already been completed and should be removed from Medication Cart B. 9. On [DATE] at 0814 hours, Medication Cart A was observed unlocked, unattended, and parked infront and facing Room D. Two CNAs were observed going inside Room D. On [DATE] at 0816 hours, an observation of Medication Cart A and concurrent interview was conducted with LVN 11. LVN 11 verified Medication Cart A was unlocked and unattended. 32179 10. Medical record review of Resident 104 was initiated on [DATE]. Resident 104 was admitted to the facility on [DATE]. Review of Resident 104's Admission/Readmission Data Tool dated [DATE], showed Resident 104 did not want to self-administer medications. Review of Resident 104's Order Summary Report dated [DATE], showed a physician order dated [DATE], for gabapentin (anticonvulsant) oral tablet 50 mg two tablets by mouth at bedtime. On [DATE] at 0745 hours, during an observation, a white capsule was found on Resident 104's bed. On [DATE] at 0900 hours, an observation and concurrent interview was conducted with LVN 7. LVN 7 verified the white capsule found on Resident 104's bed. LVN 7 stated she did not administer any white capsule to Resident 104 that morning. On [DATE] at 0910 hours, an interview and concurrent medical record review was conducted with LVN 7. LVN 7 identified the white capsule as gabapentin medication which was ordered to be administered at bedtime. LVN 7 stated the nurse should have ensured Resident 104 took the medication when handing it to them. LVN 7 verified the findings. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	49258 11. On [DATE] at 0941 hours, during the initial tour of the facility, Resident 16 was observed lying and sleeping in bed. An unlabeled container of desitin cream with 40% zinc oxide 16 oz was observed at Resident 16's nightstand table. The cream container was observed with hardened white residue around the white container and on the purple cover. Medical record review for Resident 16 was initiated on [DATE]. Resident 16 was admitted to the facility on [DATE]. Review of Resident 16's MDS assessment dated [DATE], showed Resident 16 had severe cognitive impairment. Review of Resident 16's Order Summary Report showed a physician's order dated [DATE], to wash bilateral buttocks MASD with soap and warm water, pat dry, apply zinc oxide ointment, and leave open to air as needed. On [DATE] at 1040 hours, during an observation, Resident 16 was awake but when asked questions, Resident 16 did not reply but opened her eyes and tried to cover her face with both hands. The same container of desitin with 40% zinc oxide cream was still observed at Resident 16's nightstand table. On [DATE] at 1108 hours, an observation and concurrent interview for Resident 16 was conducted with LVN 8. LVN 8 verified the unlabeled container of desitin cream with 40% zinc oxide 16 oz was observed at Resident 16's nightstand table. LVN 8 stated any cream being applied to resident with zinc oxide should not be left at the resident's bedside. LVN 8 stated it must be used by the hospice staff who were visiting Resident 16. LVN 8 further stated the facility used a cream with zinc oxide in a tube container for the residents. However, LVN 8's medication cart did not have the cream with zinc oxide which was being used for Resident 16. On [DATE] at 1010 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings for Resident 16. 48332 12. Review of facility's P&P titled Medication Labeling and Storage revised ,d+[DATE] showed the facility stores all the medications and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing medications and biologicals are locked when not in use, and trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others. During the initial tour of the facility on [DATE] at 0941 hours, Resident 127 was observed sitting at the edge of her bed, alert and fully awake. There was a box of artificial tears eye drops on top of the bedside table along with other resident's personal belongings. Resident 127 stated the box had been there for quite some time. Resident 127 stated the nurses knew it was there and gave the eye dropts to the resident. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 1059 hours, an observation of Resident 127's room and concurrent interview was conducted with LVN 6. LVN 6 verified the finding and stated the box of the tear drops should not be on placed on the resident's bedside table. Medical record review for Resident 127 was initiated on [DATE]. Resident 127 was admitted to the facility on [DATE]. Review of Resident 127's Order Summary Report dated [DATE], showed order dated [DATE], for Artificial tears Ophthalmic (eye) solution (Artificial Tear Solution) instill one drop in both eyes one time a day for dry eyes.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 51352 Based on observation, interview, and facility document review, the facility failed to ensure the cooks followed the proper procedure for the preparation of the pureed food. This failure had the risk for an inconsistent pureed product and the potential to not meet the nutritional needs of the 16 residents who received a pureed diet. Findings: 1. Review of the facility's document titled Mandarin Chicken Method (undated) showed the recipe process for 103 servings with a #6 scoop as follows: 1. Preheat grill to 350 degrees F. 2. Spray boneless chicken with vegetable spray and grill the chicken 5 to 6 minutes on each side. Internal temperature of chicken breast must register at 165 degrees F for 15 seconds at completion of cooking time. 3. Cut the chicken into bite sized pieces using sanitized equipment. Cover and set aside. 4. Combine the sugar, soy sauce, orange juice base, oil, garlic and ginger in a saucepan. 5. Heat over medium heat until sugar is dissolved, stirring often. Bring to a boil. 6. Combine the cornstarch and water; add to the sauce, stirring often. Reduce heat and simmer four to six minutes, or until sauce thickens. 7. Pour the chicken into a large skillet over medium heat. Heat chicken until it sizzles, then reduce heat and pour the sauce over the chicken. Heat through. 8. Remove and serve with a #6 scoop. Review of the facility's document titled Mandarin Chicken (undated) showed for 15 servings with #6 scoop, Ingredients: Mandarin Chicken 2 quarts and 3 1/4 cup, Thickener 3/4 cup, Water, hot 3 3/4 cup. Method: for pureed diets place portions of meat needed into a food processor. Process to a fine texture. Prepare a slurry with thickener and hot liquid. Mix well with a wire whip. Add half of the slurry to the chicken. Process for one minute; if too dry, add more slurry until meat is pudding consistency. Reheat to 165 degrees F and serve with a #6 scoop. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/16/25 at 1043 hours, a concurrent observation of the puree preparation for mandarin chicken with Cooks 1 and 2, and concurrent interview was conducted with [NAME] 1. [NAME] 1 was observed measuring two quarts and three 1/4 cups of boiled chicken into a steam table pan. [NAME] 1 stated he needed to make the mandarin sauce for the chicken. [NAME] 1 stated [NAME] 2 would begin the process for the pureed mandarin chicken. [NAME] 2 added the two quarts and three 1/4 cups plain boiled chicken to the RC (Robot Coupe, a device used to puree food) followed by 3 3/4 cup hot water. The mixture was blended. [NAME] 2 added 3/4 cup of thickener to the RC and blended the mixture for an unspecified amount of time. [NAME] 2 stated the chicken mixture was the appropriate consistency as it was thick like mashed potatoes and able to hold its shape. On 4/16/25 at 1336 hours, a test tray tasting was conducted with the DTR. The regular texture mandarin chicken tasted moist, tender, and sweet. The pureed mandarin chicken tasted bland. The DTR verified the pureed mandarin chicken did not have the same flavor as the regular texture mandarin chicken. On 4/17/25 at 1021 hours, an interview was conducted with the RD. The RD verified all recipes should be followed. 2. Review of the facility's document titled P (puree) Roasted Cauliflower (undated) showed the recipe for pureed roasted cauliflower for 16 servings with #16 scoop. Ingredients: Roasted cauliflower 2 quarts, thickener food/tbsp (tablespoon) powder 1/2 cup and 1 5/8 tablespoons, water, hot 1/4 cup and 2 1/2 tablespoons. Method: 1. Place portions needed from regular prepared recipe into a food processor. Process to a fine texture. 2. Add thickener and hot liquid. Process until smooth. 3. With a rubber spatula, scrape down sides of the bowl; reprocess 30 seconds. If product is too thick - add 1 tbsp hot liquid at a time and re-process. If finished pureed product is too thick, add (at the facilities discretion due to nutritional changes that can occur), warm water, broth, milk, or reserved cooking liquid, 1 tbsp at a time and process until product is smooth and passes the IDDSI (International Dysphagia Diet Standard Initiative - used to describe the characteristics of food and drinks) tests. Adding extra liquid or thickener can increase the end product volume and alter the nutrition content. On 4/16/25 at 1102 hours, an observation of the puree preparation for roasted cauliflower and concurrent interview was conducted with [NAME] 2. [NAME] 2 added two quarts of the roasted cauliflower to the RC. [NAME] 2 added 1/4 cup water and two and 1/2 tablespoons of thickener to the roasted cauliflower and blended the mixture. [NAME] 2 stated the mixture was too thick and added one tablespoon of warm water and blended the cauliflower mixture. [NAME] 2 stated the mixture was still too thick. [NAME] 2 added one additional tablespoon of warm water and blended the cauliflower mixture. [NAME] 2 stated the roasted cauliflower puree was still too thick. [NAME] 2 was asked to read the instructions on the pureed roasted cauliflower recipe. [NAME] 2 verified he read the quantity of ingredients that could be added; however, he did not follow the instructions on the recipe which stated to blend the roasted cauliflower before determining if liquid or thickener should have been added. [NAME] 2 stated he would restart the puree process for the roasted cauliflower. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/16/25 at 1141 hours, a second observation of the puree preparation for roasted cauliflower and concurrent interview was conducted with [NAME] 2. [NAME] 2 added two quarts of roasted cauliflower to the RC and blended the roasted cauliflower. [NAME] 2 added 1/4 cup of water and blended the mixture. [NAME] 2 stated the mixture was too thick. [NAME] 2 added 1/2 cup of water to the RC and blended the cauliflower mixture. [NAME] 2 stated the mixture was too thick. [NAME] 2 added an additional 1/2 cup of water to the RC two additional times and blended the mixture after adding each 1/2 cup of water. [NAME] 2 stated the mixture was too thick. [NAME] 2 added 2/3 cup of water to the RC and blended the mixture. [NAME] 2 stated the roasted cauliflower puree was at the appropriate consistency. On 4/16/25 at 1336 hours, a test tray tasting was conducted with the DTR. The regular texture mandarin chicken tasted moist, tender, and sweet. The pureed chicken tasted bland. The DTR verified the pureed chicken did not have the same flavor as the regular texture mandarin chicken. On 4/17/25 at 1021 hours, an interview was conducted with the RD. The RD verified all recipes should be followed.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 51352 Based on observation, interview, facility document and facility P&P review, the facility failed to ensure the food safety and sanitation guidelines were followed when: - The cool down process for TCS food was not monitored. - Hand washing was not performed by two of three cooks (Cooks 1 and 2). - The food preparation surfaces were not sanitized properly. - The kitchen floor was not in a cleanable condition. - One of two food preparation sinks did not have an air gap. - The kitchen equipment was not kept in clean condition. - The goods in the dry storage were not stored to prevent for possible pest contamination. - Two of four Dietary Aides (Diaetary Aides 2 and 3) wore large false eyelashes during the food preparation. These failures posed the risk for food borne illness in a highly susceptible resident population of 156 facility residents who received food prepared in the kitchen. Findings: Review of the facility matrix dated 4/15/25, showed 156 of 164 residents consumed the food prepared in the kitchen. 1. According to the USDA Food Code 2022, Section 3-501.14 (A) Cooked time/temperature control for safety food shall be cooled: (1) Within two hours from 57 C (135 F) to 21 C (70 F) and (2) Within a total of six hours from 57 C (135 F) to 5 C (41 F) or less. According to the USDA document titled Refrigerator & Freezer Storage Chart dated 3/2018 showed the recommended time limits to keep refrigerated food to prevent spoilage. The time limit for storing cooked meat and meat dishes in the refrigerator is three to four days. The time limit for storing opened packages of hot dogs in the refrigerator is one week. The time limit for storing gravy in the refrigerator is one to two days. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's P&P titled Food Preparation and Service revised 11/2022 showed TCS foods include ground beef, poultry, chicken, seafood, cut melon, unpasteurized eggs, milk, yogurt, and cottage cheese. The danger zone for food temperatures is above 41 degrees F and below 135 degrees F. This temperatures range promotes the rapid growth of pathogenic (disease causing) microorganisms that cause foodborne illness. Potentially hazardous foods held in the danger zone for more than four hours (if being prepared from ingredients at room temperature) or six hours (if cooked and then cooled) may cause food borne illness. The previously cooked food is reheated to an internal temperature of 165 degrees F for at least 15 seconds before holding for hot service. Reheated foods that are not consumed within two hours are discarded. a. During the initial tour of the kitchen with the DTR on 4/15/25 at 0810 hours, the following previously cooked foods were observed in the walk-in refrigerator 5 with date labeled as follows: - Baked chicken, dated 4/14/25, - Pork, dated 4/14/25, - Hot dogs, dated 4/14/25, - Mac and cheese, undated, - Spaghetti sauce, dated 4/13/25, - Mushroom gravy, dated 4/8/25, - Chicken tenders, dated 4/14/25, - [NAME] dressing, dated 4/14/25, and - Ground pork, dated 4/14/25. The DTR stated the above food items were previously cooked for the residents' meals and kept for future meal substitutions. When asked how long the previously cooked food was good for, the DTR stated the previously cooked food could be kept for seven days. On 4/17/25 at 0905 hours, a review of the cooling log and concurrent interview was conducted with the DTR. The cooling log failed to show documentation of the cool down process for the previously cooked food. The DTR verified the previously cooked food was not documented on the cool down log. On 4/17/25 at 1021 hours, an interview was conducted with the RD. The RD verified the TCS foods cooked and cooled should be monitored on the cooling log. b. According to the USDA Food Code 2022 Section 3-501.14 Cooling (B) Time/temperature control for safety food shall be cooled within 4 hours to 41 degrees F or less if prepared from ingredients at ambient temperature, such as canned tuna. Review of the facility's document titled Week-At-A-Glance dated 2025 for Spring showed the tuna salad sandwiches and egg salad sandwiches were served for dinner on week one. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/17/25 at 0905 hours, an interview was conducted with [NAME] 1. When asked about the procedure for monitoring the cooling process of the TCS foods prepared at the room temperature, [NAME] 1 stated the facility did not monitor the cooling of ambient temperature foods such as tuna salad. On 4/17/25 at 0905 hours, a review of the cooling log and concurrent interview was conducted with the DTR. The cooling log failed to show documentation of the cool down process for ambient temperature foods. 2. According to the USDA Food Code 2022, Section 2-301.14, Food employees shall clean their hands and exposed portions of their arms as specified under section 2-301.12 immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and: (E) After handling soiled equipment or utensils; (F) During food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; and (I) After engaging in other activities that contaminate the hands. On 4/16/25 at 1053 hours, [NAME] 1 was observed preparing food for lunch. [NAME] 1 went to the dry storage room and returned with soy sauce and seasonings without washing his hands. After returning to the food preparation area, [NAME] 1 touched his pants, cooking utensils, and the counter; and continued food preparation without washing his hands. On 4/16/25 at 1105 hours, during the pureed food preparation observation, [NAME] 2 picked up the utensils from the floor and continued the pureed food preparation without washing his hands. During the pureed food preparation, [NAME] 2 left the food preparation area multiple times to wash the RC parts and continued food the pureed food preparation without washing his hands. On 4/17/25 at 1021 hours, an interview was conducted with the RD. The RD verified the staff must wash their hands when changing tasks and after picking items up off the floor. 3. According to the USDA Food Code 2022, Section 3-304.14 (B) (1), cloths in-use for wiping counters and other equipment surfaces shall be held between uses in a chemical sanitizer solution at a concentration specified under 4-501.114 and laundered daily as specified under 4-802.11. Review of the facility's P&P titled Sanitization, revised 11/2022 showed the service area wiping cloths are cleaned and dried or placed in a chemical sanitizing solution of appropriate concentration. Review of the facility's sanitizing solution showed the product was an effective food contact sanitizer at 200 ppm (parts per million) on hard, non-porous surfaces. Review of the facility document titled 3-Compartment Sink Sanitizer Log dated 4/2025 showed the sanitizing solution concentration was checked twice a day at 0730 hours and 1130 hours. On 4/16/25 at 1130 hours, the sanitizing solution concentration was documented on the log as 200 ppm. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/16/25 at 1451 hours, during an interview, Dietary Aide 4 was asked to describe the manual dishwashing process. Dietary Aide 4 stated the first sink was filled with hot water and soap to wash the dishes. Dietary Aide 4 stated the second sink was filled with clean water for rinsing and the third sink was filled with cold water and sanitizer. Dietary Aide 4 was asked to demonstrate the process for checking the concentration of the sanitizing solution in the third sink. The test strip showed the sanitizer solution concentration was 100 ppm. Dietary Aide 4 stated the effective concentration for the sanitizing solution was 200 ppm. Dietary Aide 4 verified the sanitizing solution in the third sink was not the correct concentration. On 4/17/25 at 0855 hours, an observation and concurrent interview was conducted with Dietary Aide 1. Dietary Aide 1 was asked to test the sanitization solution located on the bottom shelf of the food preparation area. The test strip showed the sanitizer solution concentration was 100 ppm. Dietary Aide 1 stated the effective concentration for the sanitizing solution was 200 ppm. Dietary Aide 1 verified the current bucket of sanitizing solution was not the correct concentration. On 4/17/25 at 0858 hours, an interview was conducted with the DTR. The DTR verified the effective concentration of the sanitization solution was 200 ppm. The DTR obtained a new container of sanitizing solution test strips and retested the solution. The strip read 100 ppm. The DTR tested the second bucket containing the sanitizing solution and the test strip read 100 ppm. The DTR verified the findings and stated the chemical company had informed her that the solution must run through the tubing for a few seconds to reach the correct concentration. The DTR stated she would in-service her staff. The DTR stated the kitchen staff should inform the DTR if the sanitation solution was not at the effective concentration. On 4/17/25 at 1021 hours, an interview was conducted with the RD. The RD confirmed the kitchen staff should inform the DTR if the sanitizer concentration was below 200 ppm. 4. According to the USDA Food Code 2022 Annex 3 Section 4-201.11, Equipment and Utensils showed the equipment and utensils must be designed and constructed to be durable and capable of retaining their original characteristics so that such items can continue to fulfill their intended purpose for the duration of their life expectancy and to maintain their easy cleanability. If they cannot maintain their original characteristics, they may become difficult to clean, allowing for the harborage of pathogenic microorganisms, insects, and rodents. During the initial tour of the kitchen on 4/15/25 at 0810 hours, an observation of the kitchen floor was conducted. The floor surface in front of reach-in freezer four was approximately five feet by five feet of concrete with spots of worn off red paint. On 4/16/25 at 0932 hours, an observation and concurrent interview was conducted with the DTR. The DTR verified the flooring in front of reach-in freezer four was concrete. The DTR stated the maintenance was aware the floor surface was unfinished. On 4/17/25 at 0834 hours, an observation and concurrent interview was conducted with the Maintenance Director. The Maintenance Director verified the flooring in front of the reach-in freezer four was unfinished concrete. The Maintenance Director stated the flooring was once painted red and the paint had worn off. The Maintenance Director stated the flooring had been as observed for many years and he was unaware the unfinished concrete was an uncleanable surface. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seal Beach Health and Rehabilitation Center	3000 N Gate Road Seal Beach, CA 90740

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. According to the USDA Food Code 2022 Section 5-402.11 Backflow Prevention, (A) Except as specified in (B), (C), and (D) of this section, a direct connection may not exist between the sewage system and a drain originating from equipment in which food, portable equipment, or utensils are placed. During the initial tour of the kitchen with the DTR on 4/15/25 at 0810 hours, the drainpipe of the two-basin food preparation sink was observed to be plumbed directly to facility main drain. The DTR verified the sink was used for food preparation. On 4/15/25 at 0914 hours, an observation of the two-basin food preparation sink was conducted with the Maintenance Director. The Maintenance Director verified the two-basin food preparation sink had no air gap. 6. According to the USDA Food Code 2022 Section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils (C) Nonfood contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue and other debris. a. During the initial tour of the kitchen with the DTR on 4/15/25 at 0810 hours, a drying rack for meal trays was observed excessively worn with exposed rusted metal. The DTR verified the material on the drying rack worn out quickly and the metal was exposed and rusty. The DTR verified the drying rack was not clean. b. On 4/16/25 at 0917 hours, an observation of the dishwashing room was conducted. A drying rack for meal trays was observed with rusted metal and more than 10 trays on the drying rack were chipped and cracked. On 4/15/25 at 0932 hours, an observation of the drying rack in the dishwashing room and concurrent interview was conducted with the DTR. The DTR stated the meal trays on the drying rack were used for resident meals. The DTR verified the drying rack had rust and more than 10 meal trays on the rack were chipped and cracked. The DTR verified the drying rack was not clean. The DTR stated the damaged trays should not be used for the residents' meals. 7. According to the USDA Food Code 2022 Annex 3 Section 4-201.11, Equipment and Utensils showed the equipment and utensils must be designed and constructed to be durable and capable of retaining their original characteristics so that such items can continue to fulfill their intended purpose for the duration of their life expectancy and to maintain their easy cleanability. If they cannot maintain their original characteristics, they may become difficult to clean, allowing for the harborage of pathogenic microorganisms, insects, and rodents. During the initial tour of the kitchen with the DTR on 4/15/25 at 0810 hours, a container of pinto beans was observed with a cracked lid in the dry food storage area. The DTR verified the lid on the container was cracked. 8. According to ServSafe, a food safety training and certification program, recommends against wearing false eyelashes in food production environments due to the risk of them falling into the food and becoming a physical contaminant. This is because false eyelashes can detach and become a potential hazard (https://www.servsafe.com/). (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the tray line observation on 4/16/25 at 1208 hours, Dietary Aides 2 and 3 were observed working on the resident meal tray line wearing large false eyelashes. On 4/17/25 at 1021 hours, an interview was conducted with the RD. The RD stated she did not believe the false eyelashes could be a source of physical contamination because they were glued on the eyelid.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453 Based on interview, medical record review, and facility P&P review, the facility failed to ensure the medical records were complete and accurately maintained for two of 32 final sampled residents (Residents 19 and 37) and four of five sampled residents reviewed for closed records (Residents 54, 139, and 680). * The facility failed to ensure a copy of Resident 19's current POLST form was uploaded in the resident's electronic health record and voided the resident's previous POLST form. * The facility failed to ensure the CNA documentation for turning and repositioning and personal hygiene were completed for Residents 37, 54, 139, and 680. These failures posed of the residents not provided with accurate care and treatment since their medical record information was inaccurate and incomplete. Findings: 1. Review of the facility's P&P titled POLST (undated) showed the following: - The most current POLST in its original formal should be the first page of the medical record; - A fully executed, dated copy of the POLST, marked COPY, should be retained in the medical record in the advance directive or legal section of the medical record. This copy should be on pulsar pink paper stock so it is readily recognizable when and if the current original is transferred with the resident; and - All voided versions of the POLST, clearly marked VOID, will be retained in the medical record. Medical record review for Resident 19 was initiated on [DATE]. Resident 19 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 19's POLST form dated [DATE], showed to perform CPR or attempt resuscitation to Resident 19. Review of Resident 19's Order Summary Report showed a physician's order dated [DATE], showing Resident 19's code status as DNR. On [DATE] at 0906 hours, an interview and concurrent medical record review for Resident 19 was conducted with RN 1. When asked what Resident 19's code status was, RN 1 reviewed Resident 19's POLST form dated [DATE], and stated Resident 19 was a full code. RN 1 was informed of the physician's order for DNR code status. RN 1 stated he would follow the physician's order for the DNR code status. RN 1 was observed looking in Resident 19's hospice binder, and showed another POLST form. Review of Resident 19's POLST form dated [DATE], showed Resident 19's code status was DNR. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RN 1 verified the above findings. RN 1 verified the copy of previous POLST form dated [DATE], showing Resident 19's full code status was still in Resident 19's electronic health record and was not voided. On [DATE] at 1355 hours, an interview and concurrent medical record review for Resident 19 was conducted with the Medical Records Director. The Medical Records Director stated all resident medical records were uploaded to the PCC. The Medical Records Director stated the facility also have a separate binder to keep all original POLST forms. The Medical Records Director stated a copy of POLST form dated [DATE], was kept in the hospice binder, because she was waiting for the original POLST form from the hospice agency. When asked why the copy of the current POLST form was not uploaded to the PCC, the Medical Records Director stated she was not able to get to the binder yet. 2. Closed medical record review for Resident 139 was initiated on [DATE]. Resident 139 was initially admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 139's MDS assessment dated [DATE], showed Resident 139 had severe cognitive impairment and was dependent to the facility staff for all the ADL care. Review of Resident 139's Documentation Survey Report v2 for March and [DATE] showed the following: - For the oral hygiene, there were missing entries on ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], and [DATE] for the 1500 to 2300 hours shift; - For the personal hygiene, there were missing entries on ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE] and [DATE] for the 2300 to 0700 hours shift, and on ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], and [DATE], for the 1500 to 2300 hours shift; and - For the turning and repositioning, there were missing entries on ,d+[DATE], ,d+[DATE], ,d+[DATE], , d+[DATE] and [DATE], for the 2300 to 0700 hours shift; and on ,d+[DATE], ,d+[DATE], ,d+[DATE], and [DATE], for the 1500 to 2300 hours shift. 3. Medical record review for Resident 37 was initiated on [DATE]. Resident 37 was readmitted on [DATE]. Review of Resident 37's MDS assessment dated [DATE], showed Resident 37 had severe cognitive impairment, and was dependent to the facility staff for all the ADL care. Review of Resident 139's Documentation Survey Report v2 for March and [DATE] showed the following: - For the oral hygiene, there were missing entries on ,d+[DATE] and [DATE], for the 1500 to 2300 hours shift; - For the personal hygiene, there were missing entries on ,d+[DATE] and [DATE], for the 2300 to 0700 hours shift, and on ,d+[DATE] and [DATE], for the 1500 to 2300 hours shift; and - For the turning and repositioning, there were missing entries ,d+[DATE] and [DATE], for the 2300 to 0700 hours shift, and on ,d+[DATE] and [DATE], for the 1500 to 2300 hours shift. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 1426 hours, an interview and concurrent medical record review for Residents 37 and 139 was conducted with the DON. The DON verified the missing entries on Resident 37 and 139's documentation for the oral hygiene, personal hygiene, and turning and repositioning by the CNAs. The DON stated the CNAs were supposed to document at the end of their shifts. 32179 4. Review of the facility's P&P titled Charting and Documentation dated ,d+[DATE] showed documentation of procedures and treatmnet will include carespecific details, including: a. The dated and time the procedure or treatment was provided b. The name and title of the individuals who provided the care. c. The assessment data and or any unsual findings obtained during procedure or treatment. d. How the resident tolerated the procedure or treatment. e. whether the resident refused the procedure or treatment. f. Notification of family, phsycian or other staff if indicated and g. The signature and title of the individual documenting. Closed medical record review of Resident 54 was initiated on [DATE]. Resident 54 was admitted to the facility on [DATE]. Review of Resident 54's Documentation Survey Report V2 dated [DATE] showed the following entries: - For the oral hygiene, there were missing entries on ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], , d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], and [DATE], for the 0700 to 1500 hours shift; and , d+[DATE] and [DATE], for the 1500 to 2300 hours shift. - For the personal hygiene, there were missing entries on ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], , d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], and [DATE], for the 0700 to 1500 hours shift; , d+[DATE] and [DATE], for the 1500 to 2300 hour shift; and ,d+[DATE] and [DATE], for the 2300 to 0700 hours shift. - For the toileting hygiene, there were missing entries on ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], , d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], and [DATE], for the 0700 to 1500 hours shift; , d+[DATE] and [DATE], for the ,d+[DATE] hour shift; and ,d+[DATE] and [DATE], for the 2300 to 0700 hours shift. - For the pressure reducing, there were missing entries on ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], , d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], and [DATE] for the 0700 to 1500 hours shift; , d+[DATE] and [DATE], for the 1500 to 2300 hour shift; and ,d+[DATE] and [DATE], for the 2300 to 0700 hours shift. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- For the turning and repositioning, there were missing entries on ,d+[DATE], ,d+[DATE], ,d+[DATE], , d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], and [DATE], for the 0700 to 1500 hours shift; ,d+[DATE] and [DATE], for the 1500 to 2300 hour shift; and ,d+[DATE] and [DATE], for the 2300 to 0700 hours shift. Review of Resident 54's Documentation Survey Report V2 dated [DATE] showed the following entries: - For the oral hygiene, it was coded as 97 (not applicable) on [DATE], for the 0700 to 1500 hours and 1500 to 2300 hours shifts. In addition, there was a missing entry on [DATE], for the 0700 to 1500 hours shift. - For the personal hygiene, it was coded as 97 on [DATE], for the 1500 to 2300 and 0700 to 1500 hours shifts; and ,d+[DATE] and [DATE], for the ,d+[DATE] hours shifts. It was left blank on [DATE], for the 0700 to 1500 hours shift. - For the toileting hygiene, it was coded as 97 on [DATE], for the 2300 to 0700 hours, 1500 to 2300 hours, and 0700 to 1500 hours shifts; and [DATE], for the 2300 to 0700 hours and 1500 to 2300 hours shifts. It was left blank on [DATE], for the 0700 to 1500 hours shift. - For the pressure reducing, it was coded as 97 on [DATE], for the 2300 to 0700 hours and 0700 to 1500 hours shifts; [DATE], for the 0700 to 1500 hours shift; and [DATE], for the 0700 to 1500 hours shift. It was left blank on [DATE], for the 0700 to 1500 hours shift. - For the turning and repositioning, it was coded as 97 on [DATE], for the 1500 to 2300 hours and 0700 to 1500 hours shifts. It was left blank on [DATE], for the 0700 to 1500 hours shift. On [DATE] at 0800 hours, an interview and concurrent medical record review was conducted with the ADON regarding the above missing entries for March and [DATE]. The ADON stated the staff should have documented whether they completed the task for the resident. The documentation should either specify the type of assistance provided for ADL care or indicate that the resident refused the assistance. Coding the task as 97 was incorrect, and leaving it blank could indicate that the task was not completed. The ADON verified the findings. 48332 5. Closed medical record review for Resident 680 was initiated on [DATE]. Resident 680 was admitted to the facility on [DATE], and transferred to the acute hospital on [DATE]. Review of Resident 680's Documentation Survey Report for February 2025 showed the following entries: - For turning and repositioning, there were missing entries on ,d+[DATE] and [DATE], for the ,d+[DATE] shift; [DATE], for the ,d+[DATE] hours shift; and ,d+[DATE], ,d+[DATE], ,d+[DATE] and [DATE], for the ,d+[DATE] hours shift. On [DATE] at 1430 hours, an interview and concurrent medical record review for Resident 680 was conducted with the DON. The DON verified the above findings. The DON verified there were multiple days and shifts the turning and repositioning was not documented.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32179 Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure one of two final sampled residents (Resident 163) reviewed for hospice services received the necessary care and services. * The facility failed to ensure the hospice visit calendar and the physician certification of terminal illness were available in Resident 163's medical record. Additionally, the facility failed to ensure the staff knew who the hospice coordinator was. These failures posed the risk of delayed communication and provision of hospice care between the hospice provider and the facility. Findings: Medical record review for Resident 163 was initiated on 4/14/25. Resident 163 had been admitted to the facility on [DATE]. Review of the facility's P&P titled Palliative/End of life Car dated 3/2018 showed the assessment will include at least documentation of disease status including diagnosis and prognosis, documentation of comorbid medical and or psychiatric condition, functional status, strengths, concerns, goals and values of the resident and family, preferences and documentation for the end of life decisions and care and appropriateness of hospice referral. Review of Resident 163's Order Summary Report dated 4/9/25, showed a physician's order to admit Resident 163 to the facility under Hospice Provider A. Review of Resident 163's hospice binder failed to show the hospice staff's scheduled visits for April 2025 on the calendar. On 4/17/25 at 0920 hours, an interview and concurrent medical record review was conducted with LVN 7. LVN 7 was asked about the licensed nurse, social worker, and HA visits scheduled for April 2025 as well as the designated hospice coordinator. LVN 7 stated she was unsure and mentioned she would contact the hospice provider directly. LVN 7 also confirmed there was no designated hospice coordinator. On 4/17/5 at 0945 hours, an interview and concurrent medical record review were conducted with LVN 10. LVN 10 was asked if she knew whether the hospice had visited regarding the resident's air-loss mattress. LVN 10 stated she did not know whether they had visited on 4/14/25, when she called them or the following day. LVN 10 reviewed the hospice staff sign-in sheet, which confirmed a visit had taken place. LVN 10 stated the hospice nurse did not notify her with an update regarding the air-loss mattress request. LVN 10 also stated if she had an issue regarding hospice care, she would communicate with the QA Nurse, as the QA Nurse was the hospice coordinator. LVN 10 verified the findings. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/17/25 at 1430 hours, an interview and concurrent medical record review was conducted with LVN 13. LVN 13 was also unsure about Resident 163's hospice visit frequencies for April 2025. LVN 13 stated the hospice typically placed the calendar in the hospice binder, but the calendar for April was not available. LVN 13 also identified the social service department as the hospice coordinator. When asked about the physician's certification for hospice benefits, LVN 13 was unable to provide the documentation and verified the findings. On 4/22/25 at 1300 hours, an interview was conducted with the DON. The DON stated the hospice coordinator was the social worker. The DON acknowledged the above findings.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49258 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to maintain the infection control program and practices to help prevent the development and transmission of diseases and infections. * The facility failed to ensure the staff who had direct resident care were restricted from working while having symptoms of COVID-19 and the COVID-19 test result was still pending. * The washing machine used for the residents' laundry was not maintained to ensure a clean equipment, free from potential contamination. * The facility failed to ensure EBP were followed for Resident 37 when performing the GT site care. * The facility failed to ensure Resident 154 was on EBP. * The facility failed to ensure Resident 129's lunch tray was not put on the bedside table next to the used urinal. These failures posed the risk for not controlling the transmission of communicable diseases to other residents and employees throughout the facility. Findings: Review of the facility's P&P titled Policies and Practices - Infection Control revised 10/2018 showed the facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections. The Policy Interpretation and Implementation section showed the facility would maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public. 1. Review of the facility's P&P titled Coronavirus Disease (COVID-19) - Work Restriction and Return to Work Criteria for Staff revised 1/2025 showed staff who have symptoms of COVID-19 or have tested positive for SARS-CoV-2 (the virus that causes COVID-19 disease) infection follow the CDC guidelines and facility's policy for work restrictions and return to work criteria. The Work Restrictions for Staff with Symptoms of COVID-19 section showed symptomatic staff are restricted from work pending the results of the testing. The Return to Work Criteria for HCP (health care personnel) with Suspected or Confirmed Respiratory Viral Infection including SARS-CoV-2 Infection section showed: - The HCP with suspected or confirmed respiratory infection, including SARS-CoV-2, regardless of whether testing is performed, should not return to work until at least three days have passed since symptom onset and at least 24 hours have passed with no fever (without use of fever-reducing medicines), symptoms are improving, and they feel enough to return to work; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- If testing is performed that renders a positive result, but the individual is asymptomatic throughout their infection, HCP should not return to work until at least three days have passed since their first positive test; and - Where the first day of symptoms is day zero, making the first possible day of return to work on day 4. According to the website of CDC COVID-19, Symptoms of COVID-19 dated 3/10/25, showed the following list of possible symptoms of COVID-19: - fever or chills; - cough; - shortness of breath or difficulty breathing; - sore throat; - congestion or runny nose; - new loss of taste or smell; - fatigue; - muscle or body aches; - headache; - nausea or vomiting; and/or - diarrhea. The following list does not include all possible symptoms. Symptoms may change with new COVID-19 variants and can vary depending on vaccination status. The CDC will continue to update the list as we learn more about COVID-19. The Feeling Sick section showed to stay home and away from others (including people we live with who are not sick) if having symptoms that are not better explained by another cause. Medical record review for Resident 62 was initiated on 4/16/25. Resident 62 was admitted to the facility on [DATE]. Review of Resident 62's SARS-CoV-2 PCR Test collected on 3/31/25, showed the virus was detected, meaning the resident was positive for COVID-19. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seal Beach Health and Rehabilitation Center	3000 N Gate Road Seal Beach, CA 90740

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 62's eInteract Change in Condition Evaluation - V5.1 dated 4/1/25 at 1010 hours, showed Resident 62 was noted to have hypoxia with oxygen saturation level of 80% on room air. Resident 62 was provided with oxygen at 4 liters per minute and the oxygen saturation level went up to 95%. Resident 62 was transferred to the acute care hospital as per the physician's order. Resident 62 was discharged from the facility on 4/1/25. Medical record review for Resident 147 was initiated on 4/16/25. Resident 147 was admitted to the facility on [DATE]. Review of Resident 147's eInteract Change in Condition Evaluation - V5.1 dated 4/1/25 at 1639 hours, showed Resident 147 had a positive PCR COVID test. The physician was notified and had ordered to monitor Resident 147 of signs and symptoms of COVID-19 every shift for 14 days and report to the physician. Further review of Resident 147's medical record showed Resident 147 was discharged from the facility to home on 4/11/25. Review of the personnel record for CNA 5 was initiated on 4/16/25. Review of CNA 5's SARS-CoV-2 PCR Test collected on 3/31/25, showed the virus was detected. Further review of CNA 5's SARS-CoV-2 PCR Test result showed the result was reported on 4/1/25 at 0456 hours. Review of the facility's CNA Staffing Assignment and Sign-In Sheet showed CNA 5 worked on 3/27, 3/28, 3/29, 3/30, 3/31, and 4/1/25, from 0700 to 1530 hours. Further review of the CNA Staffing Assignment and Sign-In Sheet showed CNA 5 was assigned to Residents 62 and 147 on 3/28 and 3/31/25. Review of the personnel record for LVN 7 was initiated on 4/16/25. Review of LVN 7's SARS-CoV-2 PCR Test collected on 3/31/25, showed the virus was detected. Further review of LVN 7's SARS-CoV-2 PCR Test result showed the result was reported on 4/1/25 at 0456 hours. Review of the facility's Staffing Assignment and Sign-In Sheet showed LVN 7 worked on 3/28, 3/29, 3/30, and 3/31/25, from 0700 to 1530 hours. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/16/25 at 1324 hours, an interview was conducted with CNA 5. CNA 5 verified she worked on 3/27, 3/28, 3/29, 3/30, 3/31, and 4/1/25, from 0700 to 1530 hours. CNA 5 stated she was having sneezing, headache, watery eyes, and back pain since 3/27/25, but she thought it was related to her allergies and monthly menstrual period. CNA 5 stated DSD 2 was informed of her symptoms on 3/31/25, after noon time. CNA 5 stated on the day of 3/31/25, the facility had an on-going COVID-19 testing for all the employees and residents due to the COVID-19 outbreak in the facility. CNA 5 stated she was tested around noon time by the laboratory staff who came into the facility. CNA 5 stated after she reported her symptoms to DSD 2, she still worked until the end of her shift and the DSD 2 did not instruct her to be off from work. CNA 5 stated she went to work the following day on 4/1/25, because she was feeling better; but by the end of her shift, she was feeling very tired. CNA 5 stated at around 1500 hours on 4/1/25, DSD 2 informed her of COVID-19 test result came back positive. CNA 5 further stated she still completed her shift on 4/1/25, even after being informed of her COVID-19 test result. CNA 5 stated the symptoms she was having could have been related to COVID-19 since her COVID-19 test came back positive. CNA 5 stated DSD 2 instructed her to test herself using the COVID-19 home kit test when she was not having symptoms. CNA 5 stated she was not experiencing symptoms of COVID-19 on 4/5/25, and she tested herself using the COVID-19 home kit test and the result was negative. CNA 5 stated she sent the result to DSD 2. CNA 5 stated she went back to work on 4/6/25. On 4/16/25 at 1427 hours, an interview was conducted with LVN 7. LVN 7 verified she worked on 3/28, 3/29, 3/30, and 3/31/25 from 0700 to 1530 hours. LVN 7 she was tested for COVID-19 on 3/31/25 by the laboratory staff who came into the facility. LVN 7 stated it was the mandatory testing being done to all employees and residents in the facility. LVN 7 stated she was not having symptoms of COVID-19. LVN 7 stated when the COVID-19 outbreak had started in the facility, all employees were mandated to wear N-95 mask. LVN 7 stated on 4/1/25, she found out her COVID-19 test result was positive through another staff who sent her a message via cellphone. LVN 7 stated she did not receive a call from the DSD 2 or IP. LVN 7 stated she called the IP to confirm her COVID-19 test result. LVN 7 stated the IP confirmed her positive COVID-19 test and she was instructed by the IP to not go to work for three days. LVN 7 stated she was not having symptoms of COVID-19 all throughout her quarantine days. LVN 7 stated she did not go to work for three days. LVN 7 stated she tested herself at home for COVID-19 before she went back to work and the result was negative. LVN 7 stated she informed the IP regarding her negative COVID-19 result and for not having any symptoms of COVID-19. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/17/25 at 1450 hours, a concurrent interview and facility document review was conducted with the IP. The IP stated the facility had given in-service training regarding COVID-19 and other respiratory diseases like influenza, pneumonia and RSV which included symptoms to report. The IP stated the staff were constantly reminded by the department heads regarding symptoms of respiratory diseases, what and when to report. The IP stated the possible symptoms of COVID-19 included fever, coughing, sore throat, nasal congestion, difficulty breathing, muscle aches and headache. The IP stated some employees would report to her directly if they were having symptoms of possible COVID-19 or any respiratory illnesses which were reportable. The IP stated she would also know which employees were having symptoms of respiratory illnesses through the report of the scheduler or DSD when an employee called off sick from work. In addition, the IP stated there was communication between the IP, DSD 2 and the scheduler if the DSD 2 or the scheduler would get a report from an employee regarding having symptoms of respiratory diseases, the DSD 2 and the scheduler should report it to the IP immediately. The IP stated the facility had its first positive COVID-19 resident on 3/26/25, and she reported it to the Public Health Department. The IP stated the very first response testing for the facility happened on 3/31/25, as per guidance by the Public Health Department. The IP stated the facility contracted an outside laboratory that performed SARS-CoV-2 PCR Test every Monday to all employees and residents. The IP stated she was getting the report from the laboratory regarding the employees and residents which were positive through email and text message to her cellphone. The IP stated she then would inform DSD 2 for all employees who had positive result and she would inform the DON for all residents who had positive result. The IP stated if the employee's COVID-19 test was positive and the employee was having symptoms of COVID-19, the employee would be restricted to work for three days or until the symptoms were gone. The IP stated if the employee was positive for COVID-19 but asymptomatic, the employee could work but would be assigned only to the facility's designated COVID area. The IP stated the symptoms of CNA 5 which were sneezing, headache, watery eyes, and back pain could be possibly symptoms of COVID-19. The IP stated when CNA 5 reported those symptoms to DSD 2, CNA 5 should have been sent home immediately and should have been restricted to work while the COVID-19 test result was pending and while still having symptoms. The IP stated if the employee who was experiencing symptoms of COVID-19 and still working in the facility, the employee could potentially spread the disease to the residents he/she had direct care and to the other employees he/she was working with. The IP verified the laboratory sent her the positive COVID-19 test result for CNA 5 and LVN 7 via email and text message on 4/1/25 at around passed 0400 hours. The IP stated when she saw the result sent by the laboratory on 4/1/25 at 0643 hours, the IP forwarded to DSD 2 the email and text message. The IP stated she expected DSD 2 to inform the employees immediately of the positive result and if the employees were scheduled to work, they should have been asked if they were experiencing symptoms of COVID-19 or not, and the work restrictions would be based on whether the employee was having symptoms or asymptomatic. The IP stated she could have followed up to make sure the employees who were positive for COVID-19 were taken off from the staffing schedule, restricted to work, and a follow-up screening should have been initiated. On 4/21/25 at 1556 hours, an interview was conducted with the DON. The DON stated she was not made aware of any staff who were experiencing symptoms of COVID-19 and with pending test result was permitted to work. The DON stated if she knew a staff who was having symptoms of COVID-19 whether the staff had not been tested or tested already, she would have sent the staff home immediately and would be restricted to work based on the facility's COVID-19 work restriction protocol. The DON stated she expected the IP and DSD 2 to be responsible with this and a follow up screening should be done before an employee could go back to work. The DON was informed and acknowledged the above findings. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/21/25 at 1610 hours, an interview was conducted with the Administrator. The Administrator stated he would get the COVID-19 line list for both employees and residents from the IP. The Administrator stated the expectation for the employees was to report immediately to their immediate supervisors if they were having symptoms of COVID-19 and other respiratory diseases like the influenza, pneumonia or RSV. The Administrator stated the facility's COVID-19 work restrictions for employees should always be implemented and followed. The Administrator stated he was not made aware of any employee who should be restricted to work related to COVID-19 illness was allowed to continue to work. The Administrator stated if he was informed, he would immediately send the employee home. The Administrator was informed and acknowledged the above findings. 2. Review of the facility's P&P titled Laundry and Bedding, Soiled revised 9/2022 showed soiled laundry/bedding shall be handled, transported and processed according to best practices for infection prevention and control. The Policy Interpretation and Implementation section showed laundry equipment (e.g. , washing machines, dryers) is used and maintained according to the manufacturer's instructions for use to prevent microbial contamination of the system. On 4/18/25 at 1023 hours, a laundry room inspection was conducted with the Housekeeping Supervisor. The washing machine labeled number three was observed with heavy build up of black, yellow and white sediments on the washing machine's door, black railing below the door, front bottom part and in the black hood attached on the upper right side of the washing machine. The Housekeeping Supervisor stated they cleaned the washing machines every day. On 4/18/25 at 1105 hours, an interview was conducted with the IP. The IP stated if the laundry equipment like the washing machines and dryers were being clean daily, build up of sediments would be prevented. The IP stated the buildup of black, yellow and white sediments on the washing machine could be a potential breeding ground for bacterial growth. The IP further stated the equipment in the laundry room should be always kept clean because these were being used for the residents and it would help with infection prevention. On 4/22/25 at 1010 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 39453 3. Review of the facility's P&P titled Enhanced Barrier Precautions dated 10/2024 showed the EBPs are used an infection prevention and control intervention to reduce the spread of MDRO to residents. EBPs employ targeted gown and glove us during high contact resident care activities when contact precautions do not otherwise apply. Gloves and gown are applied prior to performing the high contact resident care activity as opposed to before entering the room. Examples of high contact resident care activities requiring the use of the gown and gloves for EBPs include: - Dressing; - Bathing/ showering; - Transferring; - Providing hygiene; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Changing linens; - Changing briefs or assisting with toileting; - Device care or use (central line, urinary catheter, feeding tube, tracheostomy/ ventilator, etc.); and - Wound care (any skin opening requiring a dressing). On 4/18/25 at 0929 hours, a GT site wound care observation and concurrent interview for Resident 37 was conducted with LVN 12 and CNA 5. LVN 12 was observed preparing the wound care supplies and entering Resident 37's room. CNA 5 was observed wearing an N95 mask, gloves, and gown, and repositioning Resident 37. LVN 12 was observed wearing an N95 mask and gloves, and repositioning Resident 37. LVN 12 was observed checking and touching Resident 37's GT site. LVN 12 was not wearing a gown when initially performing a device care and wound care on the resident's GT site. LVN 12 was observed going out of the room and donned a gown, then continued performing the GT site care to Resident 37. LVN 12 verified she did not initially wear a gown when she performed a GT site care while Resident 37 was on the EBP. 48332 4. On 4/15/25 at 0840 hours, an observation of Resident 154 and concurrent interview was conducted with Resident 154 and LVN 6. Resident 154 was observed lying in bed with a GT on left side of the abdomen. Resident 154 stated the GT was only being used for bolus feeing if she ate less than 50% of her meal trays. There was no EBP precautions in place for the resident and the resident's room. LVN 6 verified there was no EBP sign on the door and stated the EBP precautions should be in place since the resident had a GT. On 4/17/25 at 1311 hours, an interview was conducted with the IP. The IP verified the findings and stated there should be the EBP sign on the door to identify the resident on precaution. Medical record review for Resident 154 was initiated on 4/17/25. Resident 154 was initially admitted on [DATE], and was readmitted on [DATE]. Review of Resident 154's Order Summary Report dated 4/17/25, showed order dated 4/4/25, for the EBP secondary to long term use of a GT. Review of Resident 154's care plan dated 2/26/25 and revised 3/5/25, showed the resident required an EBP related to GT; would not develop an MDRO. Interventions included to place the EBP signage at door entry, provide gowns and gloves at door entry, use gown and gloves during high contact to the resident care activities (dressing, bathing, transfers, hygiene, toileting, brief changes, linen, device care, wound care). 51352 5. Review of the facility's P&P titled Bedpan/Urinal, Offering/Removing revised 2/2018 showed if the resident prefers to keep a urinal at his bedside, check it frequently. Empty and clean it as necessary. Note on the resident's care plan his request to keep the urinal at his bedside. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medical record review for Resident 129 was initiated on 4/15/25. Resident 129 was admitted to the facility on [DATE]. Review of Resident 129's H&P examination dated 1/11/25, showed Resident 129 had the capacity to understand and make decisions. Review of Resident 129's MDS Assessment Section GG - Functional Abilities dated 3/12/15, showed Resident 129 required supervision or touching assistance (the helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes the activity. Assistance may be provided throughout the activity or intermittently) for toileting. Review of Resident 129's care plan failed to show documented evidence addressing Resident 129's preference to leave the urinal at his bedside. On 4/16/25 at 1249 hours, an observation and concurrent interview was conducted with Resident 129. Resident 129's meal tray was observed on the bedside table next to a urinal containing 450 ml of urine. Resident 129 verified his urinal had urine in it and his lunch tray was placed on the bedside table near the used urinal. On 4/16/25 at 1254 hours, an observation of Resident 129's bedside table and concurrent interview was conducted with CNA 7. CNA 7 verified a used urinal containing 450 ml was on Resident 129's bedside table near his meal tray. CNA 7 stated Resident 129's meal tray should not have been put on the bedside table near his used urinal. On 4/17/25 at 1409 hours, an interview was conducted with LVN 6. LVN 6 stated it was an infection control risk to have a used urinal on the bedside table. LVN 6 verified Resident 129's meal tray should not have been placed on the bedside table when the bedside table had a used urinal on it. On 4/18/25 at 1403 hours, an interview and concurrent medical record review for Resident 129 was conducted with the DON. The DON verified the facility's P&P titled Bedpan/Urinal, Offering/Removing showed a care plan problem should have been initiated for any resident who would prefer to have the urinal at the bedside. The DON verified Resident 129's care plans did not show documented evidence of a care plan problem regarding his preference for keeping his urinal at the bedside.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. 51352 Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure two of two ice machines were cleaned and maintained as per the manufacturer's guidelines. This failure posed the risk of ice contamination and the equipment to not function in the way it was intended. Findings: 1. Review of the ice machine manufacturer guidelines (undated) located on the interior panel of the two ice machines showed sanitizing instructions to remove the front insulation panel, then pour 1.7 fluid ounces of 8. 25% sodium hypochloride (chlorine bleach) into the water tank. Replace the front insulation panel. Turn the cleaning valve until completely vertical. Review of the facility's P&P titled Ice Machines and Ice Storage Chests revised November 2022 showed the facility had established procedures for cleaning and disinfecting ice machines and ice storage chests which adhere to the manufacturer's instructions. a. On 4/15/25 at 0852 hours, an observation of the ice machine in the kitchen located by the hand washing sink and concurrent interview was conducted with the Maintenance Director. The Maintenance Director stated the two ice machines were cleaned and sanitized monthly. The interior of the ice chute (the part of the ice machine where ice was dispensed into the ice storage bin) was wiped with a clean white paper towel and brown residue was removed. The Maintenance Director verified the ice machine was not clean. The Maintenance Director stated he used 1.5 fluid ounces of 7.5% Clorox bleach to sanitize all the ice machines in the facility. The Maintenance Director verified the concentration of the Clorox bleach he used did not follow the manufacturer's guidelines for sanitation. b. On 4/16/25 at 0909 hours, an observation of the ice machine in the kitchen located by the juice machine and concurrent interview was conducted with the Maintenance Director. The interior of the ice chute of the ice machine was wiped with a clean white paper towel and brown residue was removed. The Maintenance Director verified the ice machine was not clean.

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F 0919 Level of Harm - Potential for minimal harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the appropriate services for one of 32 final sampled residents (Resident 141). * The facility failed to ensure Resident 141 had a functioning call light in order to summon staff for assistance. This failure had the potential for Resident 77 not having her needs known to the staff and may result in not receiving assistance in a timely manner. Findings: Review of the facility's P&P titled Answering the Call Light (undated) showed the purpose of this procedure is to ensure timely responses to the resident's requests and needs. In addition, general guidelines showed, to ensure the call light is plugged in and functioning at all times. On 4/15/25 at 0909 hours, during the initial tour of the facility, Resident 141 was observed awake and lying in bed. Resident 141's call light was not observed within the resident's reach. Upon further inspection, the call light cord was cut off from the call light panel on the wall. Medical record review for Resident 141 was initiated on 4/15/25. Resident 141 was admitted to the facility on [DATE]. Review of Resident 141's MDS assessment dated [DATE], showed Resident 141 had severe cognitive impairment, without impairment to upper extremities, and required set-up assistance with eating, and substantial/maximal assistance for bed mobility, transfer, dressing, and toileting. On 4/15/25 at 1006 hours, an observation for Resident 141 and concurrent interview was conducted with the IP. Resident 141 was observed awake in bed. The IP verified Resident 141's call light was cut off and there was no other means for Resident 141 to call for the staff for assistance. On 4/17/25 at 1259 hours, an interview for Resident 141 was conducted with CNA 11. When asked about Resident 141, CNA 11 stated Resident 141 was alert but forgetful, verbal, and able to move her hands. When asked if Resident 141 used the call light, CNA 11 stated she has not seen the resident used the call light, and he did not notice if the call light was working or not. On 4/18/25 at 0830 hours, an interview was conducted with the Maintenance Director. The Maintenance Director acknowledged he was informed yesterday about the call light cord that was cut off from the call light panel for Resident 141. The Maintenance Director stated the nurses usually reported to the maintenance any call light that was not working, but he did not receive any report about Resident 141's call light before yesterday. The Maintenance Director stated the maintenance department checked the call light system every week.

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F 0921 Level of Harm - Potential for minimal harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 49258 Based on observation and interview, the facility failed to ensure a safe, functional, and sanitary environment in multiple areas throughout the facility was maintained as evidenced by the following: * Black residue was observed along the walls in Shower Rooms B and D. The facility failed to maintain the integrity of the walls and sanitary conditions in Shower Rooms B and D. * The facility failed to maintain the sanitary condition in Shower Room D. The lid of the linen barrel was open, with an overload of soiled linen. An unlabeled portable toilet basin was found on the floor and a diaper was observed on top of a wheeled commode chair. * A shower chair was observed with a brownish stain on the foam seat, appearing to be a fecal matter, in Shower Room C. These failures had the potential for development and proliferation of disease-causing microorganisms. Findings: 1. On 4/22/25 at 1009 hours, an environmental inspection was conducted with the Maintenance Supervisor. During the inspection, the following was identified: - An accumulation of black residue was observed along the perimeter of the walls in two cubicles of Shower Room B. The surface of the tiles appeared darker with black stains compared to the surrounding tiles. The Maintenance Supervisor stated the presence of the black residue on the walls in the shower cubicles could indicate mold growth, which posed health risks to the residents and staff, and the housekeeping staff should properly scrub and clean the tiles. The Maintenance Supervisor further stated occasionally, the maintenance department received reports regarding this issue and assisted with the cleaning. The Maintenance Supervisor verified the above findings. On 4/22/25 at 1052 hours, an interview was conducted with CNA 8. CNA 8 stated Shower Room B was designated for the residents who had COVID-19. On 4/22/25 at 1105 hours, an interview was conducted with the Maintenance Supervisor. The Maintenance Supervisor stated the night janitorial staff cleaned all six shower rooms during the night shifts. However, the Maintenance Supervisor was unable to provide documentation confirming the showers had been cleaned. The Maintenance Supervisor verified the findings. 32179 (continued on next page)

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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 0921 Level of Harm - Potential for minimal harm Residents Affected - Some	2. On 4/22/25 at 1300 hours, an observation of Shower Room D and concurrent interview was conducted with LVN 13. Shower Room D was observed to have an accumulation of black residue along the perimeter of the walls. The lid of the linen barrel was open, with an overload of soiled linen. An unlabeled portable toilet basin was found on the floor, and a diaper was observed on top of a wheeled commode chair. LVN 13 stated the shower room should have been cleaned, as the black residue was likely mold, posing a potential health risk. In addition, LVN 13 stated the residents sometimes used this shower room. LVN 13 verified the findings. 39453 3. On 4/22/25 at 1040 hours, an inspection of the shower chairs was conducted with the Maintenance Director. Five shower chairs were observed inside Shower Room C. One of the shower chairs was observed with a brownish stain on the foam seat, appearing to be a fecal matter. The Maintenance Director verified the above findings. The Maintenance Director stated the CNAs were supposed to clean the shower chairs after each use.