STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056042	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bay Vista Healthcare & Wellness Centre, LP	5901 Downey Ave Long Beach, CA 90805

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** Based on interview and record review, the facility failed to ensure residents' medical records were updated to show documentation that advance directives (written statement of a person's wishes regarding medical treatment made to ensure those wishes are carried out should the person be unable to communicate) were discussed and written information was provided to the residents and/or responsible parties for two of six sampled residents (Resident 2 and 16). These deficient practices violated the residents' and/or the representatives' right to be fully informed of the option to formulate an advance directive and had the potential to cause conflict with the residents' wishes regarding health care. Findings: A. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) and depression (a mental health condition that causes persistent sadness and loss of interest in activities that were once enjoyable). During a review of Resident 2's Minimum Data Set (MDS- a resident assessment tool) dated 4/10/2025, the MDS indicated Resident 2 had moderate cognitive (ability to think, understand, learn, and remember) impairment. During a review of Resident 2's Social Services Progress Note dated 4/10/2025, the Social Services Progress Note indicated Resident 2 had an advance directive on file. During a review of Resident 2's Social Services Note dated 6/24/2025 at 11:25 a.m., the Social Services Note indicated Resident 2 did not have an advance directive and did not wish to formulate one. B. During a review of Resident 16's admission Record, the admission Record indicated Resident 16 was initially admitted to the facility on [DATE], and re-admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing) and paranoid schizophrenia (a pattern of behavior where a person feels distrustful and suspicious of other people and acts accordingly). (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 16's MDS dated [DATE], the MDS indicated Resident 16 was cognitively intact. During a review of Resident 16's Advance Directive Acknowledgement Form dated 6/28/2024, the Advance Directive Acknowledgement Form indicated Resident 16 did not have an advance directive. During a review of Resident 16's Social Services assessment dated [DATE], the Social Services Assessment indicated Resident 16 had an advance directive on file. During a review of Resident 16's Social Services assessment dated [DATE], the Social Services Assessment indicated Resident 16 did not have an advance directive on file. During a review of Resident 16's Social Services assessment dated [DATE], the Social Services Assessment indicated Resident 16 did not have an advance directive on file. During a concurrent interview and record review on 6/26/2025 at 9:03 a.m., with the social services director (SSD), the SSD stated the advance directive represents the residents wishes and who would make decisions for them when they are unable to do so. The SSD stated she is responsible for offering residents to formulate an advance directive if they do not have one and for getting a copy of the residents advance directive if they have one. The SSD stated she did not follow up with Resident 2 for a copy of his advance directive, but she should have. The SSD stated Resident 16's advance directive status was not accurately documented, and she should have followed up. The SSD stated it's important that the status of the advance directive is documented accurately because if not, the facility will not be able to follow the residents wishes for their care. During an interview with the Director of Nursing (DON) on 6/26/2025 at 8:22 p.m., the DON stated it is important that advance directives are accurate because it represents the wishes for the residents care they want to receive when unable to make decisions on their own. The DON stated the SSD should have followed up on Resident 2 and Resident 16's advance directive to ensure the staff were aware of the care to provide. During a review of the facility's policy and procedure (P&P) titled, Advance Directive, dated 2022, the P&P indicated, Upon admission, the Admissions Staff or Designee will provide written information to the resident concerning his or her right to make decisions concerning medical care; including the right to accept or refuse medical or surgical treatment, and the right to formulate advance directives. During the Social Service Assessment process, the Director of Social Services or Designee will also ask the residents if they have a written advance directive. If the resident has an Advance Directive, the Facility shall request a copy of the document from the resident or the resident's representative. If a copy is provided by the resident or the resident's representative, it will be placed in the medical record.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview , and record review, the facility failed to ensure one of four sampled residents (Resident 21) was free of chemical restraints (use of medication to control a patient's behavior or restrict the patient's movement and not required to treat the medical symptom) by failing to: 1.Ensure Resident 21 was provided non-pharmacological interventions (interventions that does not primarily use medicine) before administering a as needed) (prn) psychotropic medication(any drugs that affects the brain activities associated with mental processes and behavior). This failure put Resident 21 at risk for adverse reactions (unintended, harmful events attributed to the use of medication) due to unnecessary prolonged use of psychotropic medication. Findings: During a record review of Resident 21's admission Record, the admission Record indicated Resident 21 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including unspecified dementia (a progressive state of decline in mental abilities) with psychotic disturbance(a mental state where a person's thoughts and perceptions are significantly impaired leading to disconnect from reality), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), generalized anxiety disorder(mental health condition characterized by excessive, persistent, and unrealistic worry about everyday things) and chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing). During a review of Resident 21's Minimum Data Set (MDS- a resident assessment tool) dated 5/11/2025, the MDS indicated Resident 21 had severely impaired cognitive skills(a significant decline in mental abilities, making it difficult or impossible for an individual to perform daily tasks independently) and required set-up or clean-up assistance (helper sets up or cleans up and resident completes the activity) with eating and personal hygiene. The MDS indicated Resident 21 required substantial/maximal assistance(a helper does more than half the effort) with bathing , dressing, sitting to lying (ability to move from sitting on side on bed to lying flat on bed),and lying to sitting on side of bed (ability move from lying on the back to sitting on the side of the bed without back support). During a review of Resident 21's Order Listing Report for Lorazepam (Ativan- medicine used to treat anxiety and sleeping problems related to anxiety), the Order Listing Report for Lorazepam indicated the following: 1.Lorazepam 1 milligram(mg -unit of measurement) 1 tablet by mouth every 6 hours as needed for anxiety manifested by inability to relax for 14 days ordered on 8/2/2024. 2.Lorazepam 1 mg. give 1 tablet by mouth every 6 hours as needed for anxiety manifested restlessness for 14 days ordered on 8/18/2024. 3.Lorazepam 1 mg. 1 tablet by mouth every 6 hours as needed for anxiety manifested by restlessness for 14 days ordered on 9/4/2024. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4.Lorazepam 1 mg. 1 tablet by mouth every 6 hours as needed for anxiety manifested by inability to relax for 14 days ordered 10/5/2024. 5.Lorazepam 1 mg. by mouth every 6 hours as needed for anxiety manifested by inability to relax for 14 days ordered on 10/23/2024. 6.Lorazepam 1mg. give 1 tablet by mouth every 12 hours as needed for anxiety manifested by inability to relax for 14 days ordered on 10/29/2024. 7.Lorazepam 1 mg. give 1 tablet every 12 hours as needed for anxiety manifested by inability to relax for 14 days ordered on 2/25/2025. 8.Lorazepam 1 mg. give 1 tablet by mouth every 12 hours as needed for anxiety manifested by to relax for 14 days ordered on 3/22/2025. 9.Lorazepam 1 mg. give 1 tablet by mouth every 12 hours as needed for anxiety manifested inability to relax for 30 days ordered on 4/7/2025. 10.Lorazepam 1 mg. give 1 tablet by mouth every 6 hours as needed for anxiety manifested by restlessness for 14 days ordered on 5/8/2025. 11.Lorazepam 1 mg. give 1 tablet by mouth every 6 hours as needed for anxiety manifested restlessness for 30 days ordered on 5/25/2025. 12.Lorazepam 1 mg. give 1 tablet by mouth every 6 hours as needed for anxiety manifested by inability to relax for 14 days ordered on 6/24/2025. During an observation on 6/23/2025, at 10:18 a.m. and 12:33 p.m. , Resident 21 was asleep in bed, not responding to her name when called. During a dining observation on 6/23/2025, at 12:33 p.m. in Resident 21's room, Resident 21 was in an upright position, very sleepy despite the Certified Nursing Assistant (CNA 2) waking her up several times to eat. Observed Resident 21 woke up after several prodding from CNA 2 and was fed by CNA 2 within eye level. During an observation on 6/24/2025, at 10:30 am in Resident 21's room, Resident 21 was asleep in her bed. During an observation 6/24/2025, at 12: 35 p.m., in Resident 21's room, observed Resident 21 was sleepy during lunch time and the staff had to wake her up several times to feed her. During an interview on 6/25/2025, at 2:43 p.m. with CNA 4 , CNA 4 stated Resident 21 was sleepy this morning and easily fell back to sleep. CNA 4 stated she had to wake her up to do the Activities of Daily living (ADL- activities such as bathing, dressing and toileting a person performs daily)on 6/25/2025 morning like bed bath or brushing her hair. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 6/26/2025, at 12:25 p.m. with Licensed Vocational Nurse (LVN 4), Resident 21's Medication Administration Report (MAR- a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) and Progress Notes were reviewed. LVN 4 stated through record review of Progress Notes and MAR for June 2025, stated the licensed nurses administering Lorazepam were not documenting non-pharmacological interventions before administering Lorazepam 1 mg prn for anxiety. LVN 4 stated administering Lorazepam can relax the resident to the point Resident 21would not be able to participate in her daily activities because of oversedation(a state of excessive drowsiness or unconsciousness caused by administration of sedative medications[a class of drugs that slow down brain activity, inducing relaxation and sleepiness]). LVN 4 stated not performing non-pharmacological interventions before administering Lorazepam could be a form of chemical restraint (use of medication to control a patient's behavior or restrict the patient's movement and not required to treat the medical symptom) and can affect the resident's quality of life. During a telephone interview on 6/26/2025, at 9:39 a.m. with Pharmacist Consultant (PC), PC stated best practice was for the licensed nurses to always use non-pharmacological intervention prior administering Lorazepam prn. During a concurrent interview and record review on 6/25/2025, at 3:05 p.m. with RN Supervisor (RNS1), Resident 21's MAR and Order Summary Report for June 2025 were reviewed. RNS 1 confirmed Resident 21 was on Lorazepam since August 2024 and non- pharmacological interventions were not provided before Lorazepam was administered to Resident 21. RNS 1 stated Resident 21 had intermittent episodes of yelling and repeating words in a loud manner. RNS 1 stated the licensed nurses should have provided non-pharmacological interventions first to make sure the resident's needs were met and to rule out the causes of restlessness or agitation. RNS 1 stated not providing non-pharmacological interventions before administering Lorazepam could make the resident sleepy and sedated which will prevent her participating in activities of daily living and could be a form of chemical restraint. RNS 1 stated licensed nurses should also monitor for side effects (an effect of a drug that is in addition to or beyond its desired effect which can be harmful or beneficial) of Lorazepam like sedation which could lead to fall. During an interview on 6/26/2025, at 5:33 p.m. with the Director of Nursing (DON), the DON stated the licensed nurses will assess the resident for signs and symptoms of anxiety and use non-pharmacological interventions before administering prn lorazepam because the resident could develop tolerance and respiratory depression(breathing disorder characterized by slow and ineffective breathing). The DON stated lorazepam could affect her sleep cycle , making her awake at night and sleeping more on the day affecting the quality of her life. During a review of facility's policy and procedure (P&P) titled, Behavior/ Psychoactive Medication Management, dated 5/22/2025, the P&P indicated Anti-anxiety medications is one of the classes of psychotropic medicines and preventable causes of behavior should be considered for the use of psychotropic medicines including monitoring for side effects including sedation. The P&P indicated the licensed nurse will identify contributing factors related to the resident's mood, behavior and non - medication interventions to be implemented with collaboration with the healthcare practitioner, family, resident and IDT (Interdisciplinary team- team of healthcare professionals who discuss and manage resident's care) members.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2.During a review of Resident 38's admission Record, the admission Record indicated Resident 38 was initially admitted on [DATE] and was readmitted on [DATE] to the facility with diagnoses including paranoid schizophrenia(a pattern of behavior where a person feels distrustful and suspicious of other people and acts accordingly), schizoaffective disorder bipolar type(a mental illness that can affect thoughts, mood, and behavior) depression(a serious mental health condition characterized by persistent sadness and a loss of interest in activities, impacting how a person feels, thinks and handles daily tasks), and anxiety disorder (intense, excessive, and persistent worry and fear about everyday situations). During a review of Resident 38's History and Physical (H&P) dated 2/8/2025, the H&P indicated Resident 38 can make needs known but cannot make medical decisions. During a review of Resident 38's Minimum Data Set (MDS- resident screening tool) dated 4/30/2025, the MDS indicated Resident 38 had severely impaired cognitive skills and required supervision or touching assistance (helper provides verbal cues and touching steadying and /or contact guard assistance as the resident completes the activity) with eating, oral hygiene, dressing, and personal hygiene. The MDS indicated Resident 38 was taking antipsychotic (medications that help manage symptoms of psychosis[mental state where a person has difficulty distinguishing between what is real and what is not]), antianxiety (medications used to treat anxiety) and antidepressant (medicine used to treat depression) medications. During a review of Resident 38's PASSAR Level 1 dated 10/17/2025, the PASSAR Level 1 indicated negative for serious mental illness. During a review of Resident 38's Care Plan titled The resident banged head on the wall, initiated on 3/12/2025 and behavior was observed by the facility on 3/26/2025. The Care Plan's interventions included applying foam mat wall tiles for safety initiated 3/28/2025,providing companion care (a person who has their eyes and ears on the resident on regular basis), resident will be wearing helmet as needed when she bangs head on the wall for safety, and informing the physician when behavior occurs. During a review of Resident 38's Order Summary Report, the Order Summary report indicated the following physician orders: 1.Depakote (medicine used to treat bipolar disorder) 250 milligrams (mgs.- unit of measurement) 2 tablets two times a day for bipolar disorder manifested by outburst of anger ordered on 3/7/2025. 2.Ativan(Lorazepam- medicine used for to treat anxiety) 1 mg. give 1 tablet by mouth every 4 hours as needed for anxiety for 14 days manifested by irritability and pacing with verbal outburst ordered on 6/20/2025. 3.Rexulti (Brexpiprazole- an antipsychotic medication used to treat schizophrenia) 2 mgs. give 1 tablet by mouth one time a day for schizophrenia manifested by talking to self/ hearing voices ordered on 4/3/2025. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4.Seroquel(Quetiapine Fumarate- antipsychotic medication that helps manage schizophrenia and bipolar disorder)) 25 mgs. give 1 tablet by mouth two times a day for schizoaffective disorder manifested by aggressive behavior of scratching staff ordered on 6/13/2025. 5.Trazodone (a medicine used for depression) 50 mgs. give 0.5 tablet by mouth at bedtime for depression manifested by inability to sleep at night ordered on 5/3/2025. During a concurrent interview and record review on 6/25/2025, at 10:17 a.m. with Minimum Data Set Nurse (MDSN), Resident 38's PASSAR Level 1 and electronic record were reviewed. The MDSN stated the facility should submit another PASSAR Level 1 if the resident was having a significant change in condition like change in psychotropic medicines or behavioral changes. MDSN stated she did not review the PASSAR Level 1 that was submitted by another facility when resident was admitted in the facility. MDSN stated they should have submitted another PASSAR Level 1 and agreed Resident 38 had behavioral problems like banging her head on the wall. MDSN stated Resident 38 could have missed recommendations from the Department of Health Care Services for specialized care related to her mental illness because the information submitted in the PASSAR was not complete and accurate. During a review of the facility's policy and procedure (P&P) titled, Pre-admission Screening Resident Review (PASARR), dated 2022, the P&P indicated, The purpose is to ensure that all residents are screened for mental illness and intellectual disability or a related condition. During a review of the facility's P&P titled, Pre-admission Screening Level II Resident Review, dated 2022, the P&P indicated, The IDT will review the level II evaluation report to develop a care plan and arrange the Specialized Services recommended for the resident as appropriate. The States is responsible for providing and paying for specialized services for residents with mental illness or intellectual disabilities residing in a skilled nursing facility. Based on interview and record review, the facility failed to follow through and accurately assess with the Preadmission Screening and Resident Review (PASARR- a federal assessment requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are placed in facilities that can provide the appropriate care) Level I for three of 28 sampled residents (Resident 1,Resident 38 and Resident 223) to determine the facility's ability to provide the special need of the residents. The facility failed to: 1.Complete a preadmission screening and annual resident review (PASARR) I properly for Resident 1 and 223. 2. Review submitted PASARR 1 for accuracy on Resident 38 who had diagnosis of mental illness, was on psychotropic medicines (drugs that affect the brain and influence mental processes, emotions and behavior)and had a change in behavior involving self-harm during the course of resident's stay in the facility. These failures had the potential to put Resident 1, 38 and 223 at risk for not receiving necessary care and services they need. Findings: (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), schizophrenia (a mental illness that is characterized by disturbances in thought), anxiety (a feeling of worry, nervousness, or unease, typically about an imminent event or something with an uncertain outcome), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 4/28/2025, the MDS indicated Resident 1 had severe cognitive impairment (someone with significant difficulty with thinking, understanding, learning, and remembering things) was severely impaired. B. During a review of Resident 223's admission Record, the admission Record indicated Resident 223 was admitted to the facility on [DATE] with diagnoses including schizoaffective disorder (a mental illness can affect thoughts, mood, and behavior), psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), and anxiety. During review of Resident 223's MDS dated [DATE], the MDS indicated Resident 223 had moderate cognitive impairment. During a record review of Resident 1 PASARR I dated 4/23/2025 and Resident 223's PASARR I dated 6/11/2025, the PASARR I's indicated Resident 1 and 223 had serious mental illness diagnoses and were prescribed psychotropic medications but their PASARR I screening was negative. During a concurrent interview and record review on 6/24/2025 at 1:58 p.m., with the Minimum Data Set Nurse (MDSN), the MDSN indicated the interdisciplinary team (IDT- team members from different departments working together with a common purpose to set goals and make decisions to ensure residents receive the best care) review the PASARR's to ensure accuracy and if not, the PASARR is sent back to the hospital to be redone. The MDSN validated Resident 1 has a diagnosis of bipolar, but his PASARR I was negative and should have been positive. The MDSN validated Resident 223 has diagnoses of schizoaffective disorder, bipolar, and anxiety but his PASARR I was negative and should have been positive. The MDSN stated the PASARR I not being done accurately could result in the residents not receiving the necessary services and care, being hospitalized , and safety concerns if their care is not being managed with the proper resources. During an interview on 6/26/2025 at 6:10 p.m., with the Director of Nursing (DON), the DON stated she expects her staff to review and ensure the PASARR is completed accurately so the facility can provide the right care for the residents. The DON stated her understanding of the PASARR is if a resident has a mental illness, is stable and functioning, their PASARR I would be negative and only positive if the resident is unstable.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of two sampled residents (Resident 22 and Resident 11) had a Level II Preadmission Screening and Resident Review (PASARR-a federal assessment requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are placed in facilities that can provide the appropriate care) assessment done when diagnosed with a mental illness prior to admission. This failure had the potential to result in Resident 22 and Resident 11 not receiving the necessary services and appropriate psychiatric(relating to mental illness or its treatment) level of treatment and evaluation in the facility. Findings: During a review of Resident 22's admission Record, the admission Record indicated Resident 22 was admitted to the facility on [DATE] with diagnoses including diabetes mellitus, (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) paranoid schizophrenia(a mental illness that is characterized by disturbances in thought), major depressive disorder(a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety (a feeling of fear, dread, and uneasiness). During a review of Resident 22's History and physical (H&P), dated 8/24/2024, the H&P indicated Resident 22 had the capacity to understand and make decisions. During a review of Resident 22's Minimum Data Set (MDS-a resident assessment tool), dated 5/27/2025, the MDS indicated Resident 22 was independent with eating, oral hygiene, toileting, dressing and walking. During a review of Resident 22's Progress Note, dated 6/2/2025, the Progress Note indicated Resident 22 continues to benefit from psychotherapy (an approach for treating mental health issues) to reduce mood symptoms and to assist with adjustment to medical conditions, functional limitations, increased need for assistance, and rehabilitation placement. Prognosis is guarded due to medical conditions. 2. During a review of Resident 11's admission Record, the admission Record indicated Resident 11 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses including major depressive disorder, anxiety, and bipolar disorder (mood swings that range from the lows of depression to elevated periods of emotional highs). During a review of Resident 11's H&P, dated 5/16/2024, the H&P indicated Resident 11 did not have the capacity to understand and make decisions. During a review of Resident 11's MDS, dated [DATE], the MDS indicated Resident 11 was independent with eating. The MDS indicated Resident 11 needed substantial to maximal assistance from nursing staff with toileting, and showering. The MDS indicated Resident 11 required partial to moderate assistance from nursing staff with dressing, sitting and transferring. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 6/24/2025 at 1:29 p.m., with Licensed Vocational Nurse (LVN) 3, Resident 22's PASARR, dated 4/12/2024 was reviewed. The PASARR indicated Resident 22 had a Positive Level I screening. The PASARR indicated Resident 22 had a duplicate PASARR on file and the case was closed. The PASARR indicated to reopen the file, please submit a new PASARR Level I screening. LVN 3 stated Resident 22 should have a new PASARR Level I screening done due to a history of schizophrenia, anxiety and major depressive disorder. During an interview on 6/25/2025 at 10:33 a.m., with the Minimum Data Set Nurse (MDSN), MDSN stated we follow the recommendation from the determination letter. The MDSN stated Resident 22 had a duplicate PASARR Level I created with two different dates. The MDSN agreed that another Level I PASARR screening should have been reopened. The MDSN state she needs to follow up on Resident 11's PASARR Level 2 screening because she misread the determination letter dated 5/15/2024, indicating Resident 11 did not have serious mental illness. During an interview on 6/26/2025 at 11:54 a.m., with Registered Nurse Supervisor (RNS) 1, RNS 1 stated Resident 22 diagnosed with paranoid schizophrenia, major depressive disorder, and anxiety. RNS 1 stated these diagnoses were all serious mental illnesses. RNS 1 stated Resident 22 should have been screened again. RNS 1 stated Resident 22 still has unresolved psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) present. RNS 1 stated Resident 22's mental issues will not be properly addressed if the Resident 22 case was not reopened. RNS 1 stated Resident 11 had serious mental illness diagnoses of bipolar, anxiety, and major depressive disorder. RNS 1 agreed Resident 11 should have Level 1 screening reopened for a PASARR Level II evaluation. During an interview on 6/26/2025 at 6:27 p.m., with the Director of Nursing (DON), the DON agreed Resident 11 and Resident 22 needed to have a new Level I screening submitted. During a review of the facility's policy and procedure (P&P) titled Pre-admission Screening Resident Review (PASARR), revised 4/24/2024, the P&P indicated, The acute care hospital must complete a PASARR Level I and coordinate the completion of the Level II evaluation (if applicable) prior to admission to the skilled nursing facility . During a review of the facility's policy and procedure (P&P) titled Pre-admission Screening Level II Resident Review (PASARR Level II), revised 4/25/2024, the P&P indicated, The facility staff will coordinate the recommendations from the Level II PASRR determination and the PASARR evaluation report with the resident's assessment, care planning, and transitions of care .

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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** Based on observation and interview, the facility failed to ensure one of two residents' (Resident 2) was provided with personal hygiene care. This deficient practice resulted in Resident 2's facial hair being too long to shave with a razor, requiring the use of an electrical razor and had the potential to affect Resident 2's dignity. Findings: During an observation on 6/23/2025 at 10:27 a.m., in the hallway outside of Resident 2's room, Resident 2 was observed with long unkempt facial hair. Resident 2 was observed asking the staff to shave him. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) and depression (a mental health condition that causes persistent sadness and loss of interest in activities that were once enjoyable). During a review of Resident 2's Minimum Data Set (MDS- a resident assessment tool) dated 4/10/2025, the MDS indicated Resident 2 had moderate cognitive (ability to think, understand, learn, and remember) impairment and required moderate assistance (helper does less than half the effort) with personal hygiene. During a concurrent observation and interview on 6/24/2024 at 12:21 p.m., with Certified Nurse Assistant (CNA) 1, in Resident 2's room, CNA 1 validated Resident 2's face needed to be shaved, and she should have offered when she noticed it. CNA 1 stated Resident 2's facial hair is so long, she will need to use an electric razor. CNA 2 stated when Resident 2 requested a shave yesterday, it should have been done because it could affect his dignity on how he feels and looks. During an interview on 6/24/2025 at 2:33 p.m., with Licensed Vocational Nurse (LVN) 2, LVN 2 stated one of her job duties is to oversee the CNA's. LVN 2 stated Resident 2 should have had his face shaven yesterday when he requested for it to be done and not doing so could affect his dignity. During an interview on 6/26/2025 at 8:26 p.m., with the Director of Nursing (DON), the DON stated the CNA's are responsible for shaving the residents. The DON stated Resident 2 not being shaved upon his request could affect his dignity and make him feel like he is not being prioritized. During a review of the facility's policy and procedure (P&P) titled, Resident Rights- Quality of Life, dated 3/2017, the P&P indicated, Each resident shall be cared for in a manner that promotes and enhances the quality of life, dignity, respect, individuality and receives services in a person-centered manner, as well as those that support the resident in attaining and maintain his/her highest practicable well-being. During a review of the facility's CNA Job Description, undated, the CNA Job Description indicated, General duties and responsibilities: shave male residents daily or as needed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's LVN Job Description, undated, the LVN Job Description indicated, General duties and responsibilities: Supervise CNA's and to make resident rounds to ensure appropriate care is being rendered, identified, and making corrections as needed. It also indicated to meet with nursing personnel to assist in identifying and correcting problem areas and/or the improvement of resident care.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure two of two sampled residents (Resident 11 and Resident 60) were provided with a bowel and bladder retraining and/or toileting program (scheduled toileting, prompted voiding or bladder training [help to regain at least some control over patient's bladder]), to regain normal bowel and bladder function as much as possible and received appropriate treatment and services to restore continence. This failure had a potential risk for Resident 11 and Resident 60 to lose their ability to regain control of bowel and bladder function, which could result in loss of dignity. Findings: 1. During a review of Resident 11's admission Record, the admission Record indicated Resident 11 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses including urinary tract infection, (UTI- an infection in the bladder/urinary tract) acute cystitis (a sudden inflammation of the urinary bladder caused by a bacterial infection), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety (a feeling of fear, dread, and uneasiness), and bipolar (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs). During a review of Resident 11's History and Physical (H&P), dated 5/16/2024, the H&P indicated Resident 11 did not have the capacity to understand and make decisions. During a review of Resident 11's Minimum Data Set (MDS-a resident assessment tool), dated 5/28/2025, the MDS indicated Resident 11 was independent with eating. The MDS indicated Resident 11 needed substantial to maximal assistance from nursing staff with toileting, and showering. The MDS indicated Resident 11 required partial to moderate assistance from nursing staff with dressing, sitting and transferring. The MDS indicated Resident 11 always had urinary and bowel incontinence (lack of voluntary control over urination or defecation). The MDS indicated Resident 11 was not currently using a toileting program to manage bladder and bowel incontinence. During an interview on 6/24/2025 at 11:19 a.m., with Certified Nursing Assistant (CNA) 6, CNA 6 stated Resident 11 was incontinent and wears diapers and has always worn diaper in the facility. CNA 6 stated Resident 11 can tell someone when she needs to use the bathroom or needs a diaper change. CNA 6 stated Resident 11 was not part of a bowel and bladder training program. During an interview on 6/25/2025 at 11:09 a.m., with the Minimum Data Set Nurse (MDSN), the MDSN stated Resident 11 was not in any retraining program for bowel and bladder. The MDSN stated the bowel and bladder retraining program was to help the residents to be continent and prevent urinary tract infections. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/25/2025 at 11:29 a.m., with Licensed Vocational Nurse (LVN) 3, LVN 3 stated Resident 11 is incontinent and used diapers. LVN 3 stated Resident 11 can feel the urge to void. LVN 3 stated she was unsure why Resident 11 was not on a bowel and bladder retraining program. LVN 3 stated the retraining was to get them independent and to avoid skin issues or irritation. During a concurrent interview and record review on 6/26/2025 at 12:00 p.m., with Registered Nurse Supervisor (RNS) 1, Resident 11's Bowel and Bladder Program Screener, dated 8/31 2024, was reviewed. The Bowel and Bladder Program Screener indicated Resident 11 was a good candidate for bladder and bowel retraining. RNS 1 stated Resident 11 can tell when she needs to go to the bathroom. RNS 1 stated Resident 11 can benefit from the bladder and bowel training to avoid skin issues like pressure ulcers (localized damage to the skin and/or underlying tissue usually over a bony prominence) that can occur with moisture from urine or stool. 2. During a review of Resident 60's admission Record, the admission Record indicated Resident 60 was admitted to the facility on [DATE] and readmitted to the facility with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and cirrhosis of the liver (a condition where healthy liver tissue is replaced by scar tissue). During a review of Resident 60's Physician Progress Note, dated 1/14/2025, the Physician Progress Note indicated Resident 60 could make needs known but did not have the capacity to consent due to cognitive (ability to think, understand, learn, and remember) impairment. During a review of Resident 60's MDS dated [DATE], the MDS indicated Resident 60 needed partial to moderate assistance from nursing staff with toileting, showering, and transferring. The MDS indicated Resident 60 needed supervision or touching assistance with eating, oral hygiene, dressing and walking. During an interview on 6/24/2025 at 11:59 a.m., with Certified Nursing Assistant (CNA) 7, CNA 7 stated Resident 60 has episodes of incontinence and wears a diaper. CNA 7 stated Resident 60 can feel the urge to go to the bathroom. CNA 7 stated Resident 60 stated he does not like to wear diapers. CNA 7 stated Resident 60 was not on bowel and bladder retraining program. CNA 7 stated bowel and bladder training programs were important to prevent bowel and bladder issues from getting worse. During a concurrent interview and record review on 6/24/2025 at 1:42 p.m., with Licensed Vocational Nurse (LVN) 3, Resident 60's Bowel and Bladder Program Screener, dated 4/18/2025, was reviewed. The Bowel and Bladder Program Screener indicated Resident 60 was a good candidate for bladder retraining. LVN 3 stated Resident 60 was not in any bladder retraining programs. LVN 3 stated the licensed nurses were responsible for implementing the bowel and bladder retraining programs. During an interview on 6/25/2025 at 11:03 a.m., with MDSN, the MDSN stated that she was responsible for completing documentation on the Bowel and Bladder Screener. MDSN stated she should have informed the Resident 60's doctor to get an order for bowel and bladder retraining program. MDSN stated she should have discussed with the resident and responsible party about the bowel and bladder retraining program. MDSN stated the bowel and bladder retraining program was missed and not done for Resident 60. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/26/2025 at 12:15 p.m., with Registered Nurse Supervisor RNS 1, RNS 1 stated Resident 60 has episodes of incontinence. RNS 1 stated after MDSN screened Resident 60 she needed to communicate with licensed nurses that Resident 60 needs to be on a bowel and bladder retraining program. RNS 1 stated he does not know why the bowel and bladder retraining program was not implemented. RNS 1 stated that continued incontinence can cause skin breakdown to occur. During an interview on 6/26/2025 at 6:47 p.m., with the Director of Nursing (DON), the DON stated based on the Bowel and Bladder Program Screener Resident 11 and Resident 60 should have been started on the bowel and bladder training program. The DON stated the licensed nurses were responsible for implementing the bowel and bladder program and the retraining. The DON stated the bowel and bladder retraining program should have been initiated to prevent incontinence, and any issues with dignity. During a review of the facility's policy and procedure (P&P) titled Incontinence Care, revised 1/30/2025, the P&P indicated, The facility will ensure that a resident who is incontinent of bowel and bladder on admission receives services and assistance to attain/maintain continence unless his or her clinical condition is or becomes such that continence is not possible to attain/maintain.

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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** Based on observation, interview and record review, the facility failed to ensure one of six sampled residents (Resident 48) received respiratory care (specialized healthcare field that focuses on the treatment , management and prevention of respiratory disorders) consistent with professional standards of care by failing to: 1.Ensure Resident 48 's nasal cannula (medical device used to deliver supplemental oxygen to a person's nose) was not left on the floor and oxygen concentrator (medical device that provides a concentrated source of oxygen) were turned off when not in use. These failures had the potential to put Resident 48 for respiratory infection (an infection that affects respiratory tract which includes the nose, throat, and lungs caused by viruses or bacteria). Findings: During a review of Resident 48's admission Record, the admission Record indicated Resident 48 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including dependence on supplemental oxygen (refers the need for supplemental oxygen due respiratory or medical conditions), personal history of Covid-19 (previously diagnosed with Covid-19 [highly contagious respiratory disease]) , and hemiplegia (weakness or paralysis) affecting left nondominant side. During a review of Resident 48's Minimum Data Set (MDS- resident assessment tool) dated 4/1/2025, the MDS indicated Resident 48 had severely impaired cognitive skills(as significant decline in a person's ability to think, learn, remember, concentrate, make decisions, and solve problems) and was dependent (helper does all the effort and resident does none of the effort to complete the activity) on the staff with eating, bed mobility, oral hygiene, toileting hygiene, bathing, dressing and personal hygiene. During a review of Resident 48's Order Summary Report , the Order Summary Report dated 6/21/2024 indicated a physician order of continuous oxygen at 2 to 4 liters per minute (flow rate of oxygen delivered to a patient) via nasal cannula to keep oxygen saturation(a measurement of how much oxygen is carried by red blood cells in the blood expressed as a percentage) at or above 90 percent (%- out of 100) every shift for shortness of breath (sob- uncomfortable feeling that you are running out of breath). During a review of Resident 48's Care Plan, titled Resident had oxygen therapy related to shortness of breath initiated on 6/24/2025, the Care Plan goal indicated Resident 48 will have no signs and symptoms of poor oxygen absorption(body is not getting enough oxygen from the air you breathe to function properly) through the review date on 10/8/2025. The Care Plan interventions included administering continuous oxygen as ordered. During an observation on 6/23/2025, at 11:06 a.m. in Resident 48's room, a nasal cannula with the nasal prongs touching the floor located on the left side of Resident 48's bed. Observed the nasal cannula was connected to the oxygen concentrator that remained on. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 6/23/2025, at 11:19 a.m. and subsequent interview on 6/23/2025, at 11:19 a.m. with Licensed Vocational Nurse (LVN 2), LVN2 stated the certified nursing assistants should tell her when Resident 48 was moved and transferred to a wheelchair. Observed LVN 2 placed the nasal cannula back in a plastic bag near the oxygen concentrator and stated she will replace the nasal cannula that was on the floor. LVN 2 stated the oxygen concentrator should not have been left on when not in use and nasal cannula should not be left on the floor and should be kept on a plastic bag to keep it clean. LVN 2 stated Resident 48 's nasal cannula was considered dirty, and this could make the resident sick. During an interview on 6/24/2925, at 2:59 p.m., with Certified Nursing Assistant (CNA 5), CNA 5 stated LVN 2 removed the nasal cannula before the resident was transferred to the wheelchair on 6/24/2025. CNA 5 stated it was the responsibility of the licensed nurses to remove or reapply nasal cannula and turn off the oxygen. CNA 5 stated the nasal cannula should not be left on the floor because it will be contaminated and the residents could get an infection. During an interview on 6/24/2025, at 4:27 p.m. with Registered Nurse Supervisor (RNS 2), RNS 2 stated the nasal cannula should not be on the floor and the licensed nurse should have replaced the nasal cannula because it was unsanitary and residents could get a respiratory infection from using it. During an interview on 6/26/2025, at 2:02 p.m. with Infection Preventionist Nurse (IPN), IPN stated nasal cannula should have been replaced and changed when it had touched the floor to ensure the resident will not be at risk for respiratory infection. During an interview on 6/26/2025, at 3:28 p.m. with the Director of Nursing (DON), the DON stated nasal cannula that was not in use should be kept in a bag so it will not be touching the floor. The DON stated the nasal cannula that was on the floor was contaminated and could put Resident 48 at risk of getting sick. During a review of facility's policy and procedure titled, Oxygen Therapy, revised 11/2017, the P&P indicated Oxygen is administered under safe and sanitary conditions to meet resident need. The P&P indicated licensed nursing staff will administer oxygen as prescribed by the physician.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure a Registered nurse (RN) worked eight consecutive hours a day seven days a week on 2/1/25, 2/2/25, 2/8/25, 2/9/25, 2/15/25, 2/23/25, 3/9/25 and 3/23/25. This failure had the potential to affect the residents' quality of care and not be able to provide advanced care activities such as resident assessments, developing and evaluating care plans, and consulting with physicians. Findings: During a concurrent interview and record review on 6/25/25 at 4:08 p.m. with the Director of Staff Development (DSD). The facility's Census and Direct Care Service Hours Per Patient Day (DHPPD) dated 1/1/2025 through 6/24/25 were reviewed. The DHPPD indicated on 2/1/25, 2/2/25, 2/8/25, 2/9/25, 2/15/25, 2/23/25, 3/9/25 and 3/23/25 there was no RN coverage on those days. The DSD stated there needs to be an RN in case of an emergency because the RN has more knowledge in assessing the residents. During a concurrent interview and record review on 6/25/25 at 4:08 p.m. with the Administrator (ADM). The DHPPD dated 1/1/2025 through 6/24/25 was reviewed. The DHPPD indicated on 2/1/25, 2/2/25, 2/8/25, 2/9/25, 2/15/25, 2/23/25, 3/9/25 and 3/23/25 there was no RN coverage on those days. The ADM stated in those days they did not have an RN working. The ADM stated the RN has a different skill set of knowledge and that not having an RN could potentially affect the resident's quality of care. During a review of the Facility assessment dated [DATE], the Facility Assessment indicated, based on the facility's resident population and their needs for care and support, the following are the facility's general approaches to staffing to ensure that the facility has sufficient staff members with appropriate competencies and skill sets to meet the needs of the residents, as identified through resident assessments and care plans at any given time. The general staffing plan for licensed nurses providing direct care was to have one RN from 7am to 7pm and one RN from 7pm to 7am. The facility determines and reviews individual staff member assignments for coordination and continuity of care for the residents within and across the staff assignment and reviews acuity and care needs of the residents.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview , and record review , the facility failed to provide necessary behavioral care and treatment on one of three sample residents (Resident 167) by failing to: 1.Assess and monitor Resident 167's behavior after verbalization of wanting to die. 2.Follow up physician's notification about Resident's 167 suicidal ideation (thoughts of self-harm or ending one's life). 3.Provide psychiatric (study and treatment of mental, emotional, and behavioral disorders) evaluation after Resident 167's verbalization of wanting to die. These failures had the potential to put Resident 167 at risk of committing suicide due to delays in care and services. Findings: During a review of Resident167's admission Record, the admission Record indicated Resident 167 was admitted to the facility on [DATE] with diagnoses including hemiplegia partial (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction affecting left dominant side, diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) Stage III pressure ulcer(full-thickness loss of skin with dead and black tissue may be visible) on the sacral, muscle spasm (a sudden, involuntary, and often painful contraction of a muscle or group pf muscles), and muscle weakness. During a review of Resident 167's Minimum Data Set (MDS- a resident assessment tool) dated 6/13/2025, the MDS indicated Resident 167 had moderately impaired cognitive (ability to think, understand, learn, and remember) skills) and was dependent(helper does all of the effort to complete the activity) on staff with lower body dressing(ability to dress and undress below the waist) , transfer to and from a bed to wheelchair or chair and toileting hygiene. The MDS indicated Resident 167 had a Patient Health Questionnaire-9 (PHQ 9-screening tool used to assess severity of depression[mood disorder that causes persistent feeling of sadness and loss of interest) with a score of 12. (PHQ 9 score of 12 indicates moderate depression[characterized by persistent symptoms that interfere with daily functioning, but not as significantly as in major depression]). During a review of Resident 167's History and Physical (H&P) dated 6/6/2025. the H&P indicated Resident 167 had fluctuating capacity to understand and make decisions. During a review of Resident 167's Change in Condition (COC- a sudden clinically important deviation from a patient's baseline in physical, cognitive, behavioral or functional condition) Evaluation dated 6/16/2025 timed at 6:30 a.m. , the COC indicated Resident 167 refused blood sugar check and medications. The COC indicated Resident 167 physician was notified on 6/16/2025 at 7:00 a.m. The COC indicated the recommendation of the physician was to monitor Resident 167 for any noted changes in behavior and inform the physician of changes. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 167 's COC Follow Up Note dated 6/16/2025 timed at 5:23 p.m., the COC indicated the resident refused all oral medications, except medications to control blood pressure and finger stick (a procedure in which a finger is pricked with a lancet to obtain small quantity of blood) for blood sugar monitoring, The COC Follow Up Note indicated the resident verbalized signs and symptoms related to wanting to die and the physician was notified of verbalization and medication refusals. During a review of Resident 167's COC Follow Up Note dated 6/17/2025, at 6:57 a.m. , on 6/17/2025, at 12:57 p.m. , 6/17/2025 at 11:20 p.m.,6/18/2025 at 6:27 p.m., 6/18/2025 at 7:46 p.m., 6/19/2025 at 3:09 a.m. 6/19/2025 at 4:33 p.m. and 6/19/2025 timed at 19:41 p.m. indicated resident's verbalization of wanting to die was not monitored and assessed. The COC Follow Up Notes indicated Resident 167 refused all his medications and finger sticks. During a review of Resident 167's Care Plan titled, The Resident 167 is at risk of Mood Problem related to PHQ score of 12 initiated on 6/18/2025. The Care Plan's goal indicated Resident 167 will have an improved mood, a happy, calmer appearance , no signs and symptoms of depression, anxiety or sadness through review date. The Care Plan interventions included monitoring mood problems ,documenting and reporting as needed any risk for harm to self-suicidal plan, past attempt at suicide, risky actions, intentionally harmed or tried to harm self, refusing to eat, drink medicines or therapies, sense of hopelessness or helplessness and impaired judgement or safety awareness. During a review of Resident 167's COC Evaluation dated 6/23/2025 timed at 6:01 p.m., the COC indicated Resident 167 refused his medication and the physician was notified. During a review of Resident 167's Order Summary Report dated 6/23/2025, the Order Summary Report indicated to transfer Resident 167 to a general acute hospital (GACH) for further evaluation. During a review of Resident 167's Initial Psychiatric (relating to mental illness and its treatment) Consultation dated 6/10/2025, the Initial Consultation indicated Resident 167 had no new unwanted behavior at that time, mood was neutral and treatment plan indicated 20 minutes of CBT (cognitive behavior therapy- a structured , goal oriented form of talk therapy that helps people manage mental health issues and emotional concerns) to convert negative thoughts to more positive to reduce depression and anxiety. During a concurrent observation and interview on 6/23/2025, at 11:05 a.m. with Resident 167, Resident 167 was awake and lying in bed. Resident 167 stated he was afraid of the facility staff because the staff does not care. During an interview on 6/24/2025, at 3:14 p.m. with Certified Nursing Assistant (CNA5), CNA 5 stated Resident 167 refused his breakfast and lunch because he thought he was getting poisoned. CNA 5 stated she did not notify Licensed Vocational Nurse (LVN 2) about resident's refusals of meals. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 6/26/2025, at 11:22 a.m. with Licensed Vocational Nurse (LVN) 4, Resident 167's COC Evaluation Note , Progress Notes for the month of June 2025 and recent MDS were reviewed. LVN 4 stated the COC indicated Resident 167 verbalized the desire to die and the facility should have addressed the suicidal ideation right away to ensure resident's safety. LVN 4 stated it was a verbalization of harming oneself, the staff should not have left the resident alone and should have a CNA stay or sit with the resident to observe resident's behavior. LVN 4 confirmed Resident 167's behavior about wanting to die was not monitored and documented by staff in the Progress Notes. During a concurrent interview and record review on 6/26/2025, at 1:28 p.m. with Minimum Data Set Nurse (MDSN), Resident 167's electronic health record was reviewed. MDSN confirmed PHQ 9 score was 12 during MDS assessment and the social service is responsible in determining the score based on assessment. MDSN stated there was no new physician order addressing resident's episode of suicidal ideation. MDSN stated PHQ 9 score of 12 indicated moderate depression and will trigger addressing psychosocial well being that will be reflected on Resident 167's care plan. MDSN stated the facility should have addressed Resident 167's verbalization of wanting to die. MDSN verified thru recent MDS and admission Record Resident 167 had no diagnosis of depression. MDSN stated the staff did not notify her about Resident 167's desire to die. MDSN stated the facility should have done Interdisciplinary Team (IDT-group of professional and direct care staff that have primary responsibility for the development of a plan for the care of a resident) meeting addressing Resident 167's suicidal ideation , performed a psychiatric evaluation(relating to mental illness or its treatment), monitored resident's mood and involved the family. During an interview on 6/26/2025, at 2:04 p.m. with Director of Social Services (SSD), SSD stated she documents on MDS regarding Resident 167's behavior and mood. SSD stated Resident 167 had depression during MDS assessment. SSD stated if a resident has a PHQ 9 score of 12 , the resident gets referred to a psychologist(mental health professional who uses psychological evaluations and talk therapy to help people learn cope with life and mental health conditions) for possibility of depression. SSD stated she was not aware Resident 167 had verbalized to the staff that he wanted to die, and the resident should have been seen right away by a psychiatrist (a medical practitioner specializing in the diagnosis and treatment of mental illness) to assess his behavior and mood. SSD stated the facility should have done a suicide assessment (a process to figure out if someone is at risk of harming themselves), notified the physician right away and have someone watch the resident closely like a one-on-one observation(a practice where a designated staff member provides continuous, close supervision to a patient to ensure their safety and prevent harm). SSD stated she should have called the psychologist to evaluate and manage Resident 167's depression and the licensed nurse should have called and informed the physician right away to ensure resident's safety because he was verbalizing the desire to die. SSD stated Resident 167 was at risk of carrying a suicide attempt if the resident was not assessed and monitored closely. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 6/26/2025, at 2:34 p.m., and subsequent interview on 6/26/2025, 3:20 p.m., with LVN 1, Resident 167's COC dated 6/16/2025 timed at 5:23 p.m., facility's phone log intended for nurses' use were reviewed. LVN 1 stated Resident 167 was tired of muscle spasms and wanted to die out of frustration. LVN 1 stated Resident 167 felt he was not getting any better and his medicines were not effective. LVN 1 stated there was no one on one observation conducted when Resident 167 verbalized he wanted to die but they rounded frequently. LVN 1 stated he notified RN Supervisor (RNS 2) and called the nurse practitioner (NP). LVN 1 stated he told he never received a call back from the NP during his shift. LVN 1 verified through record review of phone call logs for nurses on 6/16/2025 and 6/17/2025 , that the NP did not return his call regarding resident's desire to die. LVN 1 stated Resident 167 could be at risk of being able to carry out his plan to hurt himself if he was not monitored and assessed closely. During an interview on 6/26/2025, at 3:34 p.m. and subsequent interview at 5:51 p.m. and 7:44 p.m. with the Director of Nursing (DON),the DON stated she was not informed of Resident 167 verbalization of wanting to die. The DON stated Resident 167 was frustrated in life in general and did not believe the resident had suicidal tendencies. The DON stated the staff should have assessed, monitored Resident 167, followed up the call to the physician and performed a one-on-one observation by not leaving the resident by himself right away. During a review of facility's policy and procedure (P&P) titled, Behavior/ Psychoactive Management, dated 3/24/2024, the P&P indicated the facility will provide a person-centered , comprehensive, and interdisciplinary care that will reflect best practice od standards for meeting health, safety, psychosocial, behavioral, and environmental needs of residents. The P &P indicated the facility will provide a therapeutic environment that supports residents to obtain and maintain the highest physical, mental and psychosocial being.

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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** Based on observation, interview, and record review, the facility failed to maintain a medication error rate of less than 5% (percent) during medication pass for one of the four sampled residents (Residents 46) The facility failed to: a. Administer Resident 46's Onglyza (medication for DM), Sitagliptin (medication for DM) and Risperdal (antipsychotic medication [used to treat schizophrenia and bi-polar]) within 60 minutes of its scheduled time as per facility's policy and procedure (P&P) titled, Medication Administration dated 1/1/2012. These deficient practices of medication administration error rate of 9.09% exceeded the five (5) percent threshold. Findings: During a review of Resident 46 admission Record, dated 6/25/25, the admission Record indicated Resident 46 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), paranoid schizophrenia (a mental illness that is characterized by disturbances in thought), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), and anxiety disorder(a mental health condition characterized by excessive, persistent and uncontrollable feelings of worry, fear and unease). During a review of Resident 46 History and Physical (H&P), dated 5/20/25, the H&P indicated Resident 46 was able to make decisions regarding activities of daily living (ADLs- activities such as oral hygiene, dressing and toileting a person performs daily. During a review of Resident 46 Minimum Data Set (MDS - a resident assessment tool), dated 5/22/25, the MDS indicated Resident 46 had moderate cognitive (mental action or process of acquiring knowledge and understanding through thought and the senses) impairment. The MDS also indicated Resident 46 was set-up or clean up assistance (helper sets up or cleans up) with ADLs. The MDS also indicated Resident 46 was taking an antipsychotic (used to treat schizophrenia and bi-polar) medications and hypoglycemic (used to treat DM) medications. During a review of Resident 46's Order Summary Report dated 6/25/25, the Order Summary report indicated Resident 46 was prescribed the following medications: 1.Onglyza (medication for DM) 5 milligrams (mg- unit of measure) give one tablet by mouth one time a day for DM. 2.Sitagliptin (medication for DM)100 mg give 1 tablet by mouth one time a day for DM 2, 3.benztropine (medication used to treat extrapyramidal symptoms (EPS- a group of side effects that can occur from taking certain medications that effect movement and muscle control) 1 mg by mouth two times a day (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4.Lithium 300mg give 1 capsule by mouth two times a day for bi-polar disorder manifested by labile mood switching from happy to angry 5.Risperdal (antipsychotic medication) 1 mg give one tablet by mouth two times a day for schizophrenia manifested by angry outbursts during care. During an observation on 6/25/25 at 8:15 a.m., in Resident 46's room, Licensed Vocational Nurse 1 (LVN) . LVN1 was observed giving Resident 46 lithium (medication used to treat bi-polar) and benztropine (medication used to treat EPS). During a review of Resident 46's Medication Administration Audit Report, dated 6/25/25, the Medication Administration Audit report indicated Resident 46 was scheduled to receive Onglyza 5 mg give one tablet by mouth one time a day at 9:00 am for DM 2, medication was given at 10:48 am, Sitagliptin 100 mg give 1 tablet by mouth one time a day at 9:00 am for DM 2, medication was given at 10:48 am and Risperdal 1mg give one tablet by mouth at 9:00 am for schizophrenia manifested by angry outbursts during care, medication was given at 10:48 am. During a concurrent interview and record review on 6/25/25 at 11:30 a.m., with LVN 1, Resident 46's Medication Administration Audit report dated 6/25/25 was reviewed. LVN 1 stated medication can be given one hour before scheduled administration time and one hour after scheduled administration time. LVN 1 stated he should have given Resident 46 his Onglyza, Sitagliptin and Risperdal when he gave Resident 46 his lithium and benztropine at 8:15 am. LVN 1 stated Resident 46 did receive his medications late and that Resident 46's blood sugar would not be managed well and his quality of life could have been affected when not receiving his medications on time. During an interview on 6/25/25 at 3:27 pm with the Director of Nursing (DON). The DON stated she was aware that Resident 46's Onglyza, Sitagliptin and Risperdal were given late. The DON stated medications scheduled to be given at 9:00 am can be given at 8:00 am and can be given no later than 10:00 am. The DON stated it will be harder to manage the residents' conditions when medications were not given on time. During a review of the facility's Policy and Procedure (P&P) Medication Administration dated 1/1/2012, the P&P indicated medication will be administered direct by the LVN and upon the order of a physician or licensed independent practitioner. The licensed nurse will prepare medications within one hour of administration. Medications may be given one hour before or one hour after scheduled medication times.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure one of four sampled residents (Resident 46) was free from significant medication errors by failing to administer Onglyza for diabetes mellitus 2 (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), Sitagliptin for DM 2 and Risperdal (antipsychotic medication) used to treat schizophrenia (a mental illness that is characterized by disturbances in thought) as prescribed by the physician. These failures had the potential to place Resident 46 at risk for hyperglycemia (high blood sugar) and angry outbursts. Findings: During a review of Resident 46 admission Record, dated 6/25/25, the admission Record indicated Resident 46 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), paranoid schizophrenia (a mental illness that is characterized by disturbances in thought), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), and anxiety disorder(a mental health condition characterized by excessive, persistent and uncontrollable feelings of worry, fear and unease). During a review of Resident 46 History and Physical (H&P), dated 5/20/25, the H&P indicated Resident 46 was able to make decisions regarding activities of daily living (ADLs- activities such as oral hygiene, dressing and toileting a person performs daily. During a review of Resident 46 Minimum Data Set (MDS - a resident assessment tool), dated 5/22/25, the MDS indicated Resident 46 had moderate cognitive (mental action or process of acquiring knowledge and understanding through thought and the senses) impairment. The MDS also indicated Resident 46 was set-up or clean up assistance (helper sets up or cleans up) with ADLs. The MDS also indicated Resident 46 was taking an antipsychotic (used to treat schizophrenia and bi-polar) medications and hypoglycemic (used to treat DM) medications. During a review of Resident 46's Order Summary Report dated 6/25/25, the Order Summary report indicated Resident 46 was prescribed the following medications: 1.Onglyza (medication for DM) 5 milligrams (mg- unit of measure) give one tablet by mouth one time a day for DM. 2.Sitagliptin (medication for DM)100 mg give 1 tablet by mouth one time a day for DM 2. 3.Risperdal (antipsychotic medication) 1 mg give one tablet by mouth two times a day for schizophrenia manifested by angry outbursts during care. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 46's Medication Administration Audit Report, dated 6/25/25, the Medication Administration Audit report indicated Resident 46 was scheduled to receive Onglyza 5 mg give one tablet by mouth one time a day at 9:00 am for DM 2, medication was given at 10:48 am, Sitagliptin 100 mg give 1 tablet by mouth one time a day at 9:00 am for DM 2, medication was given at 10:48 am and Risperdal 1mg give one tablet by mouth at 9:00 am for schizophrenia manifested by angry outbursts during care, medication was given at 10:48 am. During an observation on 6/25/25 at 8:15 am in Resident 46's room, Licensed Vocational Nurse 1 (LVN 1) was observed administer Resident 46's lithium (medication used to treat bi-polar) and benztropine (medication used to treat extrapyramidal symptoms (EPS- a group of side effects that can occur from taking certain medications that affect movement and muscle control), no other medications were given at this time. During a concurrent interview and record review on 6/25/25 at 11:30 a.m., with LVN 1, Resident 46's Medication Administration Audit Report dated 6/25/25 was reviewed. LVN 1 stated medication can be given an hour before scheduled administration time and an hour after scheduled administration time. LVN 1 stated he should have given Resident 46's Onglyza, Sitagliptin and Risperdal when he gave Resident 46 his medications at 8:15 am. LVN 1 stated Resident 46 received his Onglyza for DM2, Sitagliptin for DM2 and Risperdal for his schizophrenia at 10:48 a.m., and that Resident 46 could get hyperglycemia and possibly decreasing his quality of life. During an interview on 6/25/25 at 3:27 p.m., with the Director of Nursing (DON). The DON stated she was aware that Resident 46's Onglyza for DM 2, Sitagliptin for DM 2 and Risperdal for schizophrenia were given on 3/25/2025 at 10:48 a.m. The DON stated medications scheduled to be given at 9:00 am can be given at 8:00 am and can be given no later than 10:00 am. The DON stated Resident 46 was at risk for hyperglycemia and it would be harder to manage Resident 46's angry outbursts when medications are not given on time. During a review of the facility's policy and procedure (P&P) titled Medication Administration dated 1/1/2012, the P&P indicated medication will be administered direct by the LVN and upon the order of a physician or licensed independent practitioner. The licensed nurse will prepare medications within one hour of administration. Medications may be given one hour before or one hour after scheduled medication times. Cross reference F759

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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. Based on observation, interview and record review, the facility failed to ensure safe and sanitary food storage and preparation practices when the facility failed to: 1.Ensure an open bag of frozen salisbury steak was stored in a sealed plastic bag in the freezer. 2.Ensure an open box of hot rice cereal was dated, labeled and stored in a sealed bag or container. These failures had the potential to result in harmful bacteria growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to food borne illness (illness caused by food contaminated with bacteria, viruses, parasites, or toxins). Findings: During an initial kitchen observation and interview on 6/23/2025, at 8:11 a.m. with Dietary Manager (DM), observed an open plastic bag of frozen salisbury steaks in an open carton box was stored in the freezer. Observed DM took another plastic bag , placed the frozen salisbury steak in the plastic bag and returned the frozen steaks in the freezer. Observed an open box of rice hot cereal sitting on the kitchen countertop without an open date label. Observed DM she threw the rice cereal box in the garbage as the kitchen staff did not put the rice cereal in a bag to maintain the freshness of the food, and it was not labeled with an open date. During an interview on 6/25/2025, at 8:50 a.m. with [NAME] (CK1), CK 1 stated an open bag of frozen salisbury steak should be stored in a tight sealed bag to ensure freshness of the food being served to the residents. CK 1 stated an open box of rice hot cereal should have been stored in a bag and labeled with an open date so the staff would know when it will be expired. CK 1 stated not labeling and dating open food items could place residents at risk for food poisoning. During an interview on 6/25/2025, at 9;14 a.m. with DM, DM stated an open bag of frozen salisbury steaks not properly stored in a sealed bag could create freezer burns affecting the quality of food. DM stated an open box of hot rice cereal should be labeled with an open date and stored in a sealed plastic bag to ensure freshness so the kitchen staff will know when the food items will expire. DM stated not labeling and dating open food items can affect the quality of food and if served it can put residents at risk for food-borne illnesses. During an interview on 6/26/2025 at 1:10 p.m. with Registered Dietician (RD), RD stated it was important to store open bag of frozen steaks in a bag because it will prevent freezer burns. RD stated food items with freezer burns will diminish the quality of food and open frozen foods in the freezer could get contaminated in the freezer which could place residents at risk for food borne illnesses. RD stated labeling open food items with open date and storing them in a sealed bag will ensure the freshness of food and can minimize the risk of residents getting sick because staff will know when the food will expire. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of facility's policy and procedure (P&P) titled, Food Storage and Handling, dated 6/4/2024, the P&P indicated food items will be stored properly and prepared in accordance with sanitary practices and prevention of food-borne illnesses. The P&P indicated all food items will be correctly labeled, dated and foods to be frozen should be stored in an airtight container.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview and record review, the facility's Quality Assessment and Assurance Committee ([QAA] develop and implement appropriate plans of action to correct identified quality deficiencies) and the Quality Assurance Performance Improvement ([QAPI] a group who takes a systemic, interdisciplinary, comprehensive, and data driven approach to maintaining and improving safety and quality in nursing homes while involving residents and families) failed to ensure effective oversight of the facility and implementation of the facility's plan of correction (POC) of the deficient practices identified during the previous recertification survey. This failure resulted in the facility having repeat deficiencies in the areas of activities of daily living care provided for dependent residents, formulating advance directives (written statement of a person's wishes regarding medical treatment made to ensure those wishes are carried out should the person be unable to communicate), infection prevention, Quality Assurance and Performance Improvement, food storage, free of medication error rates of five percent or more, and free from psychotropic (substances that change how the brain works, affecting the person's mood, thoughts, feelings, and behavior) medication use. Findings: During a review of the facility's Statement of Deficiencies for the 2024 Recertification survey indicated the following repeat deficiencies in advance directives, activities of daily living (ADLs), infection prevention, Quality assurance and performance improvements, pharmacy services, psychotropic medication use, and food storage. During an interview on 6/26/2025 at 2:57 p.m., with the Administrator (ADM), the ADM stated the QAPI committee is currently working on falls and behavior management. The ADM stated the QAPI committee could improve address the repeat deficiencies by providing additional training, education, and in-services to the staff, increase rounding on the residents, and ensure the social services director (SSD) has a better understanding of the advance directive process. During a review of the facility's policy and procedure (P&P) titled, Quality Assurance and Performance Improvement (QAPI) Program, dated 2022, the P&P indicated, the facility implements and maintains an ongoing, facility-wide QAPI Program designed to monitor and evaluate the quality of resident care, pursue methods to improve quality of care, and resolve identified issues. The purpose is to implement a process that identifies opportunities for improvement and leads to optimal achievement in clinical and operational outcomes, and overall quality of care. To provide a structure and process to correct identified opportunities for improvement and establish benchmarks to measure outcomes.

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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** The facility failed to ensure transmission-based precautions (set of infection control measures designed to prevent the spread of infectious diseases in healthcare settings) were implemented for one of one sampled resident (Resident 22) who had an order to rule out Clostridium difficile (C. diff- a highly contagious bacteria that causes severe diarrhea) due to frequent diarrhea. This failure had the potential to expose other residents, staff and visitors to the spread of infection. Findings: During a review of Resident 22's admission Record, the admission Record indicated Resident 22 was admitted to the facility on [DATE] with diagnoses including diabetes mellitus, (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) paranoid schizophrenia(a mental illness that is characterized by disturbances in thought), major depressive disorder(a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety (a feeling of fear, dread, and uneasiness). During a review of Resident 22's History and physical (H&P), dated 8/24/2024, the H&P indicated Resident 22 had the capacity to understand and make decisions. During a review of Resident 22's Minimum Data Set (MDS-a resident assessment tool), dated 5/27/2025, the MDS indicated Resident 22 was independent with eating, oral hygiene, toileting, dressing and walking. During an interview on 6/25/2025 at 2:22 p.m., with Certified Nursing Assistant (CNA) 4, CNA 4 stated Resident 22 had diarrhea two weeks ago. CNA 4 stated we were going to test Resident 22's stool for infection. CNA 4 stated Resident 22 does not have any precautions. CNA 4 stated no protective personal equipment needs to be worn when providing care to Resident 22. CNA 4 stated Resident 22 uses adult pull-ups and needs help with putting on pull-ups. During an interview on 6/25/2025 at 2:42 p.m., with Licensed Vocational Nurse (LVN) 3, LVN 3 stated Resident 22 had an order to rule out C. diff. LVN 3 stated Resident 22 had on and off loose stools. LVN 3 stated Resident 22 had a loose stool on 6/25/2025. LVN 3 stated no stool was collected to rule out C. diff for Resident 22. LVN 3 stated Resident 22 had multiple episodes of incontinence, but no stool was collected as ordered. LVN 3 stated she does not know that stool was not collected to rule out C-diff. LVN 3 stated Resident 22 does not have any diagnosis that would cause diarrhea. LVN 3 stated the Infection Preventionist Nurse was not aware Resident 22 had diarrhea. LVN 3 stated to rule out C. diff put residents on transmission-based precautions and use Personal Protective Equipment (PPE- equipment worn to minimize exposure to hazards that cause serious workplace injuries and illnesses) and monitor Resident 22's roommates for any signs and symptoms of C. diff. LVN 3 stated C. diff can spread fast if residents were not on transmission-based precaution. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056042	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bay Vista Healthcare & Wellness Centre, LP	5901 Downey Ave Long Beach, CA 90805

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 6/26/2025 at 10:46 a.m., with Registered Nurse Supervisor (RNS) 1, Resident 22's Task for Bowel and Bladder, dated 6/2025 was reviewed. The Task for Bowel and Bladder indicated since 6/5/2025 Resident 22 was incontinent of stool seven times. RNS 1 stated stool should have been collected to rule out C. diff. RNS 1 stated Resident 22 should have been placed on contact precautions, and gowns, masks, and gloves need to be worn when caring for the resident. RNS 1 stated staff should have been made aware of implementing contact precautions(infection control measures used to prevent the spread of infections that can be transmitted by direct or indirect contact with a patient or their environment). RNS 1 stated the Infection Preventionist Nurse (IPN) should have been notified because she oversees infection control. RNS 1 stated it was the RNS who was responsible for making sure the IPN was notified about resident's order to rule out C. diff. RNS stated licensed nurses were responsible for making sure the IPN was aware of any risk for transmission-based precautions. The IPN needs to be aware so infection control protocols can be implemented. RNS 1 stated C-diff can spread quickly to the residents and staff members. RNS 1 stated if C. diff was not ruled out the resident can continue to have C. diff, increased diarrhea and altered electrolytes (minerals in your body and other body fluids). During an interview on 6/26/2025 at 12:58 p.m., with IPN, IPN stated she was not aware of the order to collect stool for C. diff. IPN stated she should have been notified right away so she can take action to prevent the spread of infection. IPN stated residents and staff were at risk for contracting C. diff. During an interview on 6/26/2025 at 6:27 p.m., with the Director of Nursing (DON), the DON stated Resident 22 should have been put on contact precaution. The DON stated nursing staff should have collected a stool sample. The DON stated Resident 22 now has another stool culture ordered to rule out what was causing Resident 22 to have loose stools. During a review of the facility's policy and procedure (P&P), titled Laboratory Services, revised 1/1/2012, the P&P indicated, .The Facility will provide laboratory services in an accurate and timely manner to meet the needs of residents per Attending Physician orders . During a review of the facility's P&P, titled Resident Isolation-Categories of Transmission-Based Precautions, date revised 1/1/2012, the P&P indicated, .Contact precautions are implemented for residents known or suspected to be infected or colonized with microorganisms that are transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. Examples of infections requiring Contact Precautions include, but are not limited to: gastrointestinal, respiratory, skin, or wound infections or colonization with multi-drug-resistant organisms (e.g., Methicillin-resistant Staphylococcus aureus [MRSA is a type of bacteria that's resistant to many common antibiotics], Vancomycin-intermediate Staphylococcus aureus [VISA- is a type of bacterial infection caused by Staphylococcus aureus bacteria that have developed decreased susceptibility to the antibiotic vancomycin {antibiotic}], Vancomycin-Resistant Staphylococcus aureus [VRSA- a type of antibiotic-resistant bacteria that is resistant to vancomycin], Vancomycin-Resistant Enterococci [VRE- a type of bacteria resistant to the antibiotic vancomycin]); Diarrhea associated with Clostridium difficile .