STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056043	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Care Center	1913 E 5th Street Long Beach, CA 90802

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45382 Based on interview and record review the facility failed to: a. involve one of 10 sampled residents (Resident 188) and his responsible party, family member (FM 1) in creating a plan of care for significant weight loss. b. ensure one of seven sampled residents (Resident 19) participated in the development and implementation of his care plan by failing to ensure Resident 19 was involved in the care planning process when Restorative Nursing Aide (RNA, nursing aide program that helps residents maintain their function and joint mobility) services for range of motion (ROM, full movement potential of a joint) exercises to both legs were discontinued. These deficient practices caused Resident 188 and FM 1 to not be informed regarding Resident 188's current health condition and Resident 19's right to be active participant in his care. Findings: During a review of Resident 188's admission record, the admission record indicated Resident 188 was admitted to the facility 12/6/2024 with diagnoses of gastrostomy tube (GT, a feeding tube), muscle wasting, non-Hodgkin lymphoma (cancer), tracheostomy tube (an opening surgically created through the neck into the trachea (windpipe) to allow air to fill the lungs), and multiple pressure ulcers. During a review of Resident 188's Weights and Vitals Summary, on 12/6/2025 (admission) Resident 188 weighed 119 lbs. On 1/3/2025 the Weights and Vitals Summary indicated Resident 188 weighed 110 lbs., a 9 lb. (7.6%) loss since admission 1 month prior. On 2/6/2025 the Weights and Vitals Summary indicated Resident 188 weighed 93.2 lbs., a 25.8 lb. (21.7%) loss since admission 60 days (2 months) prior. During a review of Resident 188's minimum data set (MDS, a resident assessment tool) dated 12/13/2024 indicated Resident 188 had severe cognitive impairment (a significant decline in cognitive abilities that significantly impact daily functioning and independence). The MDS indicated Resident 188's current weight (taken 12/6/2024) was 119 lbs., Resident 188 was receiving a therapeutic diet (e.g., diabetic), and Resident 188 was receiving 51% or more of his total calories through a feeding tube. Resident 188's medical record did not include an updated significant change MDS containing updated information regarding his cognitive function or weight loss. (continued on next page)

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

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 188's Nutrition/ Dietary Note dated 1/7/2025, the RD indicated Resident 188's weight was 110 lbs. a 9-pound (8% (number documented by RD)) weight loss in 1 month. The RD indicated Resident 188's ideal body weight (IBW) was 117 to 143 lbs., and the weight loss was significant. During an interview on 2/8/2025 at 1:23 p.m., the ADON stated it was important to involve the resident and RP in the care planning process so they could be involved in the plan of care and a care planning meeting or interdisciplinary team (IDT, brings together knowledge from different health care disciplines to help people receive the care they need) meeting should be done as soon as the resident and RP are available after a change of condition (COC). The ADON stated he could not find any information in Resident 188's chart that FM 1 was informed of the severe weight loss or invited to participate in Resident 188's plan of care for weight loss. The ADON stated he could not find a care plan for severe weight loss. The ADON stated a severe weight loss care plan was important because it ensured the staff were addressing the residents needs and they want to prevent the resident from further weight loss. During a review of the facility's policy and procedure (P/P) titled Weight Assessment and Intervention dated 3/2022, the P/P indicated the threshold for significant unplanned and undesired weight loss was to be based on the following criteria [where percentage of body weight loss = (usual weight - actual weight)/ (usual weight) x 100]: a. 1 month - 5% weight loss is significant; greater than 5% is severe. b. 3 months- 7.5% weight loss is significant; greater than 7.5% is severe. c. 6 months - 10% weight loss is significant; greater than 10% is severe. Care planning for weight loss or impaired nutrition was a multidisciplinary effort and included the physician, nursing staff, the dietitian (RD), the consultant pharmacist, and the resident or resident's legal surrogate (RP). Individualized care plans shall address to the extent possible: the identified causes of weight loss; goals and benchmarks for improvement; and time frames and parameters for monitoring and reassessment. b. During a review of Resident 19's Admission Record, the Admission Record indicated the facility initially admitted Resident 19 on 9/10/2003 and readmitted Resident 19 on 5/20/2023 with diagnoses including C1-C4 quadriplegia (spinal cord injury in the neck region causing weakness or paralysis in both arms and both legs), polyneuropathy (damage of the nerves that can cause weakness, numbness, and burning pain) and chronic obstructive pulmonary disease (lung disease that causes obstruction of airflow and can limit normal breathing). During a review of Resident 19's Order Summary Report, the Order Summary Report indicated a physician's order, ordered on 5/24/2023 and discontinued on 10/17/2024, for RNA to provide passive range of motion (PROM, movement at a given joint with full assistance from another person) exercises to Resident 19's both legs, every day, five times a week. The Order Summary Report indicated the physician's order was discontinued because Resident 19 was uncooperative and refused the RNA program. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 19's MDS dated [DATE], the MDS indicated Resident 19 was cognitively (ability to think, understand, learn, and remember) intact. The MDS indicated Resident 19 was dependent in eating, hygiene, toileting, bathing, dressing, and rolling to both sides. The MDS indicated Resident 19 had functional ROM limitations (limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk of injury) in both arms (shoulder, elbow, wrist, hand) and both legs (hip, knee, ankle, foot). During an interview on 2/4/2025 at 12:07 pm, in Resident 19's room, Resident 19 stated he did not want ROM exercises for both legs because they were straight, and he would never use them again since he was paralyzed. Resident 19 stated it was hard for him to get comfortable once both legs were moved and preferred to not have them touched. Resident 19 stated he did not feel the facility involved him enough in his plan of care. During an interview and record review on 2/7/2025 at 1:00 pm, the ADON and Restorative Nursing Aide 2 (RNA 2) of the Resident 19's medical record. RNA 2 stated she used to provide RNA services to Resident 19's both legs for many years up until October 2024. RNA 2 stated Resident 19 intermittently refused RNA services in the past but was generally cooperative with ROM to both legs. RNA 2 stated Resident 19 began refusing RNA services for both legs when a different RNA was assigned to Resident 19 for ROM exercises in October 2024. RNA 2 stated Resident 19 was particular with who assisted in his care and may have been upset when the RNA changed. RNA 2 stated she returned to assist Resident 19 with ROM exercises to both legs but Resident 19 adamantly refused and stated he no longer wanted ROM exercises to both legs. RNA 2 stated she informed Rehab who then discontinued the RNA order for ROM exercises to both legs. The ADON reviewed Resident 19's electronic record and stated there was no evidence the Physical Therapist (PT, profession aimed in the restoration, maintenance, and promotion of optimal physical function) who discontinued the RNA order discussed the plan of care with Resident 19 and/or other staff before discontinuing the RNA order for ROM exercises to Resident 19's both legs on 10/17/2024. The ADON stated the plan of care should have been discussed with Resident 19 and the responsible party, the physician should have been notified, an IDT should have been conducted, and a COC should have been initiated by nursing when Resident 19 refused RNA services since he was at high risk for contracture (loss of motion of a joint associated with stiffness and joint deformity) development and his plan of care significantly changed. The ADON reviewed Resident 19's medical record and stated there was no documented evidence to confirm that the plan of care and alternatives to maintain mobility were discussed with Resident 19, the physician was notified, a COC was initiated, and an IDT was conducted. The ADON stated Resident 19 should have been involved in his plan of care to discuss the risks, benefits, and any alternative options to ensure Resident 19 received the appropriate treatment and services to prevent a decline. The ADON stated if Resident 19 was identified as having ROM limitations, was at high risk for contracture development, and was in the facility with no ROM exercises or interventions to maintain or prevent a decline, Resident 19 could potentially have a functional decline and develop contractures. During an interview and record review on 2/7/2025 at 3:15 pm, the Minimum Data Set Coordinator (MDSC) stated residents should always be involved in the care planning process. The MDSC stated if a resident who was identified as being at high risk for contracture development refused ROM services, the plan of care should be discussed with the resident, a COC should be initiated, and an IDT should be conducted to discuss alternative treatment options and explore the reasons for refusal. The MDSC reviewed Resident 19's electronic medical record and stated there was no documented evidence to indicate the plan of care for Resident 19's RNA refusals were discussed when RNA services were discontinued for ROM exercises to Resident 19's both legs on 10/17/2024. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/7/2025 at 5:52 pm, the Director of Nursing (DON) stated it was important for residents and their responsible parties to always be informed of and involved in their plan of care. The DON stated if a resident refused to participate in a recommended RNA program, the plan of care should always be discussed with the resident and responsible party and an IDT meeting should be done to identify the reason for refusals and develop alternative interventions to prevent any decline. During a review of the facility's Policy and Procedure (P/P) titled Resident Rights, revised 3/2023, the P/P indicated Federal and State laws guarantee certain basic rights to all residents of the facility which include being informed of and participating in, his or her care planning and treatment. Cross reference: F656 and F692 45891

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. 50387 Based on observation, interview, and record review, The facility failed to respect dignity for one of two residents (Resident 119) who were under hospice care by not providing oral care when resident 119's teeth covered with brown, sticky matters. This failure has the potential to result in aspiration, tooth decay, pain, and infection, compromising Resident 119's comfort, dignity and overall health. Findings: During a review of Resident 119's Admission Record, the Admission Record indicated the facility admitted Resident 119 on 8/14/2020 with diagnoses including arteriosclerotic heart disease (a condition that occurs when the coronary arteries narrow or become blocked) and Wernicke's encephalopathy (a brain disorder caused by a severe lack of vitamin B1). During a review of Resident 119's History and Physical (H&P), dated 1/26/2025, indicated, Resident 119 did not have the capacity to understand and make decisions. During a review of Resident 119's Minimum Data Set (MDS- a resident assessment tool), dated 11/14/2024, indicated Resident 119's cognitive skills (the mental abilities your brain uses to think, process information, remember things, pay attention, and solve problems) for daily decision making was severely impaired. The MDS also indicated Resident 119 had functional impairment in range of motion on both upper and lower extremities, was dependent for oral hygiene. During a review of Resident 119's Order Summary Report, orders as of 2/6/2024, the Order Summary Report indicated that the following physician orders: a. 1/25/2025- Placed Code Status as do-not-resuscitate (DNR) b. 1/25/2025- Admit to hospice care. c. 1/31/2025- Provide suctioning as needed, including nasal tracheal suctioning if necessary d. 2/3/2025-Provide oral care for comfort. During a review of Resident 119's care plan for self-care deficits, revised on 8/24/2022 indicated that Resident 119 required total assist with her ADLs. The care plan goal indicated Resident 119 would be clean, dry and well groomed daily. The care plan interventions which included providing oral care two times a day and assisting as needed. During a review of Resident 119's care plan for 'on hospice care', initiated 1/28/2025, indicated that Resident 119 was expected to deterioration due to decline/ terminal illness. The care plan goal indicated that Resident 119 would be comfortable: kept clean and dry; maintain dignity ongoing until the next assessment. The care plan interventions which included providing good oral hygiene. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 119's Medication Administration Record (MAR), for the month of February, the MAR indicated that oral care for comfort was not provided in February, as required. During an observation on 2/3/2025 at 10:32 a.m. in Resident 119's room, observed Resident 119 sitting upright at an 80-degree angle in bed, receiving 3 liter(L)/minute(min) of oxygen via (through) nasal cannular (NC). Resident 119 had a bubbling sound in the throat, indicating the presence of secretions. Resident 119's mouth was open, and there was dried, sticky brown buildup between and covering the entire bottom teeth. During an observation on 2/4/2025 at 4:13 p.m. in Resident 119's room, observed Resident 119 sitting upright at an 80-degree angle in bed, receiving 3 L/min of oxygen via NC. Resident 119 had a bubbling sound in her throat, indicating the presence of secretions. Resident 119's mouth was open. There was dried and sticky brown buildup between and covering her entire bottom teeth. During an interview on 2/5/2025 at 9:06 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated that Resident 119 is under palliative care, she still requires all nursing care, including oral care. During a concurrent observation and interview on 2/5/2025 at 10:11 a.m. with LVN 1 in Resident 119's room, observed LVN 1 assessing the buildup inside of Resident 119's mouth. Upon inspecting Resident 119's mouth, LVN 1 stated that it was light brown, dried, and stuck between the teeth, and stated that's so bad unsure if it was food residue or another buildup. LVN 1 also stated that CNAs are responsible for providing morning care, oral care should be provided as needed, at least in the morning, to prevent aspiration, discomfort, and potential infections, and Resident 119 should not have such build up, as it can lead to aspiration, tooth decay, pain, infections and food fly can go into the resident's mouth because of it. During an interview on 2/7/2025 at 12:53 p.m. with the Director of Nursing (DON), the DON stated that oral care is essential for maintaining dignity, even in palliative care, and should be considered a necessary aspect of patient care. During a review of the facility's policy and procedure (P&P) titled, Palliative care, undated, indicated the Resident will be assisted to be a comfortable demise in a dignified manner. During a review of the facility's P&P titled, mouth care, dated 2001, indicated that the purposes of this procedure are to keep the resident's lips and oral tissues moist, to cleanse and freshen the resident's mouth and to prevent oral infection. The H&P also indicated that Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 46415 Based on interview and record review, the facility failed to ensure the residents' medical records were updated to show documentation that a resident has an advance directive (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 them to a doctor) for four of eight of sampled residents (Resident 37, 343, 55, and 46). This deficient practice had the potential to cause conflict with the residents' wishes regarding health care. 1. During a review of Resident 37's Admission record (Face Sheet), the Face Sheet indicated Resident 37 was initially admitted to the facility on [DATE] and was readmitted on [DATE] and with diagnoses including dementia (a progressive state of decline in mental abilities), gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), and contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion) on the left elbow and hand. During a review of Resident 37's History and Physical (H&P) dated 12/19/2024, the H&P indicated Resident 37 does not have the capacity to understand and make decisions. During a review of Resident 37's Minimum Data Set ([MDS] a resident assessment tool), dated 1/23/2025, the MDS indicated Resident 37's cognitive skills (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) were moderately impaired. The MDS indicated Resident 37 was dependent on all aspects of activities of daily living (ADL: eating, oral hygiene, personal hygiene). The MDS indicated Resident 37 utilized a wheelchair and have impairments on both the upper (arms/shoulders) and lower (hip/legs) extremities. During a review of Resident 37's Surrogate Decision Maker (Advance Directive) dated 2/23/2024, the advance directive indicated Resident 37 is not capable of making preferred intensity decisions with a note documented as waiting on signature from public guardian (PG: a court-appointed person who manages the care of people who cannot make decisions for themselves). During a review of Resident 37's Social Service (SS) Notes dated 7/12/2025, 10/4/2025, and 1/2/2025 indicated Social Service Director (SSD) attempted to reach PG and left a voice mail to invite them to addend Resident 37's quarterly care plan meeting. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/6/2025 at 2:30p.m. with SSD, the SSD stated she is responsible for overlooking the staffs that were assigned by different stations to complete the advance directives. SSD stated Resident 37 has a PG assigned and does not know if a different public guardian would be assigned if the current one is not responding. SSD stated the purpose of an advance directive is for a resident to put their wishes so that others will know what kind of care they would like to be provided and is important. SSD stated advance directives are offered at admission and if a resident does not have an advance directive and does not have the capacity, the advance directive cannot be executed. SSD additionally stated if the resident does not have the capacity to sign, a responsible party will sign it, and if there are no responsible party, the PG would be notified. During a concurrent interview and record review of the SS notes dated 7/12/2025, 10/4/2025, and 1/2/2025 on 2/6/2025 at 2:57p.m. with SSD, SSD stated they have quarterly care plan meetings and when there are no major changes, it is acceptable to do meetings on a quarterly basis. SSD stated if a long-term resident required medical interventions, the meetings would occur more frequently. During a review of Resident 37's Change of Condition (COC) dated 8/7/2024 at 1:51a.m., the COC indicated Resident 37 had respiratory distress (condition where breathing becomes difficult) and was transported to a General Acute Care Hospital (GACH) at 1:45a.m. During an interview on 2/6/2025 at 3:06p.m. with SSD, SSD stated respiratory distress on COC dated 8/7/2024 is considered a medical COC and would follow up sooner. SSD stated there has been many attempts to call the PG but with no response. SSD stated she does not know if the current PG is actively working as a PG and would follow up. SSD stated Resident 37's advance directive is not confirmed and would try and call the office to see if there is a different PG that can be assigned. 2. During a review of Resident 343's Face Sheet, the Face Sheet indicated Resident 343 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including dementia, psychosis, and schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). During a review of Resident 343's H&P dated 1/29/2025, the H&P indicated Resident 343 does not have the capacity to understand and make decisions. During a review of Resident 343's MDS dated [DATE], the MDS indicated Resident 343's cognitive skills were severely impaired. The MDS indicated Resident 343 is dependent on bathing, chair/bed-to-chair transfer, personal hygiene, toileting hygiene, oral hygiene, and required maximal assistance (helper supports more than half the effort required) for eating. The MDS indicated Resident 343 is impaired on both side of the upper and lower extremities. During a review of Resident 343's Advance Directive dated 12/27/2017, the advance directive indicated Resident 343 is not capable of making preferred intensity decisions and indicated Resident 343 is unable to sign and is under a public guardian. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review of Resident 343's advance directive dated 12/27/2017 on 2/6/2025 at 2:39p.m. with SSD, SSD stated Resident 343's PG does not have to sign the paper. SSD stated upon readmission, they will do an Interdisciplinary (IDT: professionals from different disciplines come together and work to plan and coordinate care) meeting and will notify the PG to come to the facility to sign the documents. SSD stated Resident 343 does not have an advance directive and the PG did not sign the document. 3. During a review of Resident 55's Face Sheet, the Face Sheet indicated Resident 55 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including MDD, dementia, and psychosis. During a review of Resident 55's H&P dated 12/18/2024, the H&P indicated Resident 55 is able to make decisions for activities of daily living. During a review of Resident 55's MDS dated [DATE], the MDS indicated Resident 55's cognitive skills were severely impaired. The MDS indicated Resident 55 is dependent on all aspects of ADL. The MDS indicated Resident 55 is impaired on one side of the upper extremity and is impaired on both sides of the lower extremities. During a review of Resident 55's Advance Directive, the advance directive indicated Resident 55 is not capable of making preferred intensity decisions and indicated Resident 55's family was called twice with no response on 1/12/2024. During a concurrent interview and record review of the advance directive dated 1/12/2024 on 2/6/2025 at 2:31p.m. with SSD, SSD stated Resident 55 has a family member 2 (FM 2) that changes her number often and has had difficulty getting in contact with the family member. SSD stated multiple attempts have been made to contact FM 2 by phone, email, reaching out to past facilities Resident 55 resided at, but has been unable to reach FM 2. SSD stated Resident 55's care had been under the facilities IDT bioethics (provide guidance and consultation on complex medical ethical situations) committee. SSD stated Resident 55 has been referred to the PG but has been waiting for the approval or might be waitlisted. SSD stated they would have attempted to call the PG office and continue following up with them. 4. During a review of Resident 46's Face Sheet, the Face Sheet indicated Resident 46 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including dementia, schizophrenia (a mental illness that is characterized by disturbances in thought), and Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements). During a review of Resident 46's H&P dated 1/20/2025, the H&P indicated Resident 46 does not have the capacity to understand and make decisions. During a review of Resident 46's MDS dated [DATE], the MDS indicated Resident 46's cognitive skills were severely impaired. The MDS indicated Resident 46 is dependent on all aspects of ADL. The MDS indicated Resident 46 is impaired on both side of the upper and lower extremities. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 46's Advance Directive dated 4/6/2022, the advance directive indicated Resident 46 is full code (FC: patient wishes to receive all possible medical interventions if they become incapacitated and require life-saving measures) by default and is awaiting response for completion from representative (via case manager: patient advocates, supporting/coordinating care for patients to navigate their health). During a concurrent interview and record review of the advance directive dated 4/6/2022 on 2/6/2025 at 2:38p.m. with SSD, SSD stated they will wait for a response for the case manager and during quarterly meetings will ask if they can fill out or sign the advance directive forms. SSD stated the advance directive should have been followed up on it since it is from 2022. During an interview on 2/8/2025 at 7:08p.m. with Director of Nursing (DON), DON stated an advance directive gives direction to the staff on what kind of care the resident wants and is done upon admission. DON stated if there any COC or a decline in overall medication condition, they will ask the family if they want to change the advance directive. During a review of the facility's Policies and Procedures (P&P), titled Advance Directives, revised 9/2022, the P&P indicated advance directives are honored in accordance with state law and facility policy. Legal Representative (i.e., substitute decision-maker, proxy, agent) - a person designated and authorized by [NAME] advance directive or state law to make treatment decisions for another person in the event the other person becomes unable to make necessary health care decisions. If the resident is incapacitated and unable to receive information about his or her right to formulate an advance directive, the information may be provided to the residents legal representative. The interdisciplinary team conducts ongoing review of the residents decision-making capacity and invokes the resident representative or health care agent if the resident is determined not to have decision-making capacity. Changes are documented in the care plan and medical record. The interdisciplinary team will review annually with the resident his or her advance directives to ensure that such directives are still the wishes of the resident. During a review of the facility's P&P, titled Social Services, revised 9/2022, the P&P indicated the social worker/social services staff are responsible for assisting residents with advance care planning, including but not limited to completion of advance directives (F578, Advance Directives).

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45382 45891 Based on observation, interview, and record review the facility failed to: a. Notify one out of 10 sampled residents (Resident 188)'s physician (MD 1) and responsible party (FM 1) when Resident 188 had a change of condition related to significant weight loss of 7.6% (9lbs) in one month on 1/3/2025, and 20.1% (24lbs) weight loss in 2 months on 1/31/2025. b. report a change of condition (COC) for one of seven sampled residents (Resident 19) who was identified as being at high risk for contracture (loss of motion of a joint associated with stiffness and joint deformity) development and had limited range of motion (ROM, full movement potential of a joint) concerns by not Reporting Resident 19's refusal of Restorative Nursing Aide (nursing aide program that help residents maintain any progress made after therapy intervention to maintain their function) services for range of motion (ROM, full movement potential of a joint) exercises to both legs in accordance with the facility's Policy and Procedure (P/P) titled, Change in a Resident's Condition or Status. The deficient practice of Resident 188 had the potential to delay care, FM 1 would not be aware of the health status of Resident 188, and Resident 188 could be subject to further weight loss. Resident 188 was reweighed on 2/6/2025 and weighed 93.2 lbs. Resident 188 had severe weight loss of 25.8 lbs. or 21.6% in 60 days. The deficient practice resulted of Resident 19 not receiving services and alternative interventions to improve ROM, prevent contractures (condition of shortening and hardening of muscles, tendons, or other tissue, often leading to joint stiffness), and improve overall mobility and physical functioning. Cross reference: F692 Findings: During a review of Resident 188's admission record, the admission record indicated Resident 188 was admitted to the facility 12/6/2024 with diagnoses of gastrostomy tube (GT, a feeding tube), muscle wasting, non-Hodgkin lymphoma (cancer), tracheostomy tube (an opening surgically created through the neck into the trachea (windpipe) to allow air to fill the lungs), and multiple pressure ulcers. During a review of Resident 188's minimum data set (MDS, a resident assessment tool) dated 12/13/2024 indicated Resident 188 had severe cognitive impairment (a significant decline in cognitive abilities that significantly impact daily functioning and independence). The MDS indicated Resident 188's current weight (taken 12/6/2024) was 119 lbs., Resident 188 was receiving a therapeutic diet (e.g., diabetic), and Resident 188 was receiving 51% or more of his total calories through a feeding tube. Resident 188's medical record did not include an updated significant change MDS containing updated information regarding his cognitive function or weight loss. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 188's Weights and Vitals Summary, on 12/6/2025 (admission) Resident 188 weighed 119 lbs. On 1/3/2025 the Weights and Vitals Summary indicated Resident 188 weighed 110 lbs., a 9 lb. (7.6%) loss since admission 1 month prior. On 2/6/2025 the Weights and Vitals Summary indicated Resident 188 weighed 93.2 lbs., a 25.8 lb. (21.7%) loss since admission 60 days (2 months) prior. During a review of Resident 188's Order Summary Report, the report indicated an order was placed 12/6/2024 to monitor Resident 188's weight weekly times (x) 4 weeks and then monthly (no weekly weights were documented in Resident 188's Weight and Vital Sign Report in the electronic medical record (EMR)). The report indicated an order was placed on 12/6/2024 and discontinued 1/7/2025 for enteral feed order: Glucerna (diabetes-specific nutrition) 1.5 calorie (cal) formula at 45 cubic centimeter (cc, a unit of measurement) per hour (hr.) for 20 hrs. via pump to provide 900 cc/1350 kilocalories (kcals) per day. An order was placed 1/7/2025 to increase Glucerna 1.5 to 55 cc/ hr. for 20 hrs. via pump to provide 900 cc/ 1350 kcal (incorrect, would have provided 1100 cc/ 1650 kcal) per day, the order was discontinued 3 days later on 1/10/2025. On 1/7/2025, an order was placed for Imodium A-D (antidiarrhea medication) 2 milligrams (mg) via GT every 4 hours as needed for loose stool for 7 days. On 1/10/2025 an order was placed to decrease the Glucerna 1.5 back down to 45 cc/hr. for 20 hrs. (900 cc/1350 kcal) per day. There were no new orders placed until 2/7/2025 to increase the tube feeding. A new order was placed on 2/7/2025 for Glucerna 1.5 at 55 cc per hour for 20 hours via pump to provide 1100CC/1650 kcal) per day. During a review of Resident 188's untitled care plan initiated 12/23/2024, the care plan focus was Resident 188 had cancer with increased risk for weight loss secondary to non-Hodgkin's lymphoma. Goals included Resident 188 having weight loss that did not exceed 5% per month and interventions included notifying the physician and Resident 188's responsible party of any change of conditions. During a review of Resident 188's Nutrition/ Dietary Note dated 1/7/2025, the RD indicated Resident 188's weight was 110 lbs. a 9-pound (8% (number documented by RD)) weight loss in 1 month. The RD indicated Resident 188's ideal body weight (IBW) was 117 to 143 lbs., and the weight loss was significant. During a review of Resident 188's Licensed Nursing Notes Dated 1/7/2025, the notes indicated Resident 188's physician (MD 1) was informed Resident 188 was having loose stool and the RD recommended Resident 188's water flush (for hydration) would be increased to 50cc/hr. related to elevated blood urea nitrogen (BUN, a kidney function laboratory test). The nurses note did not indicate MD 1 was informed of Resident 188's weight loss. During a review of Resident 188's untitled care plan initiated 1/7/2025, the care plan focus was Resident 188 was at risk for alteration in hydration status secondary to diarrhea (loose stool). Goals included reducing the risk of unplanned weight changes for Resident 188 and interventions included monitoring Resident 188's weight (frequency not identified) and report any change of plus or minus (+/-) 3 pounds per week or +/- 5 pounds per month as indicated or per policy (policy not identified). (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 188's Nutrition/ Dietary note dated 2/6/2025, the RD indicated Resident 188 was 93 lbs., a 17 lb. (15%) weight loss in one month, 26 lb. weight loss in 3 months (these numbers are documented by RD, it appears she rounded the numbers. The RD indicated the weight loss was significant and was likely related to wound healing, diarrhea, respiratory failure (a serious condition that makes it difficult to breathe on your own), and history of sepsis (blood stream infection). The RD indicated Resident 188 was tolerating tube feeding well and was not experiencing diarrhea at the time. The RD recommended to increase the tube feeding to Glucerna 1.5 at 55cc/hr. x 20 hrs. (1100 cc, 1650 kcal). During a review of Resident 188's COC form (SBAR) dated 2/7/2024, the COC indicated Resident 188 had a 26 lb. weight loss, the COC indicated MD 1 was notified of the weight loss. There were no other COCs in Resident 188's chart regarding weight loss or informing MD 1 and Resident 188's responsible party (RP), family member (FM)1 of Resident 188's weight loss. During an observation and concurrent interview on 2/5/2025 at 12 p.m., Resident 188 stated he had been losing weight recently but was hopeful he would gain some weight back because he passed his swallow evaluation (checks how well a resident swallows) the day prior (2/4/2025) and was now able to eat a little food along with his tube feeding. Resident 188 stated he hoped to gain some weight because his legs looked like bones and he wanted to be stronger to participate in therapy Resident 188 pulled his bed sheets away from his legs and Resident 188 appeared very thin with prominent bones showing in legs. During an interview on 2/5/2025 at 2:49 p.m., Registered Nurse (RN) 2 stated she was the subacute unit manager. RN 2 stated the facility usually did not complete a COC for weight loss unless it was a lot of weight, like 40 lbs. weight loss. RN 2 agreed that 9 lbs. weight loss (7.6%) was a lot of weight to lose in one month but maintained that a COC did not need to be completed. During an interview on 2/6/2025 at 10:22 a.m., RNA 1 stated she weighed Resident 188 on Friday 1/31/2025 and the resident weighed 95 lbs. RNA 1 stated she did not document the weight from 1/31/2025 in the chart but knew Resident 188 had lost a lot of weight so she verbally informed Registered Nurse (RN 3) about the weight loss on 1/31/2025. RNA 1 stated RN 3 stated that the weight loss was okay, and that Resident 188 would start gaining weight because he passed his swallow evaluation and was able to eat as well as receive tube feedings. During an interview on 2/6/2025 at 11:48 a.m., RN 3 stated on 1/31/2025, RNA 1 did inform her Resident 188 lost a lot of weight (did not know exact amount). RN 3 stated she did not inform the physician (MD 1) because she was admitting another resident (unknown) at the time. RN 3 stated she assumed Resident 188 would start gaining weight now that he was able to eat by mouth and was continuing to receive tube feeding. During an interview on 2/6/2025 at 2:04 p.m., MD 1 stated he should be notified as soon as possible for severe weight loss, and it was important he was notified so he could decide on new interventions and ensure the RD was assessing the resident's nutritional needs. During an interview on 2/7/2025 at 9:59 a.m., RN 2 stated the facility only informs the physician of a significant weight change if the RD was not in or the RD couldn't be reached. RN 2 stated they only notified the physician of significant weight loss on a as needed (PRN) basis. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/7/2025 at 12:41 p.m., Resident 188's family member (FM 1) stated nursing staff (unknown) told her In passing Resident 188 was losing weight, but no one informed her how much or made it a big deal. FM 1 stated just that morning (2/7/2025) a nurse (unknown) did a formal phone call about weight loss and informed her that Resident 188 had lost weight. FM 1 stated they did not inform her of the actual amount of weight he lost but now she was feeling worried Resident 188's health. During an interview on 2/8/2025 at 1:23 p.m., the ADON stated a COC was important documentation and monitoring done when an issue occurred outside of the resident's baseline and significant weight loss is outside of resident's baseline and should be done. The ADON stated he reviewed Resident 188's medical record and could not find a COC done for weight loss or any documentation indicating the physician or FM 1 was notified of the weight loss. The ADON the physician needed to be aware of weight loss because the physician had more options for addressing the weight loss, more interventions, and modalities to address the weight loss. During a review of the facility's P/P titled Weight Assessment and Intervention dated 3/2022, the P/P indicated the threshold for significant unplanned and undesired weight loss was to be based on the following criteria [where percentage of body weight loss = (usual weight - actual weight)/ (usual weight) x 100]: a. 1 month - 5% weight loss is significant; greater than 5% is severe. b. 3 months- 7.5% weight loss is significant; greater than 7.5% is severe. c. 6 months - 10% weight loss is significant; greater than 10% is severe. Care planning for weight loss or impaired nutrition is a multidisciplinary effort and includes the physician, nursing staff, the dietitian, the consultant pharmacist, and the resident or resident's legal surrogate (RP). Individualized care plans shall address to the extent possible: the identified causes of weight loss; goals and benchmarks for improvement; and time frames and parameters for monitoring and reassessment. During a review of the facility's P/P titled Change in Resident's Condition or Status dated 3/2022, the P/P indicated the nurse was to notify the physician and RP when there has been a significant change in the resident's physical condition. Notifications were to be made within 24 hours. The nurse was to record information relative to changes in the resident's record. b. During a review of Resident 19's Admission Record, the Admission Record indicated the facility initially admitted Resident 19 on 9/10/2003 and readmitted Resident 19 on 5/20/2023 with diagnoses including C1-C4 quadriplegia (spinal cord injury in the neck region causing weakness or paralysis in both arms and both legs), polyneuropathy (damage of the nerves that can cause weakness, numbness, and burning pain) and chronic obstructive pulmonary disease (lung disease that causes obstruction of airflow and can limit normal breathing). (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 19's Order Summary Report, the Order Summary Report indicated a physician's order, ordered on 5/24/2023 and discontinued on 10/17/2024, for RNA to provide passive range of motion (PROM, movement at a given joint with full assistance from another person) exercises to Resident 19's both legs, every day, five times a week. The Order Summary Report indicated the physician's order was discontinued because Resident 19 was uncooperative and refused the RNA program. During a review of Resident 19's MDS dated [DATE], the MDS indicated Resident 19 was cognitively (ability to think, understand, learn, and remember) intact. The MDS indicated Resident 19 was dependent in eating, hygiene, toileting, bathing, dressing, and rolling to both sides. The MDS indicated Resident 19 had functional ROM limitations (limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk of injury) in both arms (shoulder, elbow, wrist, hand) and both legs (hip, knee, ankle, foot). During a concurrent observation and interview on 2/4/2025 at 12:07 pm, in Resident 19's room, Resident 19 was lying in bed with both shoulders elevated on pillows to the side to shoulder height, both elbows bent, both wrists straight, and the neck and upper body hunched forward. Resident 19's fingers of the left hand were all bent downwards, except the middle finger which was fully straight. Resident 19's fingers of the right hand were straight and held closely together. Resident 19's both legs were straight at both hips and both knees and both feet were pointing downwards. Resident 19 stated he did not want ROM exercises for both legs because they were straight, and he would never use them again since he was paralyzed. Resident 19 stated it was hard for him to get comfortable once both legs were moved and preferred to not have them touched. During an interview and record review on 2/7/2025 at 1:00 pm, the Assistant Director of Nursing (ADON) and Restorative Nursing Aide 2 (RNA 2) reviewed Resident 19's medical record. RNA 2 stated she used to provide RNA services to Resident 19's both legs for many years up until October 2024. RNA 2 stated Resident 19 intermittently refused RNA services in the past but was generally cooperative with ROM to both legs. RNA 2 stated Resident 19 began refusing RNA services for both legs when a different RNA was assigned to Resident 19 for ROM exercises in October 2024. RNA 2 stated Resident 19 was particular with who assisted in his care and may have been upset when the RNA changed. RNA 2 stated she returned to assist Resident 19 with ROM exercises to both legs but Resident 19 adamantly refused and stated he no longer wanted ROM exercises to both legs. RNA 2 stated she informed Rehab who then discontinued the RNA order for ROM exercises to both legs. The ADON stated the physician should have been notified, an Interdisciplinary Team meeting (IDT, team of health care professionals that work together with the resident and or resident's representative to prioritize the resident 's needs and goals) should have been conducted, and a COC should have been initiated by nursing when Resident 19 refused RNA services since he was at high risk for contracture development, and it was a significant change in his plan of care. The ADON reviewed Resident 19's medical record and confirmed the physician was not notified and a COC and IDT were not initiated but should have. The ADON stated the physician should have been notified, the reason for refusal should have been investigated, and alternative options should have been explored to ensure Resident 19 received the appropriate treatment and services to prevent a decline. The ADON stated if Resident 19 was identified as having ROM limitations, was at high risk for contracture development, and was in the facility with no ROM exercises or interventions to maintain or prevent a decline, Resident 19 could potentially have a functional decline and develop contractures. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/7/2025 at 5:52 pm, the Director of Nursing (DON) stated a COC was considered anything a resident experienced different from his or her baseline. The DON stated a complete refusal of RNA services of ROM exercises to both legs was considered a COC. The DON stated once staff identified a resident had a COC, a licensed nurse created a COC Evaluation, notified the physician, notified the resident's family or responsible party, implemented interventions, updated the comprehensive care plan, and monitored the resident to ensure effectiveness. The DON stated the physician should have been notified immediately and throughout the process to assist in identifying the root cause of RNA refusals and suggest or provide alternative interventions to address the issue. The DON stated Resident 19 could potentially have a functional decline and develop contractures if the physician was not notified and interventions to maintain or improve ROM were not implemented. During a review of the facility's Policy and Procedure (P/P) titled, Change in a Resident's Condition or Status, revised 3/2023, the P/P indicated the facility would promptly notify the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status. The P/P indicated the nurse would notify the resident's attending physician or physician on call when there had been refusal of treatment or medications two or more consecutive times and when there was a need to alter a resident's treatment significantly.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50387 Based on observation, interview, and record review, the facility failed to follow facility's policy and procedure by: 1. Failing to find alternative ways to prevent fall before putting the 4 side rails up for Resident 24 and placing lap tray over Resident 161 2. Failing to obtain consents before applying restraints. 3. Failing to conduct a pre-restraining assessment and review to determine the need for restrains. 4. Failing to follow resident's care plan to have IDT meeting to discuss plan of care and to ensure appropriateness of restraint. This failure has the potential to compromise the resident's dignity and safety, create un unsafe environment, and increase the risk of further injury. Findings: 1. During a review of Resident 24's Admission Record, the Admission Record indicated the facility admitted Resident 24 on 3/5/2013 and readmitted on [DATE] with diagnoses including hemiplegia (paralysis or weakness that affects one side of the body) and hemiparesis (weakness or the inability to move on one side of the body left hand contracture (a permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff), right hand contracture, right ankle contracture, and left ankle contracture. During a review of Resident 24's History and Physical (H&P), dated 8/28/2024, indicated, Resident 24 had the capacity to understand and make decisions. During a review of Resident 24's Minimum Data Set (MDS- a resident assessment tool), dated 11/21/2024, indicated Resident 24 was cognitively (related to thinking) intact. The MDS also indicated that Resident had functional impairment in range of motion on both upper and both lower extremities and needed assistances to complete Activities of Daily Living (ADL's) During a review of Resident 24's Order Summary Report, as of 2/6/2025, the Order Summary Report indicated: a) 8/18/2024- Facility may use less restricting measures prior to initiating resident with physical or chemical restraints. b) 1/30/25- Bilateral upper and lower 1/2 (half) siderails per resident request as an enabler for bed mobility, reposition and other activities of daily living (ADL)'s, not considered as a restraint. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 24's Change of Condition (COC)/Interact Assessment Form (SBAR), dated 1/30/2025, indicated that Resident 24 fell at 4:15 a.m. while trying to turn on to left side in the bed without injury. During a review of Resident 24's care plan for actual fall, initiated 2/3/2025 indicated that Resident 24 had fall on 1/31/2025. The care plan's goal was to minimize risk of falls or injury through appropriate interventions. The care plan's interventions which included to put up bilateral 1/2 (half) siderails up per resident's request. During a review of Resident 24's care plan for bilateral upper 1/2(half) siderails, revised on 10/20/2024 indicated that the side rails was considered as an enabler. The care plan's goal indicated that Resident 24 would not have complications from use of devices. The care plan's interventions which included attempting to use less restrictive devices on an ongoing basis, discussing plan of care with interdisciplinary team (DT) and resident/ responsible party, referring to IDT members for education, evaluation and recommendation of appropriate use of device. During a review of Resident 24's care plan for safety device, initiated on 1/30/2025 indicated that facility considered bilateral and lower half siderails as an enabler for bed mobility, repositing and other ADL's. The care plan's goal which included preventing or reducing incident of injury/fall. The care plan's interventions which included preventing and managing of safety/ injury from potential falls, assessing quarterly and following up by IDT team to ensure appropriateness of restraint. During a concurrent observation and interview on 2/3/2025 at 10:53 a.m. at the door of Resident 24's room, observed a yellow star next to Resident 24's name indicating Resident 24 was at high fall risk. Upon entering the room, observed Resident lying in bed with all side rails up. Resident 24 stated that she fell down last week from the bed and staff put all side rails up and she agreed. During a concurrent observation and interview on 2/4/2025 at 8:50 a.m. in Resident 24's room, observed Resident 24 lying in bed with all side rails up, the bed's foot board with blinking lights on for 'brake not set' and 'bed not down'. During a concurrent interview and record review on 2/5/2025 at 2:10 p.m. with the Assistant Director of Nursing (ADON), Resident 24's order summary as of 2/5/2025, care plan as of 2/5/2025, IDT meeting for the month of January and February. The ADON stated that physical restraints are defined any device that restricts a resident's freedom of movement and should only be applied after following proper procedures, including: a) Assessing the resident and exploring alternative measure before using restrains. b) Obtaining a physician's order and notifying family or the responsible party (RP) c) Getting informed consent from the decision-maker, explaining the risks and benefits. d) Monitoring the effectiveness of the restraint and assessing placement, circulation and overall condition. e) Updating the care plan as needed. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The ADON stated that staff did not recognize the use of all four side rails as a restraint because the resident had requested it. However, there was no consent form showing that the resident had agreed after being informed of the risks and benefits. The ADON also stated followings: a) No pre-assessment documented where Resident 24 could lower the side rails independently, and due to Resident 24's condition, she could not lower them. b) No documentation indicating staff attempted alternative measures before applying four side rails up. c) No record of staff monitoring the restriction of movement caused by the side rails. d) No IDT meeting held regarding the four side rails. e) Despite Resident 24 being a high fall risk for several years, there were no floor mats provided to prevent injury, and the bed was not consistently kept in a low, locked position to minimize fall risks. f) Resident 24's fall on 1/30/2025 was avoidable, and staff applied the side rails without attempting to find alternative interventions. 2. During a review of Resident 161's Admission Record, the Admission Record indicated the facility admitted Resident 161 on 11/11/2022, and readmitted on [DATE] with diagnoses including Dementia (a general term a decline in mental abilities that impacts a person's daily life), muscle weakness (a lack of muscle strength that makes it hard to move muscles), and history of falling. During a review of Resident 161's MDS, dated [DATE], indicated Resident 161' cognitive (related to thinking) was severely impairment cognitive. The MDS also indicated that Resident 161 had functional impairment in range of motion on both lower extremities and needed assistances to complete following functions: a) Sit to stand (the ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed)-substantial/maximal assistance (helper odes more than half the effort, helper lift, holds, or supports trunk or limbs, but provides less than half the effort) b) Chair/bed-to chair transfer (the ability to transfer to and from a bed to a chair or wheelchair): Dependent (helper does all the effort. Resident does none of the effort to complete the activity. Or the assistance of two or more helper is required for the resident to complete the activity). During a review of Resident 161's SOAP note (Subjective, objective, Assessment, Plan- a standardized format used in medical documentation to record patient information in a concise and organized manner), dated 1/20/2025, indicated that Resident 161 had fall precautions. During a review of Resident 161's Order Summary Report, orders as of 2/6/2025, the Order Summary Report indicated that the following physician orders: (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a) 12/9/2024- Geri chair (a large, padded chair that helps people with limited mobility sit and stand) with lap tray (a flat, stable surface that you can use on your lap to work, eat, or read) as tolerated for positioning and comfort per family request and time a day for positioning and comfort. During a review of Resident 116's care plan for physical restraint in use, revised on 4/16/2024 indicated that Resident 116 was at risk for decreased mobility, decreased physical functioning and type of restraint was Geri chair with lap tray as tolerated for positioning and comfort per family request. The care plan's goal was that least restrictive measures would be employed daily and Resident 116 would be restraint free through the next assessment. During an observation on 2/3/3035 at 3:16pm in activity room, observed Resident 116 in a Geri chair with a lap tray over the resident. Resident observed trying to stand up but blocked by the lap tray several times. During a concurrent interview and record review on 2/5/2025 at 3:17 p.m. with Registered Nurse (RN) 3, Resident 116's Order Summary, as of 2/5/2024 and Care Plan, active of 2/5/2024 were reviewed. The RN 3 stated that following: a) No pre-assessment documented if the lap try was necessary for Resident 24. b) No assessment if Resident 24 could remove the lap tray independently, and due to Resident 24's condition, most of time he could not lower them. c) No documentation indicating staff attempted alternative measures before placing a lap tray over Resident 24. d) No IDT meeting held regarding the lap tray restraint. During an interview on 2/5/2025 at 4:06 p/m. with the Director of Nursing (DON), the DON stated that staff did not implement necessary safety measures before applying the side rails for Resident 24 and placing a lap tray over Resident 161 and failed to ensure a safe environment for the residents. The DON stated that staff did not follow fall prevention protocols or properly reassess Resident 24's needs before using the side rails and locking the lap tray over Resident 161. The DON also stated that this failure had the potential to compromise the resident's dignity and safety, create an unsafe environment and increase the risk of furtherer injury. During a review of the facility's policy and procedure (P&P) titled, Use of Restraints, revised April 2017, indicated the restraints shall only be used after other alternatives have been tried unsuccessfully for the safety and well-being of the resident(s), when they use of restraints is indicated, the least restrictive alternative will be used for the least amount of time necessary, and the ongoing re-evaluation for the need for restraints will be documented and followings: (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	. The definition of a restraint is based on the functional status of the resident and not the device. If the resident cannot remove a device in the same manner in which the staff applied it given that resident's physical condition (i.e., side rails are put back down, rather than climbed over), and this restricts his/her typical ability to change position or place, that device is considered a restraint.3. Examples of devices that are/may be considered physical restraints include leg restraints, arm restraints, hand mitts, soft ties or vest, wheelchair safety bars, geri-chairs, and lap cushions and trays that the resident cannot remove. 4. Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints. The assessment shall be used to determine possible underlying causes of the problematic medical symptom and to determine if there are less restrictive interventions (programs, devices, referrals, etc.) that may improve the symptoms. 5. Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative (sponsor). The order shall include the following: a. The specific reason for the restraint (as it relates to the resident's medical symptom); b. How the restraint will be used to benefit the resident's medical symptom; and c. The type of restraint, and period of time for the use of the restraint. 6. The following safety guidelines shall be implemented and documented while a resident is in restraints: a. Restraints shall be used in such a way as not to cause physical injury to the resident and to insure the least possible discomfort to the resident. b. Physical restraints shall be applied in such a manner that they can be speedily removed in case of fire or other emergency. Restraints with locking devices shall not be used. c. A resident placed in a restraint will be observed at least every thirty (30) minutes by nursing personnel and an account of the resident's condition shall be recorded in the resident's medical record. 7. Residents and/or surrogate/sponsor shall be informed about the potential risks and benefits of all options under consideration, including the use of restraints, not using restraints, and the alternatives to restraint use.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46415 Based on interview and record review, the facility failed to ensure two of three sampled residents (Residents 16 and Resident 55) Preadmission Screening and Resident Review (PASRR) assessment screening was accurate to determine the facility's ability to provide the special need of the residents. This deficient practice placed the residents at risk of not receiving necessary care and services they need. Findings: a. During a review of Resident 16's Admission record (Face Sheet), the Face Sheet indicated Resident 16 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior) [bipolar type (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs)], and major depressive disorder (MDD: (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 16's History and Physical (H&P) dated 6/15/2024, the H&P indicated Resident 16 does not have the capacity to understand and make decisions. During a review of Resident 16's Minimum Data Set [MDS] a resident assessment tool)], dated 11/8/2024, the MDS indicated Resident 16's cognitive skills (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) were severely impaired. The MDS indicated Resident 16 is dependent on all aspects of activities of daily living (ADL: bathing, sit to lying, personal, toileting, oral hygiene, and eating. The MDS indicated Resident 16 is impaired on both the upper (arms/shoulders) and lower (hips/legs) extremities. During a review of Resident 16's PASRR Level I screening dated 6/11/2024, the section that indicated whether an individual has a serious diagnosed mental disorder such as depressive disorder, anxiety disorder, schizoaffective disorder, or psychosis, and/or mood disturbance, the PASRR indicated Resident 16 did not have a serious mental illness. During an interview on 2/6/2025 at 3:47p.m. with Assistant Director of Nursing (ADON), ADON stated the hospitals do the PASRR Level I screening and will send it to the facility, and if the resident required a PASRR Level II, the hospital would follow up if the resident remained in the hospital. ADON stated if they are unable to determine whether the resident required a PASRR Level II, they will do a PASRR Level I depending on the residents medical and psychological condition. ADON stated if the PASRR Level II is not available, they will follow up ADON stated they will do another PASRR Level I screening if there is a change of condition (COC)and if a resident requires a screening, or if the PASRR Level I screening is inaccurate. b. During a review of Resident 55's Face Sheet, the Face Sheet indicated Resident 55 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including major depressive disorder (MDD), dementia (a progressive state of decline in mental abilities), and psychosis. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 55's H&P dated 12/18/2024, the H&P indicated Resident 55 is able to make decisions for activities of daily living. During a review of Resident 55's MDS dated [DATE], the MDS indicated Resident 55's cognitive skills (were severely impaired. The MDS indicated Resident 55 is dependent on all aspects of activities of daily living (ADL: bathing, sit to lying, personal, toileting, oral hygiene, and eating. The MDS indicated Resident 55 is impaired on one side of the upper extremity and is impaired on both sides of the lower extremities. During a review of Resident 55's PASRR Level I Screening dated 1/9/2025, the section that indicated whether an individual has a serious diagnosed mental disorder such as depressive disorder, anxiety disorder, schizoaffective disorder, or psychosis, and/or mood disturbance, the PASRR indicated Resident 55 did not have a serious mental illness. During a concurrent interview and record review of the PASRR Level I on 2/6/2025 at 3:56p.m. with ADON, ADON stated Resident 55 was admitted to the facility on [DATE] with has a diagnosis of psychosis and dementia and Resident 16 has a diagnosis of schizoaffective disorder (bipolar type), and MDD ADON stated Resident 55's and 16's PASRR Level I was incorrectly documented. does. ADON stated the purpose of the PASRR is so that the resident is referred accordingly based on their needs and ensure the residents' psychological and mental health needs are being addressed. During a review of the facility's policies and Procedures (P&P), titled Preadmission Screening and resident Review (PASRR), revised 6/2024, the P&P indicated each resident with serious mental illness (SMI) and/or intellectual/developmental disability/related conditions (ID/DD/RD) will have the appropriate setting, as well as specialized services and/or rehabilitative services would be needed. The facility will submit a new Level I PASRR if: any error/discrepancy in the previous PASRR screening. The facilities designated staff will review the available information from the PASRR Online System regularly .and document and maintain the records.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 45382 Based on observation, interview, and record review, the facility failed to ensure nine out of 37 sampled residents (Resident 19, Resident 21, Resident 25, Resident 40, Resident 46, Resident 55, Resident 59, Resident 74, and Resident 188) had a person-centered care plan related to: 1. The facility failed to develop and implement a care plan for Resident 19's refusal of Restorative Nursing Aide (RNA, nursing aide program that helps residents maintain their function and joint mobility) services for passive range of motion (PROM, movement at a given joint with full assistance from another person) exercises to both legs. 2. Facility failed to initiate and update care plans for resident 46 for actual seizures and seizure medications. 3 . Failed to initiate care plans for Resident 55 and Resident 21 for continued weight loss. 4. Resident 188's significant weight loss with meaningful interventions identified to prevent further weight loss 5. Resident 40's,74's and 59's individualized Preadmission Screening and Resident Review (PASRR) level 2 (is a person-centered evaluation that is completed for anyone identified by the Level 1 Screening as having, or suspected of having, a PASRR condition, i.e., serious mental illness (SMI), intellectual disability (ID), developmental disability (DD), or related condition (RC)) determination. These deficient practices can lead to resident's needs not being met, affect the resident's well-being and poor patient outcomes. Findings: 1.During a review of Resident 19's Admission Record, the Admission Record indicated the facility initially admitted Resident 19 on 9/10/2003 and readmitted Resident 19 on 5/20/2023 with diagnoses including C1-C4 quadriplegia (spinal cord injury in the neck region causing weakness or paralysis in both arms and both legs), polyneuropathy (damage of the nerves that can cause weakness, numbness, and burning pain) and chronic obstructive pulmonary disease (lung disease that causes obstruction of airflow and can limit normal breathing). During a review of Resident 19's Order Summary Report, the Order Summary Report indicated a physician's order, ordered on 5/24/2023 and discontinued on 10/17/2024, for RNA to provide passive range of motion (PROM, movement at a given joint with full assistance from another person) exercises to Resident 19's both legs, every day, five times a week. The Order Summary Report indicated the physician's order was discontinued because Resident 19 was uncooperative and refused the RNA program. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 19's Minimum Data Set (MDS, a federally mandated assessment tool), dated 1/22/2025, the MDS indicated Resident 19 was cognitively (ability to think, understand, learn, and remember) intact. The MDS indicated Resident 19 was dependent in eating, hygiene, toileting, bathing, dressing, and rolling to both sides. The MDS indicated Resident 19 had functional ROM limitations (limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk of injury) in both arms (shoulder, elbow, wrist, hand) and both legs (hip, knee, ankle, foot). During a review of Resident 19's care plan, the care plan did not indicate a care plan addressing Resident 19's refusals of RNA services for PROM exercises of Resident 19's both legs. During a concurrent observation and interview on 2/4/2025 at 12:07 pm, in Resident 19's room, Resident 19 was lying in bed with both shoulders elevated on pillows to the side to shoulder height, both elbows bent, both wrists straight, and the neck and upper body hunched forward. Resident 19's fingers of the left hand were all bent downwards, except the middle finger which was fully straight. Resident 19's fingers of the right hand were straight and held closely together. Resident 19's both legs were straight at both hips and both knees and both feet were pointing downwards. Resident 19 stated he did not want ROM exercises for both legs because they were straight, and he would never use them again since he was paralyzed. Resident 19 stated it was hard for him to get comfortable once both legs were moved and preferred to not have them touched. During an interview and record review on 2/7/2025 at 3:15 p, the Minimum Data Set Coordinator (MDSC) stated the care plan was a comprehensive (inclusive, including everything necessary) plan of care created to address the resident's needs. The MDSC reviewed Resident 19's RNA physician's order, dated 5/24/2023, for PROM exercises to Resident 19's both legs, five times a week, and confirmed the physician's order was discontinued on 10/17/2024. The MDSC stated Resident 19 was at high risk for contracture development because of his diagnosis of quadriplegia and required interventions to maintain and prevent a decline in ROM. The MDSC reviewed Resident 19's care plan and confirmed Resident 19 did not have a care plan to address Resident 19's RNA refusals. The MDSC stated it was important the facility developed a care plan for RNA refusals to ensure there were goals and interventions in place to ensure the resident maintained his or her current level of function. The MDSC stated if multiple RNA refusals were not care planned, the facility may not be providing the appropriate care and services the residents need to maintain mobility and ROM which could potentially lead to a functional decline. During an interview on 2/7/2025 at 5:52 pm., the Director of Nursing (DON) stated comprehensive care plans were developed for every resident and used as a guide for staff to identify the type of care to provide the residents in the facility. The DON stated if a resident refused recommended RNA services, a comprehensive care plan should be developed and implemented to ensure the facility had the proper interventions in place to prevent a decline. The DON stated it was important for care plans to be developed and implemented to ensure the appropriate care was provided to each individual resident. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's Policy and Procedure titled Resident Mobility and ROM, revised 7/2017, the P/P indicated residents would not experience an avoidable reduction in ROM and residents with limited ROM and mobility would receive treatment, services, and equipment to increase and/or prevent a further decrease in ROM and mobility. The P/P indicated the care plan would be developed by the interdisciplinary team based on the comprehensive assessment and would be revised as needed. The P/P indicated the care plan would include specific interventions, exercises, and therapies to maintain, prevent avoidable decline in, and/or improve mobility and ROM. 2. During a review of Resident 46's Admission record, the Admission record indicated Resident 46 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including epilepsy (seizure: a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), with status epilepticus (life-threatening medical emergency characterized by prolonged or repetitive seizures). During a review of Resident 46's H&P dated 1/20/2025, the H&P indicated Resident 46 does not have the capacity to understand and make decisions. During a review of Resident 46's MDS dated [DATE], the MDS indicated Resident 46's cognitive skills were severely impaired. The MDS indicated Resident 46 is dependent on all aspects of activities of daily living (ADL: bathing, oral hygiene, dressing, personal hygiene). The MDS indicated Resident 46 is impaired on both side of the upper and lower extremities. During a review of Resident 46's Change of Condition (COC) dated 12/21/2024 at 7:36a.m. indicated at 6:40a.m., Resident 46 was diaphoretic (sweating heavily) and shaking appearing to be having seizures. Resident 46 was taken to the hospital at 7:10a.m. During a review of Resident 46's COC dated 1/5/2025 at 4:58a.m. indicated Resident 46 was diaphoretic and was having an episode of a seizure. Resident 46 was observed having multiple episodes of seizures. First episode of seizure was at 4:58a.m., second episode at 5:11a.m., and third episode at 5:15a.m. At 5:17a.m., the paramedics arrived and was transferred to the hospital at 5:27a.m. During a review of Resident 46's Care Plan (CP), the CP indicated seizure disorder: at risk for injury, ineffective breathing pattern, and disorientation initiated on 4/14/2022 and revised on 4/17/2024. The CP additionally indicated at risk for potential drug toxicity related to use of Levetiracetam (medication used to treat epilepsy). The CP goal indicated no unrecognized signs and symptoms (s/s) of drug toxicity daily initiated 4/14/2022 with revision date 1/9/2025. During a review of Resident 46's Order Summary (physician notes), the Order Summary dated 2/6/2025 indicated orders for Levetiracetam oral solution 100 milligram (mg: unit of mass) / milliliter (mL: unit of volume) (give 10mL via g-tube two times a day for seizure disorder and Valproic Acid (generic name: Valproate Sodium: use to treat epilepsy) oral solution 250mg/5mL (give 5mL via g-tube three times a day for seizure) on 1/8/2025. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review of Resident 46's COC and CP on 2/7/2025 at 10:54a.m. with Licensed Vocational Nurse 5 (LVN 5), LVN 5 stated Resident 46 has a diagnosis of epilepsy and indicated she has had two episodes of seizures, one on 12/21/2024 and another on 1/5/2025. LVN 5 stated they when there is a COC or if a resident is on a new medication, they will have a CP. LVN 5 stated Resident 46 has an at risk for seizure disorder CP and is on Levetiracetam and Valproic Acid. LVN 5 stated Resident 46 should have a CP for the actual seizures and interventions along with the seizure medications she is on. LVN 5 stated the purpose of a CP is to provide proper care that is needed with measurable goals and interventions to determine how the goal would be achieved. LVN 5 additionally stated the interventions for the at risk for seizure disorder CP has not been updated since 4/14/2022 and would usually update the CP. During a concurrent interview and record review of Resident 46's CP on 2/8/2025 at 4:01p.m. with MDSC, MDSC stated there is a CP for seizures and they will follow it when Resident 46 has a seizure that was initiated on 4/14/2022. MDSC stated Resident 46 is on Levetiracetam, and since this medication is not part of the Black Box warning (serious or life-threatening risks associated with the drug), Resident 46 does not have to be monitored for any s/s and can be added under the same at risk for seizure disorder CP. MDSC stated she does not know the s/s Levetiracetam, however when a resident requires monitoring for s/s, it would be in the Medication Administration Record (MAR: document that tracks medications given to a patient). MDSC stated there are no orders to specifically monitor the s/s of the medication but do have a monitoring for seizure activity. MDSC stated even if a resident has a COC, they do not CP it anymore. MDSD stated Valproic Acid is a new medication and the at risk for seizure disorder CP would be updated, but there will not be new interventions as it was only a new medication, and interventions have nothing to do with it. During a concurrent interview and record review of Resident 46's CP on 2/8/2025 at 5:11p.m. with Assistant Director of Nursing (ADON), ADON stated Resident 46 should have an actual care plan for seizures to prevent the resident from having another seizure. 3. During a review of Resident 55's Admission Record, the Admission Record indicated Resident 55 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including major depressive disorder (MDD), dysphagia (difficulty swallowing), and protein-calorie malnutrition. During a review of Resident 55's H&P dated 12/18/2024, the H&P indicated Resident 55 is able to make decisions for activities of daily living. During a review of Resident 55's MDS dated [DATE], the MDS indicated Resident 55's cognitive skills (were severely impaired. The MDS indicated Resident 55 is dependent on all aspects of activities of daily living (ADL: bathing, sit to lying, personal, toileting, oral hygiene, and eating. The MDS indicated Resident 55 is impaired on one side of the upper extremity and is impaired on both sides of the lower extremities. During a review of Resident 55's CP initiated on 1/23/2024 and revised on 4/24/2024 indicated resident has alteration in nutritional status related to (r/t) diagnosis of dementia (a progressive state of decline in mental abilities), at risk for weight gain, weight loss, dehydration, and at risk for malnutrition due to dysphagia. Another CP initiated 1/8/2025 indicated anticipated weight loss related to malnutrition. There are no CP's for Resident 55's actual weight loss. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review of Resident 55's CP on 2/6/2025 at 1:14p.m. with Licensed Vocational Nurse 4 (LVN 4), LVN 4 stated Resident 55 has an anticipated weight loss related to malnutrition dated 1/8/2025 with interventions to do monthly weights but does not have a CP for an actual weight loss and should have one. LVN 4 stated Resident 55 has a CP for alternation in nutritional status initiated on 1/23/24, revised 4/24/24, but the CP has not been revised for a year and does not indicate how much weight Resident 55 lost. LVN 4 stated the purpose of CP is to have a goal and interventions that needs to be done so the resident can improve during their time in the facility. LVN stated CP is also updated to know if the resident is improving and will add more interventions for the resident to continue improving. During a concurrent interview and record review of Resident 55's Interdisciplinary (IDT: group of healthcare professionals from different departments working together to develop and implement a comprehensive care plan for a patient addressing concerns) Weight Management Care Plan dated 3/24/2024, 9/26/2024, and 1/20/2025 on 2/8/2025 at 7:24p.m. with Director of Nursing (DON), DON stated they do an IDT CP due to Resident 55's weight fluctuating and significant weight loss. DON stated Resident 55 should have had an IDT CP in June 2024 and despite having an IDT CP, Resident 55 still requires a CP for an actual weight loss. 4. During a review of Resident 21's Admission Record, the Admission Record indicated Resident 21 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including squamous cell carcinoma (skin cancer) of skin of scalp (skin covering the head) and neck, benign prostatic hyperplasia (prostate gland enlargement that can cause difficulty urinating), and chronic viral Hepatitis C (a viral infection of the liver that leads to illness and can be spread by contact with the contaminated blood). During a review of Resident 21's H&P dated 10/24/2024, the H&P indicated Resident 21 does not have the capacity to understand and make decisions. During a review of Resident 21's MDS dated [DATE], the MDS indicated Resident 21's cognitive skills were moderately impaired. The MDS indicated Resident 21 is dependent on performing majority of ADLs and required moderate assistance (assists with less than half the effort) for eating. The MDS indicated Resident 21 is impaired on both sides of the lower extremities. During a review of Resident 21's CP initiated on 2/21/2014 and revised on 1/14/2025 indicated resident has alteration in nutritional status related to (r/t) diagnosis of schizophrenia (a mental illness that is characterized by disturbances in thought), hyperlipidemia (high levels of cholesterol in blood) and is at risk for weight gain and weight loss. There are no CP's for Resident 21's actual weight loss. During a concurrent interview and record review on 2/56/2025 at 3:28p.m. with Registered Dietitian (RD), RD indicated care plans are initiated by the Dietary Manager (DM). RD stated the CP reflects interventions that was added for weight loss, but indicated there are no actual care plans for weight loss. RD stated she does not know if a care plan specifically for weight loss is needed. During an interview on 2/8/2025 at 6:50p.m. with DON, DON stated a care plan is needed as it is an individualized plan of care for the residents to address the specific concerns the resident has. (continued on next page)

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	056043	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. During a review of Resident 188's admission record, the admission record indicated Resident 188 was admitted to the facility 12/6/2024 with diagnoses of gastrostomy tube (GT, a feeding tube), muscle wasting, non-Hodgkin lymphoma (cancer), tracheostomy tube (an opening surgically created through the neck into the trachea (windpipe) to allow air to fill the lungs), and multiple pressure ulcers. During a review of Resident 188's Weights and Vitals Summary, on 12/6/2025 (admission) Resident 188 weighed 119 lbs. On 1/3/2025 the Weights and Vitals Summary indicated Resident 188 weighed 110 lbs., a 9 lb. (7.6%) loss since admission 1 month prior. On 2/6/2025 the Weights and Vitals Summary indicated Resident 188 weighed 93.2 lbs., a 25.8 lb. (21.7%) loss since admission 60 days (2 months) prior. During a review of Resident 188's minimum data set (MDS, a resident assessment tool) dated 12/13/2024 indicated Resident 188 had severe cognitive impairment (a significant decline in cognitive abilities that significantly impact daily functioning and independence). The MDS indicated Resident 188's current weight (taken 12/6/2024) was 119 lbs., Resident 188 was receiving a therapeutic diet (e.g., diabetic), and Resident 188 was receiving 51% or more of his total calories through a feeding tube. Resident 188's medical record did not include an updated significant change MDS containing updated information regarding his cognitive function or weight loss. During a review of Resident 188's Nutrition/ Dietary Note dated 1/7/2025, the RD indicated Resident 188's weight was 110 lbs. a 9-pound (8% (number documented by RD)) weight loss in 1 month. The RD indicated Resident 188's ideal body weight (IBW) was 117 to 143 lbs., and the weight loss was significant. During an interview on 2/8/2025 at 1:23 p.m., the ADON stated a care plan was required to be created Resident 188's severe weight loss, change of condition and it was important to create a care plan, so all staff involved knew the new interventions, new goals, and the problem the resident was having. The ADON stated he reviewed Resident 188's medical record and could not find a care plan for severe weight loss. The ADON stated a severe weight loss care plan was important because it ensured the staff were addressing the residents needs and they want to prevent the resident from further weight loss. During a review of the facility's policy and procedure (P/P) titled Weight Assessment and Intervention dated 3/2022, the P/P indicated the threshold for significant unplanned and undesired weight loss was to be based on the following criteria [where percentage of body weight loss = (usual weight - actual weight)/ (usual weight) x 100]: a. 1 month - 5% weight loss is significant; greater than 5% is severe. b. 3 months- 7.5% weight loss is significant; greater than 7.5% is severe. c. 6 months - 10% weight loss is significant; greater than 10% is severe. Care planning for weight loss or impaired nutrition was a multidisciplinary effort and included the physician, nursing staff, the dietitian (RD), the consultant pharmacist, and the resident or resident's legal surrogate (RP). Individualized care plans shall address to the extent possible: the identified causes of weight loss; goals and benchmarks for improvement; and time frames and parameters for monitoring and reassessment. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. During a review of Resident 40's Admission Record, the Admission Record indicated Resident 40 was admitted to the facility 10/11/2022 with diagnoses of unspecified psychosis (a severe mental condition in which thought and emotions are so affected that contact is lost with external reality), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your daily life), schizoaffective disorder (a mental health problem where you experience psychosis as well as mood symptoms) and generalized anxiety disorder (a mental health condition that causes fear, worry and a constant feeling of being overwhelmed). During a review of Resident 40's H&P dated 11/16/2024, the H&P indicated Resident 40 was recently hospitalized for evaluation and management of decompensation of schizoaffective disorder with auditory hallucinations (where you hear, see, smell, taste or feel things that appear to be real but only exist in your mind) telling her to kill herself. During a review of Resident 40' MDS sated 11/20/2024, the MDS indicated Resident 40 had moderate cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions). During a review of Resident 40's PASRR Individualized Determination Report dated 1/15/2025 indicated Resident 40 required specialized add-on services (services and supports that supplement nursing facility care to address mental health needs). Specialized add-on services determined for Resident 40 included; mental health rehabilitation activities, activities of daily living (ADL) training/ reinforcement, supportive services, psychotherapy/ counseling, neuropsychology consultation, psychiatry consultation and/or follow-up care, safety monitors, behavior monitors, pharmacy consultation, internal medicine consultation, sleep specialist consultation, ophthalmology consultation, physical therapy consultation, occupational therapy consultation, social services consultation, continence evaluation, and accessibility accommodations. 6. During a review of Resident 74's Admission Record, the admission record indicated Resident 74 was admitted to the facility on [DATE] with diagnoses including unspecified psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), unspecified dementia (a progressive state of decline in mental abilities), and anxiety disorder (persistent and excessive worry that interferes with daily activities). During a review of Resident 74's History & Physical (H&P) dated 12/25/2024, the H&P indicated Resident 74 was recently hospitalized at a general acute care hospital (GACH) for a urinary tract infection and schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). During a review of Resident 74's Minimum Data Set (MDS - a resident assessment tool), dated 12/29/2024, the MDS indicated was able to understand and be understood by others, had some ability to recall information, required supervision for eating and oral hygiene, and required moderate assistance (helper does less than half of effort) for toileting, bathing, and dressing. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 74's PASRR Individualized Determination Report dated 12/22/2024, the report indicated Resident 74 required specialized add-on services (services and supports that supplement nursing facility care to address mental health needs). Specialized add-on services determined for Resident 74 included; mental health rehabilitation activities, activities of daily living (ADL) training/ reinforcement, supportive services, psychotherapy/counseling, substance rehabilitative services psychology consultation, psychiatry consultation and/or follow-up care, safety monitors, behavior monitors, sleep specialist consultation, physical therapy consultation, occupational therapy consultation, continence evaluation, and accessibility accommodations. 7. During a review of Resident 59's Admission Record, the admission record indicated Resident 59 was admitted to the facility on [DATE] with diagnoses including major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety disorder (persistent and excessive worry that interferes with daily activities), and schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). During a review of Resident 59's MDS, dated [DATE], the MDS indicated was able to understand and be understood by others, had some ability to recall information, required supervision for eating, oral hygiene, toileting, bathing, and dressing. During a review of Resident 59's PASRR Individualized Determination Report dated 10/23/2024, the report indicated Resident 59 required specialized add-on services (services and supports that supplement nursing facility care to address mental health needs). Specialized add-on services determined for Resident 59 included; mental health rehabilitation activities, ADL) training/ reinforcement, supportive services, psychotherapy/ counseling, psychology consultation, neuropsychology consultation, psychiatry consultation and/or follow-up care, safety monitors, behavior monitors, internal medicine consultation, pain services consultation, sleep specialist consultation, physical therapy consultation, occupational therapy consultation, social services consultation, smoking cessation program, and accessibility accommodations. During an interview on 2/8/2025 at 5:29 p.m., the assistant director of nursing (ADON) stated the PASRR was an assessment that determined if a resident needed anything for their mental health needs. The ADON stated the PASRR level 2 determination informs the facility what services the resident would benefit from. The ADON stated he oversaw PASRRs in the facility but did not create individualized care plans based on their PASRR recommendations. The ADON stated it would be important to create a care plan for PASRR recommendations because it would sure all departments (social services, activities, nursing, etc.) would be on the same page and ensure the residents were meeting their goals and receiving all necessary care. During a review of the facility's P/P titled Care Plans, Comprehensive Person-Centered dated 3/2022, the P/P indicated a comprehensive, person-centered care plan that included measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs was developed and implemented for each resident. 45891 46415 50144

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50387 Based on interview and record review, the facility failed to ensure that a resident with a Full Code status (resident wants all life saving measures in case of life threatening emergencies) and in distress, received Cardiopulmonary Resuscitation (CPR-an emergency procedure to restart a person's heart, chest compressions) immediately, reducing the residents chances of survival and adverse health outcomes for one of 145 residents with Full Code status (Resident 44). The facility failed to: 1.Ensure Registered Nurse (RN) 2 announced a Code Blue (an announcement that signifies a medical emergency where a patient is experiencing a life-threatening situation) when Resident 44 had no palpable (rhythmic beat of a blood vessel indicating a heartbeat, that can be felt by touch) heartbeat. 2.Ensure RN 2 provided resuscitation and basic life support such as CPR immediately without loss of critical time to Resident 44, when Resident 44 no longer had a palpable pulse on [DATE]. 3.Ensure RN 2 was knowledgeable of the facility's policies and procedures regarding initiating CPR when a full code resident is unresponsive. 4.Ensure RN 2 implemented the facility's policy and procedure (P&P) titled, Emergency Procedure - Cardiopulmonary Resuscitation, revised February 2018, which indicated if an individual was found unresponsive and not breathing normally, a licensed staff, certified in CPR/BLS shall initiate CPR and the American Heart Association ([AHA] the leader in resuscitation science, education, and training, and publisher of the official Guidelines for CPR) guidelines which indicated First responder will call for help, send available staff to call a Code Blue, retrieve emergency medical equipment, assess the residents' level of consciousness, circulation, airway, and breathing and begin CPR, call 911, CPR will continue until the paramedics arrive and assume responsibility. These deficient practices delayed life-saving resuscitation attempts, such as CPR to ensure Resident 44's body had uninterrupted blood, and oxygen circulation, to prevent irreversible damage such as brain damage and or death. The facility had 145 residents, with a Full Code status and at risk of not receiving CPR in case of cardiopulmonary arrest. On [DATE] at 4:43 p.m., an Immediate Jeopardy ([IJ] a situation in which the facility's noncompliance with one or more requirements of participation had caused, or is likely to cause serious injury, harm, impairment, or death to a resident) was called in the presence of the Administrator (ADM) and the Director of Nursing(DON) due to the facility's failure to identify the need for and initiate basic life support to Resident 44, including CPR immediately upon discovering the resident was unresponsive. On [DATE] at 1:34 p.m., the Facility submitted an acceptable IJ removal plan (IJRP- an intervention to immediately correct the deficient practices). After verification the IJRP was implemented through observation, interview, and record review, the IJ was removed while onsite on [DATE] at 4:44 p.m., in the presence of the ADM and the DON. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of Resident 44's Admission Record, the Admission Record indicated Resident 44 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including Type II Diabetes (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), Sepsis (blood infection), and Urinary Tract Infection (UTI- disease causing bacteria in the urinary tract). During a review of Resident 44's Nursing Admission Assessment, dated [DATE], the Nursing Admission Assessment indicated Resident 44 had an admitting diagnosis of pneumonia (a lung infection that make it difficult to breath). The Nursing Admission Assessment indicated Resident 44 had completed antibiotics (medicines that treat bacterial infections by killing bacteria or stopping them from growing) at the GACH prior to admission. During a review of Resident 44's History and Physical (H&P), dated [DATE], the H&P indicated, Resident 44 did not have the capacity to understand and make decisions. During a review of Resident 44's Minimum Data Set (MDS- a resident assessment tool), dated [DATE], the MDS indicated Resident 44 had severely impaired cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making. The MDS indicated Resident 44 had functional limitation in range of motion (the distance and direction a joint can move) on upper extremity (your arm, including your shoulder, elbow, wrist, and hand) and lower extremity (your leg, including your hip, thigh, knee, shin, ankle, and foot), The MDS indicated Resident 44 needed assistance from two or more helpers for the resident to transfer to and from a bed to a wheelchair. During a review of Resident 44's Order Summary Report, as of [DATE], the Order Summary Report indicated there was an order on [DATE] to provide CPR. During a review of Resident 44's Life-Sustaining Treatment (POLST-resident's preferences for medical treatment), dated [DATE], the POLST indicated that facility must attempt CPR if Resident 44 had no pulse and was not breathing. During a review of Resident 44's care plan for Advance Directive (a document that expresses the resident's health care wishes should they be unable to speak for themselves), revised [DATE], the care plan indicated that CPR was to be performed, with interventions including respecting Resident 44's or family's wishes regarding resuscitation efforts. During a review of Resident 44's Change of Condition (COC)/Interact Assessment Form (situation, background, assessment, and recommendation [SBAR] a verbal or written communication tool that helps provide essential, concise information, usually during crucial situations), dated [DATE] at 11p.m., the COC indicated Resident 44's oxygen saturation (amount of oxygen in blood) level was between 88 to 90 percent (%) on room air (RA) (oxygen saturation reference range 95%-100%). The COC indicated facility staff placed Resident 44 on oxygen at 2 Liters (L)/ minute (min) nasal canula (NC) and Resident 44's oxygen saturation went up to ,d+[DATE]%. The COC indicated Resident 44 was placed on 72-hour monitoring, and her Medical Doctor (MD) was notified on [DATE] at 11:30 p.m. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of Resident 44's COC dated [DATE], the COC indicated at 7:30 a.m. on [DATE] Resident 44 was up in her wheelchair. The COC indicated Resident 44's vital signs (VS) were: Blood Pressure ,d+[DATE] millimeters of mercury (mmHg- unit of measure. Reference range ,d+[DATE] mmHg), Heart Rate 84 (beats) /(per) minute (min-reference range 60 to 100), Oxygen saturation 93% with oxygen 2L/min via NC, Temperature (measure how well the body can make and get rid of heat) 97.9 degree (Reference range 96.8 degree to 98.6 degree) and Respiration Rate 16 (breaths)/min (Reference range 12 to 20 /min) prior to the incident. The COC indicated at 8:40 a.m., Resident 44 was up in her wheelchair, diaphoretic (sweating heavily), eyes closed with VS: HR ,d+[DATE]/min, oxygen saturation 88% with oxygen at 2L/min via NC. The COC indicated Resident 44 had a palpable (detectable by touch) pulse (heartbeat) of 50 beats/min then Resident 44 was transferred to her bed. The COC indicated Resident 44's heart rate started to fluctuate (vary) from ,d+[DATE]/min and her oxygen level dropped to 80%. The COC indicated staff did not observe Resident 44's chest rise and fall (indicating breathing), so staff grabbed the Ambu-bag (a handheld device that helps patients' breath when they aren't breathing well or at all) and started providing breaths until the paramedics arrived at 8:45 a.m., and initiated CPR. The COC indicated RN 1 and RN 2 were aware that Resident 44 was full code before calling the paramedics at 8:41 a.m. During a review of the Paramedics Report, dated [DATE], the Paramedics Report indicated Resident 44 had a cardiac arrest (when the heart suddenly stops beating, preventing blood and oxygen from being pumped to the body's organs) on [DATE] at 8:30 a.m., witnessed by staff. The Paramedics Report indicated the emergency medical staff (EMS - Paramedics) arrived at resident's room at.8:44 a.m. and found Resident 44 lying in bed pulseless, apneic (an involuntary pause in breathing), with fixed and dilated pupils (a person's pupils are wide open and do not respond to light, indicating a serious medical condition, often associated with brain damage or severe head injury). The Paramedics Report indicated facility staff noticed Resident 44 was breathing with increased effort, so they began ambuing (the act of using an Ambu-bag) the resident. The Paramedics Report indicated facility staff never initiated chest compressions, even though Resident 44 was observed to be in full cardiac arrest. The Paramedics Report indicated the paramedics immediately initiated CPR on Resident 44 and achieved Resident 44's return to spontaneous circulation (ROSC - when heartbeat and breathing return to normal. During a review of Resident 44's Emergency Documentation-MD notes, from the GACH, dated [DATE], the Emergency Documentation-MD notes indicated EMS brought Resident 44 to the GACH's Emergency Department (ED) from the facility after EMS provided emergency services including CPR at the facility (where Resident 44 resided). The Emergency Documentation-MD notes indicated according to EMS, upon EMS's arrival, Resident 44 was pulseless. The Emergency Documentation-MD note indicated EMS initiated CPR, provided emergency services and Resident 44's ROSC was achieved. The Emergency Documentation-MD note indicated Resident 44's diagnoses at the ED included cardiopulmonary arrest. The note indicated Resident 44 was admitted to the intensive care unit (ICU GACH Unit that cares for seriously ill patients that need constant observation). During an interview on [DATE], at 9:38 a.m., with CNA 1, CNA 1 stated on [DATE] at approximately 8:30 a.m. , she entered Resident 44's room to assist Resident 44 with her breakfast and observed Resident 44 sitting in her wheelchair sweating. CNA 1 stated she called CNA 2 to check on Resident 44. CNA 1 stated CNA 2 entered the room, assessed Resident 44, and told her (CNA 1) not to feed Resident 44 her breakfast. CNA 1 stated she stayed with Resident 44 while CNA 2 went to get help. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 10:17 a.m., with RN 2, RN 2 stated on [DATE] at approximately 8:35 a.m., when she entered Resident 44's room, she observed Resident 44 was lying down, appeared sweaty, and pale. RN 2 stated she checked Resident 44's pulse manually and felt Resident 44's pulse. RN 2 stated the oximeter readings of heartbeat on Resident 44's finger fluctuated between 36 beats/min, to 46 beats/min, and Resident 44's oxygen saturation dropped from 88% to 70%. RN 2 stated she left Resident 44's room and returned with a crash cart (cart stocked with emergency medical equipment, supplies, and drugs for use by medical personnel especially during efforts to resuscitate a patient experiencing cardiac arrest). RN 2 stated she suctioned (to suck out or remove something, like thick liquids using a force created by a vacuum) her Resident 44's mouth to remove secretions. RN 2 stated after suctioning Resident 44, she manually checked Resident 44's pulse and it went up to 50/min. RN 2 stated, when Resident 44's pulse was no longer detectable manually, she relied on the oximeter readings of Resident 44's pulse, which still indicated a pulse at 32/min. RN 2 stated she (RN 2) did not initiate CPR because the oximeter indicated Resident 44 had a pulse, although she could not obtain Resident 44's pulse manually. During an interview on [DATE] at 10:14 a.m., with Treatment Nurse (TXN) 1 stated, she was aware Resident 44 was a full code. TXN 1 stated staff should have initiated chest compressions when Resident 44 stopped breathing and had no pulse. During an interview on [DATE] at 10:52 a.m., with RN 2, RN 2 stated she did not initiate chest compressions when she (RN 2) could no longer detect Resident 44's pulse from the resident's carotid artery (the main blood vessels that supply blood to the brain face, and neck). RN 2 stated the oximeter still displayed a pulse reading. RN 2 stated, if the heart rate was not palpable manually, but the oximeter showed numeric values of 30's/min, 40/min and 50/min, it indicated a regular rhythm. RN 2 stated she did not initiate chest compressions when she (RN 2) could no longer detect Resident 44's pulse from the resident's carotid artery (the main blood vessels that supply blood to the brain face, and neck). RN 2 stated she did not announce a Code Blue, because she believed Resident 44 still had a heart rate based on the oximeter reading. During an interview on [DATE] at 12:15 p.m., the Director of Nursing (DON), stated if the COC involved a Resident's unresponsiveness, staff must assess the Resident's lung function and pulse immediately. The DON stated if the resident did not have a detectable pulse staff must start chest compressions immediately, provide breathing support, and call a Code Blue for emergency intervention. The DON stated if an oximeter indicated numbers like 30's/min, 45/min, 50/min without a palpable pulse, it could be an indication that the resident was not okay, and it was important to provide timely CPR. During an interview on [DATE] at 4:17 p.m., Resident 44's primary doctor stated Resident 44 was a full code, and the staff should have provided CPR when Resident 44 experienced a cardiac arrest. During a review of the facility's P&P titled, Emergency Procedure - Cardiopulmonary Resuscitation, revised February 2018, indicated Personnel have completed training on the initiation of cardiopulmonary resuscitation (CPR) and basic life support (BLS), including defibrillation, for victims of sudden cardiac arrest. The P&P indicated sudden cardiac arrest (SCA) was a loss of heart function due to abnormal heart rhythms (arrhythmias). 1. Victims of cardiac arrest may initially have gasping respirations or may appear to be having a seizure. Training in BLS includes recognizing presentations of SCA. (continued on next page)

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Colonial Care Center	1913 E 5th Street Long Beach, CA 90802

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. The chances of surviving SCA may be increased if CPR is initiated immediately upon collapse. 3. Early delivery of a shock with a defibrillator plus CPR within ,d+[DATE] minutes of collapse can further increase chances of survival. 4. If an individual (resident, visitor, or staff member) was found unresponsive and not breathing normally, a licensed staff certified in CPR/BLS will initiate CPR unless the person had a do not resuscitate (DNR) order, or obvious signs of irreversible death (e.g., rigor mortis). The P&P indicated, if the resident's NR status was unclear, CPR will be initiated until it was determined that there was a DNR or a physician's order not to administer CPR. According to the P&P, if the first responder was not CPR-certified, that person will call 911 and follow the 911 operator's instructions until a CPR-certified staff member arrived. The P&P indicated Preparation for Cardiopulmonary Resuscitation was as follows: 1. The facility's procedure for administering CPR would incorporate the steps covered in the 2010 AHA Guidelines for CPR and Emergency Cardiovascular Care. 2. Select and identify a CPR team for each shift in the case of an actual cardiac arrest, with a designated team leader who would be responsible for coordinating the CPR. The team The P&P also indicated Preparation for Cardiopulmonary Resuscitation was as follows : 1. If an individual was found unresponsive, briefly assess for abnormal or absence of breathing. If sudden cardiac arrest is likely, begin CPR: Instruct a staff member to activate Code Blue and call 911. Verify or instruct a staff member to verify the code status of the individual. Initiate the basic life support (BLS) sequence of events. 2. The BLS sequence of events is referred to as C-A-B (chest compressions, airway, breathing). 3. Chest compressions: a Following initial assessment, begin CPR with chest compressions; b Push hard to a depth of at least 2 inches (5 cm) at a rate of at least 100 compressions per minute; c Allow full chest recoil after each compression; and d Minimize interruptions in chest compressions. 4. Airway: Tilt head back and lift chin to clear airway. 5. Breathing: After 30 chest compressions provide 2 breaths via ambu-bag or manually (with CPR shield). (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	6. All rescuers, trained or not, should provide chest compressions to victims of cardiac arrest. Trained rescuers should also provide ventilations with a compression-ventilation ratio of 30:2. 7. Continue with CPR/BLS until emergency medical personnel arrive. During a review of AHA's article titled 11 things to know to save a life with CPR, published [DATE], the article indicated according to research, each minute of delayed CPR, there was a decreased chance of survival by about 10%.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46415 Based on interview and record review, the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical well-being for one of three sampled residents (Resident 55) by failing to: 1. Follow the facility policy and procedure to monitor and document assessments and interventions provided to Resident 55 during change of condition (COC). 2. Not creating and implementing a patient centered care plan for actual weight loss. 3. Assess Resident 55's continued weight loss. These deficient practices resulted in Resident 55 requiring a gastrostomy (g-tube: a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) to prevent further weight loss. Findings: During a review of Resident 55's Admission record the Admission record indicated Resident 55 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including, protein-calorie malnutrition, major depressive disorder (MDD: a mood disorder that causes a persistent feeling of sadness and loss of interest), and dysphagia (difficulty swallowing). During a review of Resident 55's History and Physical (H&P) dated 12/18/2024, the H&P indicated Resident 55 is able to make decisions for activities of daily living. During a review of Resident 55's Minimum Data Set ([MDS] a resident assessment tool)], the MDS dated [DATE], the MDS indicated Resident 55's cognitive skills (were severely impaired. The MDS indicated Resident 55 is dependent on all aspects of activities of daily living (ADL: bathing, sit to lying, personal, toileting, oral hygiene, and eating. During a review of Resident 55's CP initiated on 1/23/2024 and revised on 4/24/2024 indicated resident has alteration in nutritional status related to (r/t) diagnosis of dementia (a progressive state of decline in mental abilities), at risk for weight gain, weight loss, dehydration, and at risk for malnutrition due to dysphagia. The CP intervention indicated the following: 4/23/2024-add sugar free (SF) 4-ounce (oz: unit of weight) HPN with lunch for one (1) month (completed) 7/6/2024-add SF 4 oz High Protein Nutritional (HPN) at 10:00a.m. and 2:00p.m. for three (3) months 8/13/2024-add SF ice cream with lunch and dinner. 10/9/2024-add 4 oz. HPN twice a day (BID) for two (2) months. (change in diet order) (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/5/2024-increase sugar free HPN to three times a day for weight management. Increase Glucerna shake (calorically dense formula for residents who are diabetic) to three times a day (TID) for weight management. 12/20/2024-add SF 4 oz. juice with lunch and dinner. 12/26/2024-add 4 oz HPN TID. Add ice cream with lunch and dinner. Add Glucerna with meals. Report significant weight loss and gain to medical doctor (MD) and family. During a review of Resident 55's Order Summary Report (physician notes) dated 2/6/2025, the order summary report indicated Mirtazapine (medication used to treat depression) Tablet 7.5 milligram (mg: unit of mass/weight) [give 1 tablet by mouth at bedtime for depression as manifested by (m/b) poor oral (PO) intake less than 50 percent (%). The order summary report indicated to monitor for potential side effects antidepressant (Mirtazapine); sedation, weight gain, weight loss. The order summary indicated monitor episodes of depression m/b poor PO intake less than 50% [zero (0)=greater (>) 50% of meal intake, 1=less (<) than 50% of meal intake for (Mirtazapine) use. These three orders were ordered 12/17/2024. During a review of Resident 55's Weights and Vitals Summary dated 2/7/2025, the weights and vitals summary indicated the following: 5/6/2025 122 pounds (lbs) [-7.5 percent (%) change [Comparison weight 2/5/2024, 133 lbs, -8.3%, -11 lbs] 6/5/2025 120 lbs [-10% change [Comparison weight 1/10/2024, 134 lbs, -10.4%, -14 lbs] 7/3/2024 118 lbs [-10% change [Comparison weight 1/10/2024, 134 lbs, -11.9%, -16 lbs] 8/5/2024 116 lbs [-10% change [Comparison weight 3/5/2024, 129 lbs, -10.1%, -13 lbs] 9/5/2024 114 lbs [-10% change [Comparison weight 3/8/2024, 128lbs, -10.9%, -14 lbs] 10/4/2024 112 lbs [-10% change [Comparison weight 4/5/2024, 125 lbs, -10.4%, -13 lbs] 1/3/2025 104 lbs [-10% change [Comparison weight 8/5/2024 , 116 lbs, -10.3%, -12 lbs] [-5% change [Comparison weight 12/5/2024, 110 lbs, -5.5 %, -6 lbs] During a review of Resident 55's Change of Condition (COC) dated 2/28/2024, the COC indicated Resident 55 had variable by mouth (PO) intake. The nursing notes indicated the nurse was notified by a nursing assistant Resident 55 was not eating sufficiently for breakfast and received orders to draw labs. During a review of Resident 55's COC dated 12/13/2024, the COC indicated Resident 55 had critical lab results for sodium level 167 (normal level 135 to 145 milliequivalents per liter (mEq/L: unit used to measure concentration of substance). Resident 55 was ordered to go to general acute care hospital (GACH) due to having severe dehydration (when body loses more fluids than intakes) and acute kidney injury (kidneys suddenly lose their ability to function properly). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 55's Nutritional assessment dated [DATE], the nutritional assessment indicated Resident 55's required calories is 1220 to 1525 (normal range 1900 to 2000kcal) 20-25 kilocalories per kilogram (kcal/kg: is a unit of measurement used to estimate caloric needs based on body weight), required protein of 61-67 (1 to 1.1 gram per kg (g/kg: unit of mass) (normal range 88-90gm), and required fluid intake of 1220 to 1525 (1 milliliter (unit of measurement for volume) per (kcal: unit of heat energy) (mL/kcal) (normal range 1800 to 2000mL). Resident 55's summary of level of care indicated moderate as Resident 55's weight fluctuates, lab data is consistent with potential for malnutrition, and food intake fluctuates. Implementation plan indicated by mouth 25 to 60% of meals. Resident weight is 134 lbs and is above IBM. During a review of Resident 55's Nutritional assessment dated [DATE] at 3:11p.m., the nutritional assessment indicated Resident 55's required calorie is 1225 to 1470 (25-30kcal/kg), required protein 49-54 (1-1.1gm/kg), and required fluid of 1225 to 1470 (1mL/kcal). Resident 55's PO intake is 10-80% for meals. Problems indicated weight loss of 5% in last 30 days or 7.5% in the last 90 days or 10% in the last 180 days). Other issues identified was left forearm abrasion, 3% weight loss in 1 month, 6% in last 3 months, 11% in last 6 months likely related to recent hospitalization , poor po intake. Summary of level of care indicated high risk with excessive weight loss/gain. Lab data/diagnosis consistent with potential for or presence of malnutrition. Food intake poor. Resident receives tube feeding, has pressure sores or is in critical medical condition. Implementation plan indicated Glucerna three times a day with meals, ice cream two times a day with lunch/dinner, and 4 oz. HPN three times a day. During a concurrent interview and record review of the progress notes on 2/05/25 at 3:54 p.m. with Registered Dietitian (RD), RD stated Resident 55 on 2/24/2024 had low PO intake so she recommended nutritional shake for lunch and dinner, and indicated Resident 55 was sent out to the hospital in April 2024 RD stated the Certified Nursing Assistant (CNA) would notify her if the Resident does not like the shakes. During a concurrent interview and record review of Resident 55's MAR dated 1/1/2025 to 1/31/1025 on 2/5/2025 at 4:04p.m. with RD, RD stated the MAR reflecting Glucerna Shake with meals for supplement 237mL PO order date 12/26/2024 does not indicate how much Resident 55 drank as there is only a check mark. RD stated the MAR should reflect the percentage or mL of how much Resident 55 drank the Glucerna to get an exact intake. RD stated she makes her rounds and like to see if the residents have the shakes in their hands, but indicated the only way to know if the resident is eating or drinking the shakes is by talking to the nurse. RD stated Resident 55 has constant significant weight changes, however it was a slow gradual weight loss. RD stated Resident 55 is supposed to ideally be getting 1225 to 1470 calories for a baseline weight within 90 to 110 lbs. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review of Resident 55's MAR dated on 2/1/2025 to 2/28/2025 on 2/6/2025 at 1:14p.m. with Licensed Vocational Nurse 4 (LVN 4), LVN 4 stated Resident 55 does not eat much and gets Glucerna three times a day and indicated she drank about 20% today. LVN 4 stated Resident 55 ate 30% of her breakfast and had a strawberry milk shake that is given to Resident 55 at 10:00a.m. and at 2:00p.m. LVN 4 stated the MAR dated 2/1/2025 to 2/28/2025 indicated the check mark on Glucerna for breakfast, lunch, and dinner indicates that it was given to Resident 55, but does not know how much she drank and needs to be monitored. LVN 4 stated if there is a weight loss, she will report it to the RD, inform the doctor, family, and would do a COC to ensure she is being monitored for 3 days if she is not eating as she may be dehydrated. LVN 4 stated not monitoring the resident may lead to confusion and death. LVN 4 stated the RNA does not communicate or report to her if there is a weight loss and checks on her own. LVN 4 stated if there is a weight loss, she would ask the RD if they would want to change the diet. LVN 4 stated the RD asks how the resident is eating or if they like what they have or if the current diet needs to be changed. LVN 4 stated she has not seen Resident 55 eat ice cream, but she likes the shakes and drink water but does not eat much food. LVN 4 stated since Resident 55's breakfast and lunch intake are about 30-35% and at times has eaten 40%, but her baseline has been 30-35%. During a concurrent interview and record review of Resident 55's CP on 2/6/2025 at 1:55p.m. with Licensed Vocational Nurse 4 (LVN 4), LVN 4 stated Resident 55 has an anticipated weight loss related to malnutrition dated 1/8/2025 with interventions to do monthly weights but does not have a CP for an actual weight loss. LVN 4 stated Resident 55 has a CP for alternation in nutritional status initiated on 1/23/24, revised 4/24/24, but the CP has not been revised for a year and does not indicate how much weight Resident 55 lost. LVN 4 stated the purpose of CP is to have a goal and interventions that needs to be done so the resident can improve during their time in the facility. LVN stated CP is also updated to know if the resident is improving and will add more interventions for the resident to continue improving. During an interview on 2/6/2025 at 2:03p.m. with Certified Nursing Assistant 4 (CNA 4), CNA 4 stated Resident 55 is not alert and does not know where she is at. CNA 4 stated Resident 55 is a one to one (1:1) feeder, is on a pureed diet (foods that have been blended or mashed), and stays with Resident 55 from 20 to 30 minutes as she does not want to eat. CNA 4 stated she has eaten 30% for breakfast and lunch and indicated when she does not want the food, she would say she wants milk and Glucerna is her favorite as she drinks all of it. CNA 4 stated she would notify the nurse if a resident does not eat as the resident can get sicker and dehydrated. CNA 4 stated Resident 55 likes to hold the cup that has the fluids and ensures she drinks all the milk, water, and juice. CNA 4 stated depending on the day, there are times Resident 55 would drink the nourishments and at times will spit it out. CNA 4 stated she gets regular portions and desserts, but primarily drink the Glucerna. During an interview on 2/6/2025 at 2:13p.m. with Restorative Nursing Aide 4 (RNA 4), RNA 4 stated if a resident loses more than 10 lbs in 2 to 3 weeks, that is considered a significant weight loss RNA 4 stated she will report the weight to Restorative Nursing Aide 2 (RNA 2) and RNA 2 will input the weights into the computer. RNA 4 stated when weights are done on a monthly basis, they will try to get the weight within the first or second week. RNA 4 stated if a resident has a history of not eating, they will do weekly weights for the first 3 to 4 weeks, and if the resident eats 50% or more of their meal, they will discontinue the weekly weights and will not be weighed on a monthly basis. RNA 4 stated when there is a weight loss that requires immediate attention, she will report it to RNA 2 and the Charge Nurse (CN) as it is unusual for a resident to lose 5 to 10 lbs . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review of Resident 55's weekly weights on 2/6/2025 at 3:30p.m. with RNA 2, RNA 2 stated if a resident gets admitted at 100 lbs and gains 5 lbs and becomes 105 lbs, she will notify the RD. RNA 2 stated RD comes every week and if a resident gains or loses weight, she will document it on the paper and report it to the Supervisor and CN that the resident keeps losing weight RNA 2 stated she reported the recent weight loss for Resident 55 to the Director of Nursing (DON), doctor was notified, and from 1/28/2025, Resident 55 has been on weekly weights as she continues to lose weight. RNA 2 stated she notifies the RD about Resident 55 losing weight as it is alarming, and the resident is not eating and does not want her to continue losing weight. During an interview on 2/7/2025 at 1:44p.m. with RD, RD stated DM attends the IDT meetings monthly. RD stated the IDT weight variance is done by the DM and licensed nurses monthly as well. RD stated she has separate meetings when it comes to weights and will discuss it with the nurses. RD stated it is case by case and will speak to the nurses individually regarding the residents who have weight concerns. RD stated the RNA will weigh the resident upon admission (weekly for the first 4 weeks and then monthly). RD stated if a resident starts to lose weight, they will continue to monitor and will keep them on a list of residents they need to chart once a month. RD stated a significant weight loss is when a resident loses 5% in 1 month, 7.5% in 3 months, and 10 % in 6 months. RD stated the weight for 2/2025 is not in the system yet and indicated the RNA will notify about weight loss sometimes, but stated she waits until it is documented in the system electronically RD stated if a resident has significant weight loss, she will do an assessment right away which includes their weight changes, medications they are on, how much food they are intaking, diet order, nourishments, and anything that is discussed with the nursing staff. RD stated Resident 55 was having significant weight loss RD indicated Resident 55 lost 5 lbs during 3/8/2024 (128 lbs) from 2/5/2024 (133 lbs. RD stated if Resident 55 is within her IBM range, she would receive 25-30cal/kg, but if resident is below her IBM range, they would add additional calories to get to her IBM RD stated she was not sure whether the interventions provided worked or not, but indicated it is trial and error, timing of the nourishments, and identifying what works best for Resident 55. RD stated in 7/3/2024, Resident 55's food intake was 40-100%. RD stated she recommended a g-tube on 1/25/2025 as she believes they did and tried everything they could from January 2024 to December 2024 to address Resident 55's continued weight loss and indicated Resident 55's weight loss was unavoidable. RD stated she checks to ensure weight is addressed during the IDT meetings, with the doctor, family, but not necessarily for significant weight changes. During a concurrent interview and record review of Resident 55's weekly weights on 2/8/2025 at 1:31p.m. with Assistant Director of Nursing (ADON), ADON stated care plan identifies what the goals are and how the problem is being addressed in a particular situation. ADON stated significant weight loss would trigger a weight loss due to the COC ADON stated if no one followed up, the resident would continue to lose weight. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/8/2025 at 2:24p.m. with DON, DON stated the RD, or the DM attend the IDT. DON reiterated the RD does not attend the IDT and will discuss the concerns with DM or when the RD is here. DON stated DM can make recommendations but cannot assess the weight and protein intakes and the RD primarily does the recommendations. DON stated if there is a significant weight loss, it triggers an IDT meeting. DON stated if there are no IDT meetings regarding significant weight loss, they will miss out on the cause, what could have been done to help resident to address nutritional needs, what can they do to maintain weight, further decline, or weight loss. DON stated they would address the COC that is occurring with the resident as a significant weight loss is change from their baseline for the resident. DON stated the doctor is notified if there are any changes to ensure they are aware of what is going on with their residents. DON stated weekly weights are important as they are done to monitor the resident that continues to lose weight and see if the interventions in place are effective. During a concurrent interview and record review of Resident 55's Weights and Vitals Summary dated 2/7/2025 on 2/8/2025 at 7:19p.m. with DON, DON stated if the resident has significant weight loss, the weight loss would be triggered. DON stated the significant weight loss was triggered on 5/6/2024 and does not remember if she did an IDT for May 2024, and if there was another weight loss triggered (June), another IDT would have been done to see what they can do and ask RD. DON stated Resident 55 should have had an IDT on a monthly basis and she is the one responsible doing the IDTs. DON stated IDT is done monthly if a resident continuously loses weight and indicated if she missed it, she missed it and did not do it. During a concurrent interview and record review of Resident 55's IDT Weight Management Care Plan dated 3/24/2024, 9/26/2024, and 1/20/2025 on 2/8/2025 at 7:24p.m. with Director of Nursing (DON), DON stated they do an IDT CP due to Resident 55's weight fluctuating and significant weight loss. DON stated Resident 55 should have had an IDT CP in June 2024 and despite having an IDT CP, Resident 55 still requires a CP for an actual weight loss. During a concurrent interview and record review of Resident 55's CP alteration in nutritional status on 2/8/2025 at 7:27p.m. with DON, DON stated for Resident 55's weight loss, she has looked at her diagnosis, see if she had an infection, what her meal intake was, determine if the resident needs extra servings, identify if anything happened in the last 3 months, or if she is getting antidepressant medications. DON stated Resident 55 is on Mirtazapine (antidepressant) to stimulate appetite. DON stated she look at labs and if they are abnormal, she will ask the nurse to inform the doctor about the abnormal lab results and should be documented that the doctor was notified. DON stated all of the interventions on the CP with added supplements is not good and was not effective. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review of Resident 55's weekly weights on 2/8/2025 at 7:38p.m. with DON,. DON stated if she is notified that a resident has weight loss, she will ask to have the resident reweighed on the same day. DON stated resident's weekly weights are not documented in their electronic system and indicated the weekly weights documented on paper can get lost. DON stated the do weights upon readmission, and if they do not monitor weight, the resident can continue to lose weight, be malnourished, and be dehydrated. DON stated RD calculates how much nutrition a resident requires and also does the nutrition assessments on admission and annually. DON stated Resident 55 should have had a ST screen to see if her diet needed to be changed of determine if she has dysphagia and is not sure why she was not sent out to the hospital for a reevaluation. DON stated she is not sure if they addressed her medication Mirtazapine, and it could have contributed to her weight loss. DON stated they could have done a re-eval with the psychologist for her medications. DON stated Resident 55 could have also had the carcinoembryonic antigen (CEA: test is not used for cancer screening but is used to detect cancer) screening as it could have answered why Resident 55 is losing weight, or have done the IDT weekly when the weight loss was triggered, or could have done the IDT monthly to better monitor her weight. During a review of the facility's P&P, titled Weight Assessment and Intervention revised 3/2022, the P&P indicated resident weights are monitored for undesirable or unintended weight loss or gain. Any weight change of 5% or more since the last weight assessment is retaken the next day for confirmation. If the weight is verified, nursing will immediately notify the dietitian in writing. Unless notified of significant weight change, the dietitian will review the unit weight record monthly to follow individual weight trends over time. The threshold for significant unplanned and undesired weight loss will be based on the following criteria [where percentage of body weight loss = (usual weight-actual weight)/(usual weight) x 100]: a. 1 month-5% weight loss is significant, greater than 5% is severe b. 3 months-7.5% weight loss is significant; greater than 7.5% is severe c. 6 months-10% weight loss is significant; greater than 10% is severe. Undesirable weight change is evaluated by the treatment team whether or not the criteria for significant weight change has been met The physician and the multidisciplinary team identify conditions and medications that may be causing anorexia, weight loss or increasing the risk of weight loss. For example: cognitive or functional decline; chewing or swallowing abnormalities, medication-related adverse consequences; increased need for calories and/or protein; fluid and nutrient loss. Care planning for weight loss or impaired nutrition is a multidisciplinary effort and includes the physician, nursing staff, the dietitian, the consultant pharmacist, and the resident or resident's legal surrogate. Individualized care plans shall address to the extent possible: a. the identified causes of weight loss, b. goals and benchmarks for improvement; and c. time frames and parameters for monitoring and reassessment. (continued on next page)

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	056043	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Care Center	1913 E 5th Street Long Beach, CA 90802

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interventions for undesirable weight loss are based on careful consideration of the following: nutrition and hydration need of the resident, environmental factors that may inhibit appetite or desire to participate in meals; medications that may interfere with appetite, chewing, swallowing, or digestion; and use of supplementation and/or feeding tubes. During a review of the facility's P&P, titled Nutritional assessment dated [DATE], the P&P indicated as part of the comprehensive assessment, a nutritional assessment, including current nutritional status and risk factors for impaired nutrition, shall be conducted for each resident. The dietician, in conjunction with the nursing staff and healthcare practitioners, will conduct a nutritional assessment for each resident upon admission (within current baseline assessment timeframes) and as indicated by a change in condition that places the resident at risk for impaired nutrition. As part of the comprehensive assessment, the nutritional assessment will be a systematic, multidisciplinary process that includes gather and interpreting data and using that data to help define meaningful interventions for the resident at risk for or with impaired nutrition. The nutritional assessment will be conducted by the multidisciplinary team and shall identify at least the following components: Nursing: usual body weight; description of the resident's usual intake and appetite; a history of reduced appetite or progressive weight loss or gain prior to admission; current clinical conditions and recent events that may have affected a resident's nutritional status and risk factors; usual meal and snack patterns. Dietician: an estimate of calorie, protein, nutrient and fluid needs; whether the resident's current intake is adequate to meet his or her nutritional needs. The multidisciplinary team shall identify, upon the resident's admission and upon his or her change of condition, the following situations that place the resident at increased risk for impaired nutrition (Note: Many residents have multiple, co-existing risk factors.): medication changes-includes changes resulting in loss of appetite, nausea, constipation, lethargy, decreased absorption, swallowing difficulty, etc. increased need for calories and/or protein-onset or exacerbation of diseases or conditions that result in a hypermetabolic state and an increased demand for calories and protein (e.g., cancer, COPD, liver disease; hyperthyroidism, wounds). During a review of the facility's P&P, titled Interdepartmental Notification of Diet (Including Changes and Reports revised 10/2017, the P&P indicated nursing services shall notify the physician and dietician when a nutritional problem (e.g., weight loss, pressure ulcer, eating problem, etc.) has been identified and shall collaborate with the dietician and physician to initiate an appropriate process of clinical review for causes of the nutritional problem.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45382 Based on observation, interview, and record review, the facility failed to provide treatments and services to five of seven sampled residents (Residents 19, 37, 66, 95, and 109) to prevent and/or limit a decline in joint (where two bones meet) range of motion (ROM, full movement potential of a joint) and mobility (ability to move). 1. For Resident 95, the facility failed to ensure the Restorative Nursing Aide (RNA, nursing aide program that helps residents maintain their function and joint mobility) order for the application of a resting hand splint (RHS, splint secured from the hand to the forearm to position the hand in a functional position) to Resident 95's left hand was written appropriately to include a maximal wear time of two (2) hours. 2. For Resident 19, the facility failed to provide RNA passive range of motion (PROM, movement at a given joint with full assistance from another person) exercises to Resident 19's both arms (shoulder, elbow, wrist, hand), five (5) times a week as ordered. 3. For Resident 37, the facility failed to provide RNA PROM exercises to Resident 37's both legs and both arms, 5 times a week as ordered. 4. For Resident 66, the facility failed to provide ambulation (walking) exercises using a front wheeled walker (FWW, mobility device with two wheels in the front used for support when standing or walking), 5 times a week as ordered from October 2024 to December 2024 and three (3) times a week as ordered from December 2024 to January 2025. 5. For Resident 109, the facility failed to provide ambulation exercises using hand -held assistance (HHA, helper places their hands on the resident to perform the task), 5 times a week as ordered. These deficient practices had the potential to cause residents to have skin break down (tissue damage caused by friction, shear, moisture, or pressure), pain, discomfort, a decline in mobility, ROM loss leading to contracture (loss of motion of a joint associated with stiffness and joint deformity) development, and a decline in physical functioning such as the ability to eat, dress, and walk. Findings: 1. During a review of Resident 95's Admission Record, the Admission Record indicated the facility initially admitted Resident 95 on 3/6/2024 and readmitted the resident on 1/13/2025 with diagnoses including epilepsy (disorder that causes episodes of seizures or altered consciousness), aphasia (loss of ability to understand or express speech, caused by brain damage), and acute respiratory failure (condition that occurs when the lungs cannot get enough oxygen into the blood). (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 95's Occupational Therapy (OT, profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) Discharge Summary, dated 3/27/2024, the OT Discharge Summary indicated Resident 95 safely wore a resting hand splint on the left hand, fingers, and wrist for up to 2 hours. The OT Discharge Summary indicated Resident 95 was discharged from OT services due to highest practical level achieved. The OT Discharge Summary recommendations indicated an RNA program for RNA to apply a left resting hand splint to the resident's tolerance, 5 times a week. During a review of Resident 95's RNA Order Summary Report, the Order Summary Report indicated a physician's order, dated 3/27/2024, for RNA to apply a resting hand splint to Resident 95's left hand to the resident's tolerance, every day, 5 times a week. During a review of Resident 95's Minimum Data Set (MDS, a federally mandated assessment tool), dated 12/12/2024, the MDS indicated Resident 95 was non-verbal and had severely impaired cognitive skills (ability to think, understand, learn, and remember) for daily decision making. The MDS indicated Resident 95 was dependent with hygiene, bathing, dressing, and rolling to both sides. The MDS indicated Resident 95 had functional limitations in ROM (limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk of injury) on both arms (shoulder, elbow, wrist, hand) and both legs (hip, knee, ankle, foot). During a review of Resident 95's Census List (record of hospitalization s, room changes, and payer source changes), the Census List indicated Resident 95 was transferred to the hospital on 1/6/2025 and returned to the facility on [DATE]. During a review of Resident 95's RNA Order Summary Report, the Order Summary Report indicated a physician's order, dated 1/14/2025, for RNA to apply a resting hand splint to Resident 95's left hand to the resident's tolerance, every day, 5 times a week. During an observation of an RNA session on 2/5/2025 at 11:32 am, in Resident 95's room, Resident 95 was lying in bed with the head rotated to the left. Resident 95 had a tracheostomy (a tube placed into a surgically created hole through the front of the neck and into the windpipe-trachea) tube and was mouthing words. Resident 95's both arms were slightly bent at the elbows and resting at the sides of the body. Resident 95's left wrist was fully bent in a downward position and the hand was slightly closed with the knuckles of all the fingers straight and the middle joints and tips of the fingers bent. Restorative Nursing Aide 3 (RNA 3) assisted with PROM exercises to Resident's both arms and both legs. RNA 3 stated Resident 95 wears a splint on the left hand because the left hand and left wrist were contracted. After the exercises were complete, RNA 3 applied a resting hand splint Resident 95's left hand. RNA 3 stated she kept the splint on Resident 95's left hand for about 3 to four (4) hours a day. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 2/5/2025 at 11:50 am, RNA 3 reviewed Resident 95's RNA physician orders and RNA task. RNA 3 confirmed the RNA orders and task indicated no splint wear time. RNA 3 stated the Rehabilitation Department (Rehab) created the RNA program and entered the RNA orders and RNA tasks into the electronic documentation system. RNA 3 stated if there was no wear time listed on the RNA order, RNA would not know how long to leave the splint on a resident. RNA 3 stated RNAs were unable to determine how long a resident should wear a splint because they were not qualified to do so. RNA 3 stated she put the splint on Resident 95's left hand for 3 to 4 hours daily because that is what Resident 95 tolerated but was unsure of how long she was supposed to leave it on since the wear time was not written in the RNA order. During a concurrent interview and record review on 2/5/2025 at 2:48 pm, Occupational Therapist 1 (OT 1) stated the purpose of splints was to prevent a decline in a resident's ROM. OT 1 stated a licensed Physical Therapist (PT, profession aimed in the restoration, maintenance, and promotion of optimal physical function) or OT assessed a resident's need for splints and determined a splint wear schedule (length of time and frequency a person can tolerate wearing the splint for safety, comfort, and maximal benefits) before transitioning a resident to an RNA program. OT 1 stated the licensed therapist established the RNA program and wrote the RNA splinting orders. OT 1 stated the RNA splinting order must include a splinting wear time, specifically the maximal wear time a resident was able to safely tolerate a splint before having any negative effects from the splint. OT 1 reviewed Resident 95's OT Discharge Summary, dated 3/27/2024, and confirmed the last time she saw Resident 95 for OT services was on 3/27/2024. OT 1 confirmed Resident 95 tolerated 2 hours of wearing the left resting hand splint at the time of discharge from OT on 3/27/2024. OT 1 reviewed the RNA orders, dated 3/27/2024 and 1/14/2025, and stated the RNA order was re-written or carried over upon re-admission to the facility in January 2025. OT 1 confirmed Resident 95's RNA order for the application of a resting hand splint to Resident 95's left arm, dated 1/14/2025, did not include a splint wear time. OT 1 stated the RNA orders should always include a splint wear time since Rehab determined the splint wear schedule and RNAs would not know how long to safely keep the splint on a resident. OT 1 stated the RNA order should have included a splint wear time of up to 2 hours since that is how long Resident 95 was able to tolerate the resting hand splint upon discharge from OT services on 3/27/2024. OT 1 stated if a splint wear time was not included in the RNA order, it could potentially lead to skin break down, skin irritation, and discomfort. During an interview on 2/7/2025 at 5:52 pm, the Director of Nursing (DON) stated Rehab was responsible for assessing the types of splints, determining the splint wear time for all residents in the facility, and establishing the RNA program. The DON stated all RNA splinting orders must include a wear time since Rehab determined how long a resident was able to safely tolerate wearing a splint. The DON stated if the splint wear time was not included in the RNA order, RNA would not know how long the resident should wear the splint which could potentially lead to discomfort, pain, and skin breakdown. 2. During a review of Resident 19's Admission Record, the Admission Record indicated the facility initially admitted Resident 19 on 9/10/2003 and readmitted Resident 19 on 5/20/2023 with diagnoses including C1-C4 quadriplegia (spinal cord injury in the neck region causing weakness or paralysis in both arms and both legs), polyneuropathy (damage of the nerves that can cause weakness, numbness, and burning pain) and chronic obstructive pulmonary disease (lung disease that causes obstruction of airflow and can limit normal breathing). (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 19's Order Summary Report, the Order Summary Report indicated a physician's order, dated 5/22/2023, for RNA to provide PROM exercises to Resident 19's both arms, every day, 5 times a week. During a review of Resident 19's RNA Documentation Survey Report (RNA flowsheet, daily record of RNA services provided for each month) for November 2024, the RNA flowsheets indicated for RNA to provide PROM exercises to Resident 19's both arms, every day, 5 times a week. The squares on the RNA flowsheet were blank on the following seven (7) days: 11/1/2024, 11/7/2024, 11/12/2024, 11/19/2024, 11/21/2024, 11/26/2024, and 11/29/2024. During a review of Resident 19's RNA flowsheets for December 2024, the RNA flowsheets indicated for RNA to provide PROM exercises to Resident 19's both arms, every day, 5 times a week. The squares on the RNA flowsheet were blank on the following six (6) days: 12/2/2024, 12/6/2024, 12/19/2024, 12/20/2024, 12/25/2024, and 12/30/2024. During a review of Resident 19's RNA flowsheets for January 2025, the RNA flowsheets indicated for RNA to provide PROM exercises to Resident 19's both arms, every day, 5 times a week. The squares on the RNA flowsheet were blank on the following eight (8) days: 1/6/2025, 1/9/2025, 1/17/2025, 1/23/2025, 1/24/2025, 1/28/2025, 1/29/2025, and 1/30/2025. During a review of Resident 19's MDS, dated [DATE], the MDS indicated Resident 19 was cognitively intact. The MDS indicated Resident 19 was dependent in eating, hygiene, toileting, bathing, dressing, and rolling to both sides. The MDS indicated Resident 19 had functional ROM limitations in both arms and both legs. During a concurrent observation and interview on 2/4/2025 at 12:07 pm, in Resident 19's room, Resident 19 was lying in bed with both shoulders elevated on pillows to the side to shoulder height, both elbows bent, both wrists straight, and the neck and upper body hunched forward. Resident 19's fingers of the left hand were all bent downwards, except the middle finger which was fully straight. Resident 19's fingers of the right hand were straight and held closely together. Resident 19 stated he was concerned about the ROM of his arms because staff rarely assisted with arm exercises. During a concurrent interview and record review on 2/6/2025 at 10:21 am, the Director of Staff Development (DSD) stated she supervised the RNAs. The DSD reviewed the Resident 19's physician's orders and RNA Flowsheets for November 2024, December 2024, and January 2025. The DSD confirmed Resident 19 had a physician's orders for RNA to provide PROM exercises to Resident 19's both arms, 5 times a week. The DSD stated a blank square on the RNA flowsheet grid indicated the resident was not seen for RNA treatment that day. The DSD confirmed Resident 19 missed 7 days of scheduled RNA services for the month of November, 6 days of scheduled RNA services for the month of December, and 8 days of scheduled RNA services for the month of January. The DSD stated Residents 19 did not receive RNA treatments as ordered by the physician. The DSD stated it was important for RNA to provide services as prescribed by the physician because missed treatments could place residents at risk for a functional decline. 3. During a review of Resident 37's Admission Record, the Admission Record indicated the facility initially admitted Resident 37 on 5/23/2012 and readmitted Resident 37 on 12/18/2024 with diagnoses including contractures to the left hand and left elbow and peripheral vascular disease (reduced circulation of blood to a body part due to a narrowed or blocked blood vessel). (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 37's Order Summary Report, the Order Summary Report indicated a physician's order, dated 8/13/2024, for RNA to provide PROM exercises to Resident 19's both arms, every day, 5 times a week. During a review of Resident 37's Order Summary Report, the Order Summary Report indicated a physician's order, dated 8/13/2024, for RNA to provide PROM exercises to Resident 19's both legs, every day, 5 times a week. During a review of Resident 37's RNA Flowsheets for October 2024, the RNA flowsheets indicated for RNA to provide PROM exercises to Resident 37's both arms and both legs, every day, 5 times a week. The squares on the RNA flowsheet were blank on the following 3 days on both RNA tasks: 10/7/2024, 10/10/2024, and 10/29/2024. During a review of Resident 37's RNA Flowsheets for November 2024, the RNA flowsheets indicated for RNA to provide PROM exercises to Resident 37's both arms and both legs, every day, 5 times a week. The squares on the RNA flowsheet were blank on the following 6 days on both RNA tasks: 11/7/2024, 11/8/2024, 11/12/2024, 11/19/2024, 11/26/2024, and 11/29/2024. During a review of Resident 37's RNA Flowsheets for December 2024, the RNA flowsheets indicated for RNA to provide PROM exercises to Resident 37's both arms and both legs, every day, 5 times a week. The squares on the RNA flowsheet were blank on the following 4 days on both RNA tasks: 12/2/2024, 12/6/2024, 12/162024, and 12/18/2024. During a review of Resident 37's MDS, dated [DATE], the MDS indicated Resident 37 was severely cognitively impaired. The MDS indicated Resident 37 was dependent in eating, hygiene, toileting, bathing, dressing, rolling to both sides, and bed to chair transfers. The MDS indicated Resident 37 had functional ROM limitations in both arms and both legs. During an observation on 2/4/2025 at 11:06 am, in Resident 37's room, Resident 37 was sitting in a chair to the right side of the bed. Resident 37's left hand was in a fist and the fingers of the right hand were hyperextended (the extension of a body part beyond it's normal limits) at the middle joints and bent at the fingertips. Resident 37's legs were covered with blankets. During a concurrent interview and record review on 2/6/2025 at 10:21 am, the Director of Staff Development (DSD) stated she supervised the RNAs. The DSD reviewed the Resident 37's physician's orders and RNA Flowsheets for October 2024, November 2024, and December 2024. The DSD confirmed Resident 37 had 2 physician's orders for RNA to provide PROM exercises to Resident 37's both arms and both legs, 5 times a week. The DSD stated a blank square on the RNA flowsheet grid indicated the resident was not seen for RNA treatment that day. The DSD confirmed Resident 37 missed 3 days of scheduled RNA services for the month of October, 6 days of scheduled RNA services for the month of November, and 5 days of scheduled RNA services for the month of December. The DSD stated Residents 37 did not receive RNA treatments as ordered by the physician. The DSD stated it was important for RNA to provide services as prescribed by the physician because missed treatments could place residents at risk for a functional decline. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. During a review of Resident 66's Admission Record, the Admission Record indicated the facility initially admitted Resident 66 on 3/1/2022 and readmitted Resident 66 on 3/5/2024 with diagnoses including muscle weakness, chronic obstructive pulmonary disease (lung disease that causes obstruction of airflow and can limit normal breathing), and osteoarthritis (loss of protective cartilage that cushions the ends of your bones). During a review of Resident 66's Order Summary Report, the Order Summary Report indicated a physician's order, dated 6/13/2024, for RNA to provide ambulation exercises using a FWW, 5 times a week. During a review of Resident 66's RNA Flowsheets for October 2024, the RNA flowsheets indicated for RNA to provide ambulation exercises using a FWW, every day, 5 times a week. The squares on the RNA flowsheet were blank on the following 3 days: 10/17/2024, 10/29/2024, and 10/30/2024. During a review of Resident 66's RNA Flowsheets for November 2024, the RNA flowsheets indicated for RNA to provide ambulation exercises using a FWW, every day, 5 times a week. The squares on the RNA flowsheet were blank on the following 2 days: 11/28/2024 and 11/29/2024. During a review of Resident 66's MDS, dated [DATE], the MDS indicated Resident 66 had moderately impaired cognition. The MDS indicated Resident 66 required supervision or touching assistance for eating, oral hygiene and rolling to both sides, partial/moderate assistance for upper body dressing, sit to stand transition, transfers, walking 10 feet, and substantial/maximal assistance for toilet hygiene, bathing, and lower body dressing. The MDS indicated Resident 66 had functional ROM limitations in both arms. During a review of Resident 66's Order Summary Report, the Order Summary Report indicated a physician's order, dated 12/19/2024, for RNA to provide ambulation exercises using a FWW, 3 times a week. During a review of Resident 66's RNA Flowsheets for December 2024, the RNA flowsheets indicated 2 separate tasks for RNA to provide ambulation exercises using a FWW, every day, 5 times a week from 12/1/2024 to 12/19/2024, and 3 times a week from 12/19/2024 to 12/31/2024. The squares on the RNA flowsheet were blank on the following 5 days: 12/10/2024, 12/12/2024, 12/17/2024, 12/21/2024, and 12/24/2024. During a review of Resident 66's RNA Flowsheets for January 2025, the RNA flowsheets indicated for RNA to provide ambulation exercises using a FWW, every day, 3 times a week. The squares on the RNA flowsheet were blank on the following 3 days: 1/4/2025, 1/9/2025, and 1/21/2025. During a concurrent observation and interview on 2/4/2025 at 10:58 am, in Resident 66's room, Resident 66 was lying in bed, holding and reading a book overhead. Resident 66 had a wheelchair with his name on it against the wall in front of the bed. Resident 66 stated staff assisted with walking exercises one time a week. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 2/6/2025 at 10:21 am, the Director of Staff Development (DSD) stated she supervised the RNAs. The DSD reviewed the Resident 66's physician's orders and RNA Flowsheets for October, November 2024, December 2024, and January 2025. The DSD confirmed Resident 66 had 2 physician's orders for provide ambulation exercises using a FWW, 5 times a week from 6/13/2024 to 12/19/2024 and 3 times a week from 12/19/2024 to current date. The DSD stated a blank square on the RNA flowsheet grid indicated the resident was not seen for RNA treatment that day. The DSD confirmed Resident 66 missed 3 days of scheduled RNA services for the month of October, 2 days of scheduled RNA services for the month of November, 5 days of scheduled RNA services for the month of December, and 3 days of scheduled RNA services for the month of January. The DSD stated Residents 66 did not receive RNA treatments as ordered by the physician. The DSD stated it was important for RNA to provide services as prescribed by the physician because missed treatments could place residents at risk for a functional decline. 5. During a review of Resident 109's Admission Record, the Admission Record indicated the facility initially admitted Resident 109 on 5/20/2022 and readmitted Resident 109 on 6/13/2024 with diagnoses including muscle weakness, low back pain, and osteoarthritis. During a review of Resident 109's Order Summary Report, the Order Summary Report indicated a physician's order, dated 8/30/2024, for RNA to provide ambulation exercises with HHA, 3 times a week. During a review of Resident 109's RNA Flowsheets for October 2024, the RNA flowsheets indicated for RNA to provide ambulation exercises with HHA to Resident 109, 5 times a week. The squares on the RNA flowsheet were blank on the following 3 days: 10/7/2024, 10/10/2024, and 10/29/2024. During a review of Resident 109's RNA Flowsheets for November 2024, the RNA flowsheets indicated for RNA to provide ambulation exercises with HHA to Resident 109, 5 times a week. The squares on the RNA flowsheet were blank on the following 5 days: 11/7/2024, 11/12/2024, 11/19/2024, 11/26/2024, and 11/29/2024. During a review of Resident 109's RNA Flowsheets for December 2024, the RNA flowsheets indicated for RNA to provide ambulation exercises with HHA to Resident 109, 5 times a week. The squares on the RNA flowsheet were blank on the following 4 days: 12/2/2024, 12/6/2024, 12/20/2024, and 12/25/2024. During a review of Resident 109's MDS, dated [DATE], the MDS indicated Resident 109 had severely impaired cognition. The MDS indicated Resident 109 required supervision or touching assistance for eating, oral hygiene, toileting hygiene, rolling to both sides, transfers, and walking 50 feet and partial/moderate assistance for bathing, dressing, sit to stand transition, and toilet transfers. The MDS indicated Resident 109 had functional ROM limitations in one arm. During a review of Resident 109's RNA Flowsheets for January 2025, the RNA flowsheets indicated for RNA to provide ambulation exercises with HHA to Resident 109, 5 times a week. The squares on the RNA flowsheet were blank on the following 5 days: 1/6/2025, 1/9/2025, 1/17/2025, 1/24/2025, and 1/29/2025. (continued on next page)

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	056043	A. Building B. Wing	02/06/2025

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 2/6/2025 at 10:21 am, the Director of Staff Development (DSD) stated she supervised the RNAs. The DSD reviewed the Resident 109's physician's orders and RNA Flowsheets for October 2024, November 2024, December 2024, and January 2025. The DSD confirmed Resident 109 had a physician's orders for RNA to provide ambulation exercises using HHA with Resident 109, 5 times a week. The DSD stated a blank square on the RNA flowsheet grid indicated the resident was not seen for RNA treatment that day. The DSD confirmed Resident 109 missed 3 days of scheduled RNA services for the month of October, 5 days of scheduled RNA services for the month of November, 4 days of scheduled RNA services for the month of December, and 5 days of scheduled RNA services for the month of January. The DSD stated Residents 109 did not receive RNA treatments as ordered by the physician. The DSD stated it was important for RNA to provide services as prescribed by the physician because missed treatments could place residents at risk for a functional decline. During an interview with the Director of Nursing (DON) on 2/7/2025 at 5:52 pm, the DON stated the purpose of the RNA program was to maintain a resident's current level of function and to prevent any functional declines. The DON stated missed RNA treatments could potentially cause a resident to experience a decline in overall function and mobility. During a review of the facility's undated Policy and Procedure (P/P) titled Splinting, the P/P indicated splinting would be recommended in accordance with evaluation findings and resident/family consent. The P/P indicated residents adjusted to new splints over time by following a wearing schedule that designated the amount of time the splint was to be worn and the amount of time the splint should remain off. The P/P indicated the wearing schedule was established by a physician and therapist in collaboration with each other. The P/P indicated once the wearing schedule was established, a physician's order was needed that specified the type of splint, where it was to be applied, and the wearing schedule. During a review of the facility's P/P titled Resident Mobility and ROM, revised 7/2017, the P/P indicated residents would not experience an avoidable reduction in ROM and residents with limited ROM and mobility would receive treatment, services, and equipment to increase and/or prevent a further decrease in ROM and mobility. During a review of the facility's P/P titled, Restorative Nursing Program, revised 7/2017, the P/P indicated residents would receive restorative nursing care as needed to promote optimal safety and independence.

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45891 Based on observation, interview, and record review, the facility failed to ensure a resident, who was receiving feeding through a gastrostomy tube ([GT] a soft tube surgically placed into the stomach to provide nutrition and medications), did not have a severe weight loss (a weight loss greater than five percent (%) in one month, or greater than 7.5% in three months, and greater than 10% in six months) for one of 48 residents receiving GT feeding (Resident 188). The facility failed to ensure: 1.The licensed nurses conducted a change of condition (COC) assessment and monitored Resident 188 closely including weekly weights, signs and symptoms of malnutrition (condition that develops when the body is deprived of vitamins, minerals and other nutrients it needs to maintain healthy tissues and organ function), and dehydration (a dangerous loss of body fluid caused by illness, sweating, or inadequate intake), when the resident had A.Significant weight loss of (nine pounds ([lbs.] a unit of weight measurement) in one month (12/6/2024 [119 lbs.]-1/3/2024 [110lbs]) which was 7.6 % of Resident 188's admission body weight of 119 lbs., B.Weight loss of 24 lbs. in two months (12/6/2024 [119 lbs.]-1/31/2025 [95 lbs.]) on 1/31/2025 which was 20. 1% of Resident 188's admission body weight of 119 lbs. C.Weight loss of 25.8 lbs. on 2/6/2025 (12/6/2024 [119 lbs.] - 2/6/2025 93.2 lbs.]) which was 21.6% of Resident 188's admission body weight of 119 lbs. 2. The licensed nurses notified Resident 188's physician and responsible party (RP) of Resident 188's 7.6% significant weight loss identified on 1/3/2025 and 20.1% weight loss in two months identified on 1/31/2025 in accordance with Resident 188's untitled care plan dated 12/23/2024. 3. Resident 188's assigned nurse (unknown) notified the Registered Dietician (RD) to evaluate Resident 1 when the resident had a nine lbs. weight loss on 1/3/2025. 4. Registered Nurse (RN) 3 notified the RD on 1/31/2025 for the RD to evaluate Resident 188's 20.1% weight loss, in accordance with the untitled care plan dated 12/23/2024 when Resident 188 was noted to have continued weight loss. 5. The Interdisciplinary Team ([IDT] a team of different health care professionals working together to develop care interventions for a resident), including the RD met after Resident 188's significant weight loss was first identified on 1/3/2025, and then on 1/31/2025, to develop interventions to prevent further weight loss. 6. The IDT developed an individualized care plan with measurable goals to address Resident 188's weight loss identified on 1/3/2025 and 1/31/2025. 7. Restorative Nursing Assistant ([RNA] certified nursing aide program that helps residents to maintain their function and joint mobility) 1 documented Resident 188's weight right after weighing Resident 188 on 1/31/2025 on the RNA Monthly Weight Report. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	8. The RD did not wait until 2/6/2025 (30 days later) to reassess the effectiveness of Resident 188's nutritional interventions recommended on 1/7/2025, including increasing Resident 188's GT feeding 10 additional cubic centimeter ([cc], a unit of measurement) per hour (hr.) to 55 cc/hr, once his diarrhea (loose stool) subsided, per IDT/ care plan review, continue to monitor weight trends (unknown frequency), and reassess as needed (unknown frequency) the interventions recommended (on 1/7/2025). As a result of these deficient practices, Resident 188 had severe weight loss of 25.8 lbs. equal to 21.6% in 60 days. These deficient practices placed Resident 188 and 48 facility residents recieving enteral feeding at risk for malnutrition, dehydration, and possible death. On 2/8/2025 at 4:44 p.m., an Immediate Jeopardy ([IJ] a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment, or death to a resident) was called in the presence of the facility's Director of Nursing (DON) and the administrator (ADM) due to the facility's failure to implement interventions to prevent Resident 188's severe weight loss, and placed 48 residents recieving enteral feeding at risk for malnutrition, dehydration, and possible death. On 2/9/2025 at 1:13 p.m., the facility submitted an acceptable IJ Removal Plan ([IJRP] interventions to immediately correct the deficient practices). After onsite verification of the facility's IJRP's implementation through observation, interview, and record review, the IJ was removed on 2/9/2025 at 3:10 p.m., in the presence of the DON and ADM. The IJRP included the following immediate actions: a. A change of condition assessment, Situation Background Assessment Recommendation ([SBAR] a communication tool used to share information in a structured way) for severe weight loss was completed on 2/6/2025, which included vital signs (clinical measurements, specifically pulse rate, temperature, respiration rate, and blood pressure, that indicate the state of a patient's basic body functions), pain, laboratory (medical procedure that involves testing a sample of blood, urine, or other substance from the body) results reviewed and obtained new physician orders on 2/6/2025 for adding Liquacel (protein supplement) and to increase GT feeding to 55cc/hr. b. On 2/8/2025, the assistant director of nursing (ADON) conducted another assessment, indicating the Resident 188 remained at his baseline (starting point used for comparisons) condition with normal vital signs, and without any sign of distress. c. On 2/8/2025, the IDT members, including the RD, conducted an IDT care plan meeting. During the meeting, the IDT members addressed Resident 188's overall condition with severe weight loss of 12/6/2024 119lbs, 1/3/2025 ll0lbs (-9 lbs.), 2/6/2025 93.2lbs. (25.8 lbs.) The physician instructed to start weekly weight for four weeks and repeat the comprehensive metabolic panel ([CMP] a blood test to check liver, kidney, and metabolic health) on 2/10/2025. d. RNA 1 will receive a performance correction notice, and a one-on-one in-service by the DON regarding weight documentation, emphasizing the importance of recording the weight on the same day it was measured. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	e. On 2/8/2025, the weights management in-service was initiated until all licensed nurses, including part-time and night ([NOC] 11 p.m. to 7 a.m. shift) will be completed. In-service will be expected to be completed by 2/10/2025. Any licensed nurse unable to attend the in-service due to part time status, emergency or leave of absence has been removed from the schedule and must be given an in-service prior to returning to work. Weight Management in-service includes: e1. Conducting a change of condition assessment for significant or severe weight change: loss or gain of 3 lbs. within a month, 5% a loss or gain of at least 5% in 30 days, 7.5% in 90 days, or 10% in 180 days. e2. Licensed nurses will notify RD and physician of the significant or severe weight changes. e3. Conduct significant weight loss IDT care plan to include useful interventions based on assessment. f. The DON and ADON initiated review of all residents' weight records (180 residents) for the past 30 days to ensure that all significant or severe weight changes had proper assessments, RD recommendations, MD notifications, and updated plan of care. All reviews will be completed by 2/10/2025. g. The DON and the ADON will conduct monthly in-services to licensed nurses regarding weight management for 3-months, covering the following details: Conducting a change of condition assessment for significant or severe weight change: loss or gain of 3 lbs. within a month, 5% a loss or gain of at least 5% in 30 days, 7 .5% in 90 days, or 10% in 180 days. DON and/or designee will notify RD and physician of the significant or severe weight changes. Conduct significant or severe weight loss IDT care plan to include useful interventions based on assessment. Note that education on oral gratification is not considered a useful intervention for promoting weight gain. h. The DON and/or designee will repeat a monthly in-service for three months to RNA responsible for weights documentation, to ensure all weights are recorded on the same day it is measured. i. On 2/8/2025, the DON created a weight management monitoring log, including significant or severe weight loss. j. The DON/ADON will meet with the RNA weekly for four weeks, then monthly for three months to ensure timely weight documentation. k. The DON/ADON will participate in weekly weight management meeting and document the findings with corrective actions in the monitoring log. L. The DON/ADON will monitor weight variance through weekly weight meeting to ensure all residents with weight variance (significant or severe) will be addressed. The DON will discuss weight management related findings during the monthly QA meeting for three months to ensure ongoing compliance with the state and federal regulations. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	(cross reference: F553, F580, F656, and F865) Findings: During a review of Resident 188's Admission Record, the Admission Record indicated Resident 188 was admitted to the facility 12/6/2024 with diagnoses including muscle wasting (the shrinking and weakening of muscles), non-Hodgkin lymphoma (cancer [invasive growth of disease causing organisms]), tracheostomy tube (an opening surgically created through the neck into the trachea [windpipe] to allow air to fill the lungs), and multiple pressure ulcers (Injury to skin and underlying tissue resulting from prolonged pressure on the skin) and had a GT. During a review of Resident 188's Minimum Data Set ([MDS] a resident assessment tool) dated 12/13/2024, the MDS indicated Resident 188 had severe cognitive impairment (a significant decline in cognitive abilities that significantly impact daily functioning and independence) for daily decision making. The MDS indicated Resident 188's current weight as of 12/6/2024 was 119 lbs. The MDS indicated Resident 188 was receiving a therapeutic (a meal plan that controls the intake of certain foods or nutrients) diet and was receiving 51% or more of his total calories through a feeding tube. During a review of Resident 188's untitled Care Plan initiated on 12/23/2024, the Care Plan indicated Resident 188 had cancer with an increased risk for weight loss secondary to non-Hodgkin's lymphoma. The untitled Care Plan indicated Resident 188's goal was not to have a weight loss exceeding 5% per month. The Care Plan interventions included RD evaluations and to notify the physician and Resident 188's responsible party of any change of conditions. During a review of a document titled, Weekly-Weights- Station Subacute (a level of care needed by a patient who does not require hospital level acute care but who requires more intensive licensed skilled nursing care than is provided to the majority of patients in a skilled nursing facility) Summary dated 12/2024, the document indicated Resident 188's admitting weight was 119 lbs. and was weighed weekly after admission on 12/6/2024. Resident 188's weight was as follows: 1. On 12/11/2024 Resident 188's weight was 115 lbs. There was four lbs. weight loss in five days since admission on12/6/2024. 2. On 12/18/2024 Resident 188's weight was 112 lbs. There was another three lbs. weight loss in a week from 12/11/2024. 3. On 12/27/2024 Resident 188's weight was 110 lbs. There was another two lbs. weight loss in a week from 12/28/2024. 4. On 1/3/2025 Resident 188's weight was 110 lbs. The Weekly Weights and Vitals Summary did not indicate the aforementioned weekly weights were recorded and addressed in Resident 188's electronic medical record (EMR) and the resident's weekly weight loss was addressed. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of Resident 188's Weights and Vitals Summary, dated 12/6/2024, the Weekly Weights and Vitals Summary indicated Resident 188 weighed 119 lbs. The Weights and Vitals Summary dated 1/3/2025 indicated Resident 188's weight was 110 lbs., a nine lbs. (7.6%) weight loss since admission. The Weights and Vitals Summary did not indicate Resident 188's weekly weight measurements were continued when the weight loss was identified on 1/3/2025. During a review of Resident 188's Weights and Vitals Summary dated 2/6/2025, the Weights and Vitals Summary indicated Resident 188 weighed 93.2 lbs., which was a 25.8 lb. (21.7%) weight loss since admission. During a review of Resident 188's Order Summary Report (physician's orders), the Order Summary Report indicated an order was placed on 12/6/2024 to monitor Resident 188's weight weekly for four weeks and then monthly. The Order Summary Report indicated an order for monthly weights was placed on 12/6/2024. The Order Summary Report indicated there was an order placed on 12/6/2024 for GT feeding with Glucerna (diabetes-specific nutritional formula) 1.5 calorie ([cal] a unit of energy derived from nutrition) at 45 cubic centimeters (cc) per hour (hr) for 20 hours via GT pump (device to administer feeding formula) to provide 900 cc equal to1350 kilocalories (kcals) per day and discontinued on 1/7/2025. During a review of Resident 188's change of condition (COC)- Licensed Nurse Note dated 12/14/2024, the note indicated Resident 188 was having frequent loose stools (diarrhea). During review of Resident 188's Order Summary Report the Order Summary Report indicated on 1/7/2025, an order was placed for Imodium A-D (antidiarrhea medication) 2 milligrams (mg) via GT every four hours as needed for loose stool for seven days. During a review of Resident 188's Nutrition/ Dietary Note dated 1/7/2025 at 10:56 a.m., the Nutrition/Dietary Note indicated the RD documented Resident 188's weight was 110 lbs. with a nine lbs. weight loss in one month. The RD documented Resident 188's ideal body weight ([IBW] the healthiest weight per height) range was 117 lbs. to 143 lbs., and Resident 188's nine lbs. weight loss was significant. The Nutrition/Dietary Note indicated the RD recommended to increase the Glucerna 1.5 from 45 cc/hr to 55 cc/hr to provide 1100cc/1650 kcal per day. The Nutrition/Dietary Note indicated the RD recommended to monitor the resident's weight trends (frequency not specified) and she (RD) documented she would reassess the resident's nutritional needs as needed. There was an addendum (additional information) added on 1/7/2025 to the Nutrition/ Dietary Note indicating Resident 188 was able to tolerate the GT feeding well and had no nausea (feeling sick to your stomach), vomiting (throwing-up forces the contents of the stomach up through the food pipe) or diarrhea. During a review of Resident 188's Nutrition/ Dietary Note dated 1/7/2025 at 1:13 p.m., the Nutrition/ Dietary Note indicated the RD discussed Resident 188's frequent loose stools with a nurse (unknown) and to hold the order to increase the GT feeding to 55 cc/hr due to Resident 188's diarrhea. The Nutrition/ Dietary Note indicated the GT feeding would be increased once the diarrhea resolved. During a review of Resident 188's Medication Administration Record (MAR) for January 2025, the MAR indicated Imodium A-D was last given to the resident on 1/13/2025 for loose stool. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of Resident 188's Order Summary Report for January 2024, the Order Summary Report indicated an order dated 1/7/2025 to increase Glucerna 1.5 to 55 cc/hr. to administer for 20 hours via GT pump to provide 900 cc/1350 kcal per day. This order was discontinued three days later on 1/10/2025. The Order Summary Report indicated on 1/10/2025 an order was placed to decrease the Glucerna 1.5 back down to 45 cc/hr to administer for 20 hours to provide 900 cc/1350 kcal per day. The Order Summary Report indicated there were no new orders placed until 2/7/2025. On 2/7/2025 there was a new order to increase the GT feeding with Glucerna 1.5 at 55 cc per hour for 20 hours via GT pump to provide 1100 cc/1650 kcal per day. During a review of Resident 188's Licensed Nurses Progress Notes dated 1/7/2025, the Licensed Nurses Progress Notes indicated Resident 188's physician (MD 1) was informed Resident 188 was having loose stool and the RD recommended to increase Resident 188's GT water flush (water given through the GT for hydration) to 50cc/hr related to elevated (no result specified) blood urea nitrogen ([BUN] a kidney function laboratory test). The Licensed Nurses Progress Notes did not indicate MD 1 was informed of Resident 188's nine lbs. weight loss. During a review of Resident 188's Care Plan (untitled) initiated on 1/7/2025, the Care Plan indicated Resident 188 was identified to be at risk for dehydration secondary to diarrhea. The Care Plan indicated the goal for Resident 188 was to reduce the risk of unplanned weight changes. The Care Plan interventions included monitoring Resident 188's weight (frequency not identified) and report (unspecified to whom) any change of plus or minus (+/-) of three pounds per week or +/- five pounds per month per policy (policy not identified). This Care Plan did not include Resident 188's actual weight loss of 7.5% (nine lbs.) that had been identified on 1/3/2025 or the interventions to reduce the risk of continued weight loss from occurring. During a concurrent observation and interview on 2/5/2025 at 12 p.m., with Resident 188, in Resident 188's room, the resident was observed receiving Glucerna 1.5 through GT at rate of 45 cc/hr. Resident 188 stated he had been losing weight recently but was hopeful he would gain some weight back because he passed his swallow evaluation (checks how well a resident swallows) on 2/4/2025 and was now able to eat a little food along with his tube feeding for oral gratification (the pleasure derived from oral activities such as eating). Resident 188 stated he hoped to gain some weight because his legs looked like bones. Resident 188 was observed pulling his bed sheets away from his legs. Resident 188 legs were observed being very thin with prominent bones. Resident 188 stated he wanted to be stronger to participate in therapy. During an interview on 2/5/2025 at 12:03 p.m., Licensed Vocational Nurse (LVN) 6 stated RNA 1 was responsible for measuring and recording weights. LVN 6 stated RNA 1 had not reported any recent weight changes for Resident 188. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 2/5/2025 at 2:49 p.m., Registered Nurse (RN) 2 stated as of 2/5/2025, the last weight recorded for Resident 188 was on 1/3/2025. RN 2 stated RNA 1 was supposed to turn monthly weights in by the fifth day of every month but they were not yet completed. RN 2 stated the facility usually did not complete a COC for weight loss unless it was a lot of weight, like a 40 lbs. weight loss. RN 2 agreed that a nine lbs. (7. 6%) weight loss was a lot of weight to lose in one month. RN 2 stated that a COC did not need to be completed for a 7.5% weight loss. RN 2 stated if Resident 188 had been weighed weekly for four weeks after he was admitted on [DATE], per physician's order, the RD could have assessed Resident 188 sooner than 1/7/2025 and identified the gradual weight decrease. RN 2 stated she reviewed Resident 188's electronic medical record and could not find any documentation that Resident 188 was weighed weekly as RD recommended. During an interview on 2/6/2025 at 10:22 a.m., RNA 1 stated she weighed Resident 188 on Friday 1/31/2025 and the resident weighed 95 lbs. RNA 1 stated she did not document the weight for 1/31/2025 in Resident 188's chart but I knew Resident 188 had lost a lot of weight so she (RNA 1) verbally informed RN 3 about the weight loss on 1/31/2025. RNA 1 stated RN 3 stated that the weight loss identified on 1/31/2025 was okay, and that Resident 188 would start gaining weight because he passed his swallow evaluation and was able to eat (for oral gratification) as well as receive tube feedings. RNA 1 could not produce any documentation that the resident's weight of 95 lbs. on 1/31/2025 was documented. RNA 1 pointed to her head and stated, it is all in here. RNA 1 stated the residents' monthly weights on the sub-acute unit were not entered into the computer yet because she had yet to complete taking all the weights for the month and would finish by 2/7/2025. During an interview on 2/6/2025 at 11:48 a.m., RN 3 stated on 1/31/2025, RNA 1 did inform her Resident 188 lost a lot of weight (did not know exact amount). RN 3 stated she did not inform the physician because she was admitting another resident at the time. RN 3 stated she assumed Resident 188 would start gaining weight now that he was able to eat by mouth and was continuing to receive tube feeding. RN 3 stated Resident 188's diarrhea had stopped sometime mid-January 2025 (exact date unknown). During an observation on 2/6/2025 at 12:02 p.m., RNA 1 and LVN 3 were observed weighing Resident 188 using a mechanical lift (device used to assist with transfers [from one surface to another] and movement of individuals who require support for mobility beyond the manual support provided by caregivers alone) containing a scale. Resident 188 weighed 93.2 lbs. (total of 25.8 lbs. weight loss from admission weight of 119 lbs. on 12/6/2024). During an interview on 2/6/2025 at 12:21 p.m., the RD stated the nursing staff did not notify her of Resident 188's identified weight loss on 1/3/2025. The RD stated residents' monthly weights were documented in the residents' medical records and were printed out for her review every Monday or Thursday (in general). The RD stated on 1/7/2025, she reviewed Resident 188's weight report dated 1/3/2025 which indicated the resident weighed 110 lbs. and had a weight loss of nine lbs. The RD stated she assessed Resident 188 on 1/7/2025. The RD stated she had not reassessed Resident 188 since 1/7/2025 (30 days ago) when she evaluated him for significant weight loss and did not implement any interventions such as measuring his weight weekly because she (RD) did not feel Resident 188 required weekly weights for close monitoring. The RD stated she was unable to increase Resident 188's GT feeding on 1/7/2025 because Resident 188 had diarrhea. The RD stated she did not reassess Resident 188 after the diarrhea subsided on 1/13/2025. The RD stated she did not feel it was necessary to monitor Resident 188's significant weight loss of 7.6% more frequently than monthly. The RD stated it was important to monitor severe weight loss closely to ensure the residents health status did not decline. The RD stated the potential outcome of severe weight loss was malnutrition. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 2/6/2025 at 2:04 p.m., MD 1 stated he should have been notified as soon as possible of Resident 188's severe weight loss. MD 1 stated it was important he was notified so he could decide on new interventions and ensure the RD was assessing the resident's nutritional needs. During a review of Resident 188's Nutrition/ Dietary Note dated 2/6/2025, the Nutrition/ Dietary Note indicated Resident 188 weighed 93 lbs., and had a 17 lbs. (15%) weight loss in one month from 1/3/2025 to 2/6/2025 and had 26 lbs. weight loss in three months from 12/6/2025 to 2/6/2025. The Nutrition/ Dietary Note indicated the weight loss was significant and was likely related to pressure ulcer healing, diarrhea, and respiratory failure (a serious condition that makes it difficult to breathe on your own). The Nutrition/ Dietary Note indicated Resident 188 was tolerating GT feeding well and was not experiencing diarrhea at the time on 2/6/2025. The Nutrition/ Dietary Note indicated the RD recommended to increase the GT feeding to Glucerna 1.5 at 55cc/hr for 20 hrs. to provide 1100 cc/1650 kcal daily. During a review of Resident 188's COC/ Interact Assessment form (SBAR) dated 2/7/2024, the COC indicated Resident 188 had a 26 lbs. weight loss. The COC indicated MD 1 was notified of the weight loss. During a review of Resident 188's COC/ Interact Assessment forms (SBAR), the COC/Interact Assessment forms did not indicate there were any other COCs from admission (on 12/6/2024) to 2/7/2025 in Resident 188's chart regarding weight loss or that MD 1 or Resident 188's responsible party (RP), family member (FM)1were informed of the resident's severe weight loss. During an interview on 2/7/2025 at 12:41 p.m., Resident 188's FM 1 stated nursing staff (unknown) told her in passing Resident 188 was losing weight, but no one informed her how much weight. FM 1 stated on 2/7/2025, the morning nurse (unknown) called her about Resident 188's weight loss and informed her that Resident 188 had lost weight. FM 1 stated they did not inform her of the actual amount of weight he lost but now she was feeling worried about Resident 188's health. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 2/8/2025 at 1:23 p.m., the ADON stated a COC was important documentation including monitoring when an issue outside of the resident's baseline occurred. The ADON stated a significant weight loss was outside of Resident 188's baseline and a COC should have been initiated. The ADON stated he reviewed Resident 188's medical record and did not find a COC completed for weight loss or any documentation indicating the physician or FM 1 was notified of the weight loss. The ADON stated the RD needed to be made aware of significant weight loss but so did the physician because the physician had more options for addressing the weight loss, more interventions, and modalities to address the weight loss. The ADON stated a care plan should have been created for the weight loss as a change of condition. The ADON stated it was important to create a care plan, so all staff involved knew the new interventions, new goals, and the problem the resident was having. The ADON stated he reviewed Resident 188's medical record and did not find a care plan for the resident's severe weight loss. The ADON stated it was important to monitor interventions for a COC to see if interventions were effective. The ADON stated the IDT should have met and discussed Resident 188's weight loss so that they could collaborate and come up with new solutions for the weight loss and recommend them to the physician. The ADON stated the IDT was to be done as soon as the RP and resident were available to be involved in the care planning. The ADON stated as soon as Resident 188's diarrhea subsided on 1/13/2025 the RD should have reassessed the resident and the physician should have been notified so they could decide if GT feeding could have been increased. The ADON stated the potential outcome of not monitoring severe weight loss or reassessing the resident's interventions was further weight loss. The ADON stated based on Resident 188's current weight of 93.2 lbs., the interventions were not working and the IDT meeting should have been conducted to address the resident's progressive weight loss. During an interview on 2/8/2025 at 1:57 p.m., the RD stated she did not attend IDT meetings for weight loss. The RD stated the IDT discussed Resident 188's case but the notes of the IDT discussion were not written down. The RD stated if it was not documented, it was not done. The RD stated RNA 1 did not write down any weights on 1/31/2025, she (RNA 1) just told her (RD) the weight verbally on 2/6/2025. The RD stated the potential outcome of not being notified right away of weight loss was a delay of interventions to prevent further weight loss. The RD stated she based her assessment of Resident 188's chart and information obtained from nurses but did not assess or speak to the resident himself. During an interview on 2/8/2025 at 2:33 p.m., the DON stated facility staff cannot assume a weight loss was expected based on the resident's diagnosis. The DON stated they must closely monitor the resident's weight trends (via weekly weights) to see if any other interventions could be implemented for the resident. The DON stated she was not made aware Resident 188 had severe weight loss and that his weight loss was not discussed during an IDT meeting. The DON stated communication among the care team was important so weights can be addressed appropriately. The DON stated it was important to reassess the interventions to see if the interventions were working and revise and add new interventions as needed. During an interview on 2/8/2025 at 3:02 p.m., the director of staff development (DSD) stated the weights should be documented in the resident's chart right away after obtaining the weight. The DSD stated, we are all human and the RNAs could forget a weight or mix up the weights of different residents if they did not write them down right away. The DSD stated accurate weights were important so an accurate nutritional assessment could be done, and weights could be accurately monitored. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 2/8/2025 at 3:26 p.m., the medical director (MD 2) stated the physician needed to be informed as soon as weight loss was identified. MD 2 stated any significant weight fluctuations needed to be addressed. MD 2 stated continued weight loss was not good and affected a resident's well-being, could lead to malnutrition and slow pressure sore healing. During a review of the facility's policy and procedure (P/P) titled Nutritional assessment dated ,d+[DATE], the P/P indicated as part of the comprehensive assessment, the nutritional assessment was to be a systematic, multidisciplinary process that included gathering and interpreting data and using that data to help define meaningful interventions for the resident at risk of impaired nutrition. During a review of the facility's P/P titled Weight Assessment and Intervention dated 3/2022, the P/P indicated weights were to be recorded in each unit's weight record chart and in the individual's medical record. Any weight change of 5% or more since last weight assessment was retaken the next day for confirmation and if the weight is verified, the nursing team was to immediately notify the RD in writing. Residents were to be weighed at an interval determined by the IDT. The threshold for significant unplanned and undesired weight loss was to be based on the following criteria [where percentage of body weight loss = (usual weight - actual weight)/ (usual weight) x 100]: a. 1 month - 5% weight loss is significant; greater than 5% is severe. b. 3 months- 7.5% weight loss is significant; greater than 7.5% is severe. c. 6 months - 10% weight loss is significant; greater than 10% is severe. Care planning for weight loss or impaired nutrition is a multidisciplinary effort and includes the physician, nursing staff, the dietitian, the consultant pharmacist, and the resident or resident's legal surrogate (RP). Individualized care plans shall address to the extent possible: the identified causes of weight loss; goals and benchmarks for improvement; and time frames and parameters for monitoring and reassessment. During a review of the facility's P/P titled Change in Resident's Condition or Status dated 3/2022, the P/P indicated the nurse was to notify the physician and RP when there has been a significant change in the resident's physical condition. Notifications were to be made within 24 hours. The nurse was to record information relative to changes in the resident's record. During a review of the facility's Registered Dietician (RD) Consultant job description dated 4/2022, the job description indicated the RD was to work with the ADM, nursing, and other department heads on planning resident care issues, and quality assessment monitoring and reporting. The RD was responsible for evaluating the nutritional needs of the residents and documenting in the nutritional record.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46415 Based on observation, interview, and record review, the facility failed to ensure tube feedings were properly managed for three (3) of four (4) sampled residents (Resident 16, 84, and 37) with a gastrostomy tube (GT or g-tube: a tube that is passed through the abdominal wall to the stomach used to provide nutrition) by failing to: 1. Ensure Resident 16's tube feeding was disconnected after the administration of feeding. 2. Ensure the feedings were replaced in a timely manner for Residents 84 and Resident 37 that were hanging and were not administered for more than 24 hours (hrs) later. These deficient practices had the potential to place Residents 16, 84, and 37 at risk for infection. 1. During a review of Resident 16's Admission Record, the Admission Record indicated Resident 16 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including GT, chronic obstructive pulmonary disease (COPD: a chronic lung disease causing difficulty in breathing), gastroesophageal reflux disease (GERD: stomach acid that flows back from the stomach into the tube that connects the mouth and stomach), and chronic kidney disease (moderate damage to the kidneys). During a review of Resident 16's History and Physical (H&P) dated 6/15/2024, the H&P indicated Resident 16 did not have the capacity to understand and make decisions. During a review of Resident 16's Minimum Data Set ([MDS] a resident assessment tool)], dated 11/8/2024, the MDS indicated Resident 16's cognitive skills (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) were severely impaired. The MDS indicated Resident 16 was dependent in all aspects of activities of daily living (ADL: bathing, sit to lying, personal, toileting, oral hygiene, and eating. The MDS indicated Resident 16 was impaired on both the upper (arms/shoulders) and lower (hips/legs) extremities. During a review of Resident 16's Order Summary (physician notes) dated 2/5/2025, the physician notes indicated (Nepro: therapeutic nutrition designed for people who have reduced kidney function) at 50 cubic centimeter (cc: unit of volume that measures space occupied by solid or liquid) per hour (hr.) for 20 hours (hrs.) via pump to provide 1000CC/1800 kilocalories (kcals: unit measurement of energy used to describe calorie content of food) per day with an active date of 6/12/2024. During a concurrent observation and interview on 2/3/2025 at 11:14 a.m., with Licensed Vocational Nurse 5 (LVN 5), LVN 5 stated Resident 16's tube feeding was not turned on but it was still connected to Resident 16's g-tube. LVN 5 stated anything can happen to the G-tube or the resident whether the tube feeding is running or not. LVN 5 stated if the resident does not get up, the feeding tube stayed connected to Resident 16. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/8/2025 at 7:07 p.m. with Director of Nursing (DON), the DON stated the feeding tube should not be attached to the resident if the feeding is done or empty. The DON stated it can create more problems such as abdominal distention (feeling of fullness and swelling in the abdomen), air, and restlessness (inability to relax) for Resident 16. 2. During a review of Resident 84's Admission Record, the Admission Record indicated Resident 84 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including gastrostomy, gastroparesis (condition where the stomach muscles do not work to move food to be digested), and hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness or paralysis on one side of the body) following unspecified cerebrovascular disease (CVD: condition that affect the blood vessels in brain) affecting left non-dominant side. During a review of Resident 84's H&P dated 5/2/2024, the H&P indicated Resident 84 does not have the capacity to understand and make decisions. During a review of Resident 84's MDS dated [DATE], the MDS indicated Resident 84's cognitive skills were intact. The MDS indicated Resident 37 was dependent in performing a majority of ADL's and required maximal assistance for oral hygiene. The MDS indicated Resident 84 was impaired on both the upper and lower extremities. During a review of Resident 84's physician notes dated 2/6/2025, the physician notes indicated Jevity 1.5 (calorie dense and fiber fortified formula that provides a balanced nutrition for long- or short-term use of tube feeding) at 45cc/hr. for 20hrs via pump to provide 900cc/1350kcal per day with an active date of 1/29/2024. During an observation on 2/3/2025 at 3:10 p.m., in Resident 84's room, the Jevity 1.5 that was dated 2/2/2025 at 12 (did not indicate a.m. or p.m.) was running at 45cc/hr. The Jevity had about 700mililiter (mL: unit of volume) left to infuse. During an observation on 2/4/2025 at 9:39 a.m. in Resident 84's room, the Jevity 1.5 that was dated 2/2/2025 at 12 (did not indicate a.m. or p.m.) was turned off and was empty. During a concurrent observation and interview on 2/4/2025 at 9:57 a.m., with the DON, the DON stated the Jevity 1.5 feeding was dated 2/2/2025 at 12:00 and does not know if it was in the a.m. or p.m. The DON stated the staff should have hung another container of Jevity and changed the tube feeding yesterday (2/3/2025). The DON stated the tube feeding was finished, and it has been hanging for 48 hours. The DON stated the Jevity 1.5 feed label indicated that it should not be hung for more than 24 hours. DON stated tube feedings must be changed per manufacturers instructions, as it may cause gastrointestinal (conditions affecting the digestive system) problems and diarrhea if the resident received a feeding that was hanging over 48 hrs. 3. During a review of Resident 37's Admission Record, the Admission Record indicated Resident 37 was initially admitted to the facility on [DATE] and was readmitted on [DATE] and with diagnoses including hypertension (high blood pressure), gastrostomy, and contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion) on the left elbow and hand. During a review of Resident 37's H&P dated 12/19/2024, the H&P indicated Resident 37 does not have the capacity to understand and make decisions. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 37's MDS dated [DATE], the MDS indicated Resident 37's cognitive skills were moderately impaired. The MDS indicated Resident 37 was dependent on all aspects of ADL. The MDS indicated Resident 37 utilized a wheelchair and have impairments on both the upper and lower extremities. During a review of Resident 37's physician notes dated 2/6/2025, the physician notes indicated Jevity 1.5 at 45cc/hr. for 20 hrs via pump to provide 900cc/1350kcal per day (on at 12:00 p.m. and off at 8:00a.m. of until dose limit is completed) with an active date of 1/29/2025. During a concurrent observation and interview on 2/3/2025 at 3:36 p.m., with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated Resident 37's tubing for the tube feeding was wrapped around the right side of the residents side rails and the tube was taught. LVN stated he changes tube feeding within 48 hrs and is in the facility policy. LVN 2 stated Resident 37's tube feeding that is hanging was dated 2/2/2025 at 5:00 a.m. and indicated it should have been replaced as the feeding can go bad and is a safety concern. LVN 2 stated the water bag does not have a label on it, and they would normally label it. LVN 2 stated the water bag should have been replaced as it is replaced every 24 hours. During a review of the facility's policies and Procedures (P&P), titled Enteral Feedings-Safety Precautions, revised 11/2018, the P&P indicated the facility will remain current in and follow accepted best practices in enteral nutrition. Change administration sets for open-system enteral feedings at least every 24 hours, or as specified by the manufactured. Change administration sets for closed-system enteral feeds in according the manufacturer's instructions. During a review of Jevity 1.5 Cal Complete, Balanced Nutrition with Fiber manufacturer guideline, updated 7/22/2024, the manufacturer guideline indicated unless a shorter hang time is specified by the set manufacturer, hand product for up to 48 hours after initial connection when clean technique and only one new set are used. Otherwise hang for no more than 24 hours.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 45891 Based on interview and record review the facility failed to 1. Ensure Restorative Nurse Assistant (RNA 1) was competent regarding documenting residents' weight in the resident's medical record and licensed nurses (unknown) including Registered Nurses (RN 2 and RN 3) were competent in reporting changes of condition related to weight loss to the registered dietician (RD), physician (MD 1), and the responsible party (Family Member (FM)1) for one of 10 sampled residents (Resident 188). These deficient practices had the potential to cause inaccurate nutrition assessments and the potential for a delay in care and implementation of interventions to prevent further weight loss for Resident 188. Cross reference: F692 Findings: During a review of Resident 188's admission record, the admission record indicated Resident 188 was admitted to the facility 12/6/2024 with diagnoses of gastrostomy tube (GT, a feeding tube), muscle wasting, non-Hodgkin lymphoma (cancer), tracheostomy tube (an opening surgically created through the neck into the trachea (windpipe) to allow air to fill the lungs), and multiple pressure ulcers. During a review of a handwritten document titled Weekly-Weights- Station Subacute found in the RNA binder in the subacute station dated 12/2024, the handwritten document indicated Resident 188 was weighed weekly after admission with the following weights: 12/11/2024: 115 lbs. (4 lbs. weight loss in 5 days since 12/6/2024) 12/18/2024: 112 lbs. (3 lbs. weight loss in a week) 12/27/2024: 110 lbs. (2 lbs. weight loss in a week) 1/3/2024: 110 lbs. The weekly weights noted above were not identified in Resident 188's electronic medical record and the weekly weight loss was not addressed. During a review of Resident 188's Weights and Vitals Summary, on 12/6/2025 (admission) Resident 188 weighed 119 lbs. On 1/3/2025 the Weights and Vitals Summary indicated Resident 188 weighed 110 lbs., a 9 lb. (7.6%) loss since admission 1 month prior. On 2/6/2025 the Weights and Vitals Summary indicated Resident 188 weighed 93.2 lbs., a 25.8 lb. (21.7%) loss since admission 60 days (2 months) prior. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 188's minimum data set (MDS, a resident assessment tool) dated 12/13/2024 indicated Resident 188 had severe cognitive impairment (a significant decline in cognitive abilities that significantly impact daily functioning and independence). The MDS indicated Resident 188's current weight (taken 12/6/2024) was 119 lbs., Resident 188 was receiving a therapeutic diet (e.g., diabetic), and Resident 188 was receiving 51% or more of his total calories through a feeding tube. Resident 188's medical record did not include an updated significant change MDS containing updated information regarding his cognitive function or weight loss. During a review of Resident 188's untitled care plan initiated 12/23/2024, the care plan focus was Resident 188 had cancer with increased risk for weight loss secondary to non-Hodgkin's lymphoma. Goals included Resident 188 having weight loss that did not exceed 5% per month and interventions including RD evaluation and notifying the physician and Resident 188's responsible party of any change of conditions. During a review of Resident 188's Nutrition/ Dietary Note dated 1/7/2025, the RD indicated Resident 188's weight was 110 lbs. a 9-pound (8% (number documented by RD)) weight loss in 1 month. The RD indicated Resident 188's ideal body weight (IBW) was 117 to 143 lbs., and the weight loss was significant. The RD recommended to increase the Glucerna 1.5 from 45 cc/hr. to 55 cc/hr. to provide 1100cc, 1650 kcal) per day. The RD indicated to monitor weight trends (frequency not specified), and she would reassess as needed. An addendum added 1/7/2025 to this note indicated Resident 188 was able to tolerate the feeding well and had no nausea/ vomiting or diarrhea (N/V/D). During a review of Resident 188's Nutrition/ Dietary note entered later that day on 1/7/2025, the RD indicated she discussed with nurse (unknown) and the increase in tube feeding would be held due to diarrhea. The RD indicated the tube feeding would be increased once diarrhea resolved (Imodium last given 1/13/2025, 6 days later). During a review of Resident 188's Licensed Nursing Notes Dated 1/7/2025, the notes indicated Resident 188's physician (MD 1) was informed Resident 188 was having loose stool and the RD recommended Resident 188's water flush (for hydration) would be increased to 50cc/hr. related to elevated blood urea nitrogen (BUN, a kidney function laboratory test). The nurses note did not indicate MD 1 was informed of Resident 188's weight loss. During a review of Resident 188's untitled care plan initiated 1/7/2025, the care plan focus was Resident 188 was at risk for alteration in hydration status secondary to diarrhea (loose stool). Goals included reducing the risk of unplanned weight changes for Resident 188 and interventions included monitoring Resident 188's weight (frequency not identified) and report any change of plus or minus (+/-) 3 pounds per week or +/- 5 pounds per month as indicated or per policy (policy not identified). During a review of Resident 188's Nutrition/ Dietary note dated 2/6/2025, the RD indicated Resident 188 was 93 lbs., a 17 lb. (15%) weight loss in one month, 26 lb. weight loss in 3 months (these numbers are documented by RD, it appears she rounded the numbers. The RD indicated the weight loss was significant and was likely related to wound healing, diarrhea, respiratory failure (a serious condition that makes it difficult to breathe on your own), and history of sepsis (blood stream infection). The RD indicated Resident 188 was tolerating tube feeding well and was not experiencing diarrhea at the time. The RD recommended to increase the tube feeding to Glucerna 1.5 at 55cc/hr. x 20 hrs. (1100 cc, 1650 kcal). (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 188's COC form (SBAR) dated 2/7/2024, the COC indicated Resident 188 had a 26 lb. weight loss, the COC indicated MD 1 was notified of the weight loss. There were no other COCs in Resident 188's chart regarding weight loss or informing MD 1 and Resident 188's responsible party (RP), family member (FM)1 of Resident 188's weight loss. During an observation and concurrent interview on 2/5/2025 at 12 p.m., Glucerna 1.5 was hanging for Resident 188 with a rate of 45 cc/hr. Resident 188 stated he had been losing weight recently but was hopeful he would gain some weight back because he passed his swallow evaluation (checks how well a resident swallows) the day prior (2/4/2025) and was now able to eat a little food along with his tube feeding. Resident 188 stated he hoped to gain some weight because his legs looked like bones (Resident 188 pulled his bed sheets away from his legs and Resident 188 appeared very thin with prominent bones showing in legs) and he wanted to be stronger to participate in therapy. During an interview on 2/5/2025 at 12:03 p.m., LVN 6 stated RNA 1 was responsible for subacute weights but had not reported any recent weight changes for Resident 188. During an interview on 2/5/2025 at 2:49 p.m., Registered Nurse (RN) 2 stated she was the subacute unit manager. RN 2 stated as of 2/5/2025, the last weight recorded for Resident 188 was on 1/3/2025. RN 2 stated RNA 1 was supposed to turn monthly weights in by the 5th of every month but they were not yet completed at that time. RN 2 stated the facility usually did not complete a COC for weight loss unless it was a lot of weight, like 40 lbs. weight loss. RN 2 agreed that 9 lbs. weight loss (7.6%) was a lot of weight to lose in one month but maintained that a COC did not need to be completed. RN 2 stated the RD would have assessed Resident 188 sooner than 1/7/2025 if the gradual weight loss was identified during the weekly weights upon admission. RN 2 stated she reviewed Resident 188's medical record and could not find any weekly weights. During an interview on 2/6/2025 at 10:22 a.m., RNA 1 stated she weighed Resident 188 on Friday 1/31/2025 and the resident weighed 95 lbs. RNA 1 stated she did not document the weight from 1/31/2025 in the chart but knew Resident 188 had lost a lot of weight so she verbally informed Registered Nurse (RN 3) about the weight loss on 1/31/2025. RNA 1 stated RN 3 stated that the weight loss was okay, and that Resident 188 will start gaining weight because he passed his swallow evaluation and was able to eat as well as receive tube feedings. RNA 1 could not produce any documentation that the weight of 95 lbs. was documented when taken on 1/31/2025, RNA 1 pointed to her head and stated, it is all in here. RNA 1 stated the subacute monthly weights were not in the computer yet because she had yet to complete taking all the weights for the month and would finish by 2/7/2025. During an interview on 2/6/2025 at 11:48 a.m., RN 3 stated on 1/31/2025, RNA 1 did inform her Resident 188 lost a lot of weight (did not know exact amount). RN 3 stated she did not inform the physician because she was admitting another resident at the time. RN 3 stated she assumed Resident 188 would start gaining weight now that he was able to eat by mouth and was continuing to receive tube feeding. RN 3 stated Resident 188's diarrhea had stopped sometime mid-January 2025 (exact date unknown). During an observation on 2/6/2025 at 12:02 p.m., RNA 1 and LVN 3 weighed Resident 188 using a mechanical lift (devices used to assist with transfers and movement of individuals who require support for mobility beyond the manual support provided by caregivers alone) containing a scale. Resident 188 weighed 93.2 lbs. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/6/2025 at 12:21 p.m., the RD stated the nursing staff did not notify her of any identified weight loss until after the residents' monthly weights were taken by Restorative Nursing Assistants (RNAs). The RD stated residents' monthly weights were documented in the residents' medical records and are printed out, for her review every Monday or Thursday. The RD stated on 1/7/2025, she reviewed Resident 188's weight report dated 1/3/2025 which indicated the resident weighed 110 lbs. and had lost weight. The RD stated, she then assessed Resident 188. During an interview on 2/6/2025 at 2:04 p.m., MD 1 stated he should be notified as soon as possible for severe weight loss, and it was important he was notified so he could decide on new interventions and ensure the RD was assessing the resident's nutritional needs. During an interview on 2/7/2025 at 9:59 a.m., RN 2 stated the facility only informs the physician of a significant weight change if the RD was not in or the RD couldn't be reached. RN 2 stated they only notified the physician of significant weight loss on a as needed (PRN) basis. RN 2 stated the point of monitoring a resident with weight loss closely was to ensure the interventions implemented were effective. During an interview on 2/7/2025 at 12:41 p.m., Resident 188's family member (FM 1) stated nursing staff (unknown) told her In passing Resident 188 was losing weight, but no one informed her how much or made it a big deal. FM 1 stated just that morning (2/7/2025) a nurse (unknown) did a formal phone call about weight loss and informed her that Resident 188 had lost weight. FM 1 stated they did not inform her of the actual amount of weight he lost but now she was feeling worried Resident 188's health. During an interview on 2/8/2025 at 1:23 p.m., the ADON stated a COC was important documentation and monitoring done when an issue occurred outside of the resident's baseline and significant weight loss is outside of resident's baseline and should be done. The ADON stated he reviewed Resident 188's medical record and could not find a COC done for weight loss or any documentation indicating the physician or FM 1 was notified of the weight loss. The ADON stated the RD needed to be made aware of significant weight changes but so did the physician because the physician had more options for addressing the weight loss, more interventions, and modalities to address the weight loss. The ADON stated a care plan was required to be created for the weight loss change of condition and it was important to create a care plan, so all staff involved knew the new interventions, new goals, and the problem the resident was having. The ADON stated he reviewed Resident 188's medical record and could not find a care plan for severe weight loss. The ADON stated it was important to monitor interventions for a COC to see if interventions were effective and the IDT should meet so that they can collaborate and come up with new solutions for the weight loss and recommend it to the physician. The ADON stated the IDT was to be done as soon as the RP and resident are available- they need to be involved in the care. The ADON stated as soon as Resident 188's diarrhea subsided (1/13/2025) the RD should have reassessed the resident and the physician should have been notified so they could decide if the tube feeding could have been increased. The ADON stated the potential outcome of not monitoring severe weight loss or reassessing the resident's interventions was further weight loss. The ADON stated based on Resident 188's current weight (93.2 lbs.), the interventions were not working, and an IDT should have been conducted for the resident. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/8/2025 at 1:57 p.m., the RD stated RNA 1 did not write down any weights on 1/31/2025, she just told her the weight verbally for Resident 188 on 2/6/2025 (6 days later). The RD stated if it was not documented, it was not done. The RD stated the potential outcome of not being notified right away of weight loss was a delay of interventions and further weight loss. During an interview on 2/8/2025 at 3:02 p.m., the director of staff development (DSD) stated the weights should be documented immediately in the resident's chart after obtaining the weight. The DSD stated, we are all human and the RNAs could forget a weight or mix up the weights of different residents if they were not written down right away. The DSD stated accurate weights were important so an accurate nutritional assessment could be done, and weights could be accurately monitored. During a review of the facility's P/P titled Weight Assessment and Intervention dated 3/2022, the P/P indicated weights were to be recorded in each unit's weight record chart and in the individual's medical record. Any weight change of 5% or more since last weight assessment was retaken the next day for confirmation and if the weight is verified, the nursing team was to immediately notify the RD in writing. Residents were to be weighed at an interval determined by the IDT. The threshold for significant unplanned and undesired weight loss was to be based on the following criteria [where percentage of body weight loss = (usual weight - actual weight)/ (usual weight) x 100]: a. 1 month - 5% weight loss is significant; greater than 5% is severe. b. 3 months- 7.5% weight loss is significant; greater than 7.5% is severe. c. 6 months - 10% weight loss is significant; greater than 10% is severe. Care planning for weight loss or impaired nutrition is a multidisciplinary effort and includes the physician, nursing staff, the dietitian, the consultant pharmacist, and the resident or resident's legal surrogate (RP). Individualized care plans shall address to the extent possible: the identified causes of weight loss; goals and benchmarks for improvement; and time frames and parameters for monitoring and reassessment. During a review of the facility's P/P titled Change in Resident's Condition or Status dated 3/2022, the P/P indicated the nurse was to notify the physician and RP when there has been a significant change in the resident's physical condition. Notifications were to be made within 24 hours. The nurse was to record information relative to changes in the resident's record.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45891 Based on observation, interview, and record review, the facility failed to: 1.Ensure Resident 177's physician order for Aspirin [a medication used to prevent heart attack (flow of blood and oxygen is blocked) and stroke (loss of blood flow to a part of the brain)] was administered as a chewable according to manufacturer formulation specifications instead of being swallowed, on 2/5/2025. 2.Ensure the correct medication administration route (is often classified by the location at which the drug is administered) was ordered for one of eight sampled residents (Resident 52) who had a gastrostomy tube (GT, a tube inserted through the wall of the abdomen directly into the stomach. It can be used to give drugs and liquids, including liquid food, to the patient). These deficient practices had to potential for Resident 52 to receive medication orally (by mouth) and aspirate (breathe something in; inhale) and had a potential for Resident 177 to be at risk for stroke. Findings: 1.During a review of Resident 177's Admission record (face sheet), dated 2/6/2025, the face sheet indicated Resident 177 was admitted to the facility on [DATE] with diagnoses including hypertension (HTN-high blood pressure) and hyperlipidemia (high cholesterol). During a review of Resident 177's Minimum Data Set (MDS - a resident assessment tool), dated 11/20/2024, the MDS indicated Resident 177's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was not intact, required supervision when eating, and required moderate (helper does less than half the effort) to maximal (helper does more than half the effort) for hygiene and bathing. During a review of Resident 177's Physician Order Summary dated 2/6/2025, the Order Summary indicated Aspirin 81 Oral Tablet Chewable 81 Milligrams (MG - unit of measurement) Give 1 tablet by mouth one time a day for cerebrovascular accident (CVA) prophylaxis. During an observation on 2/5/2025 at 9:53 a.m. in Resident 177's room, Registered Nurse (RN) 4 prepared and administered Resident 177's medications which included one tablet of chewable aspirin 81 MG. Resident 177 was observed swallowing the Aspirin 81 MG tablet. During an interview on 2/5/2025 at 10:10 a.m. with RN 4, RN 4 stated Resident 177 swallowed the aspirin instead of chewing it as ordered. RN 4 stated the efficacy of the aspirin will be affected. During an interview on 2/8/2025 at 6:50 p.m. with the Director of Nursing (DON), the DON stated if aspirin is not administered per manufacturer guidelines, the aspirin will not be effective, the resident may have gastrointestinal stress, and is at an increased risk of having a stroke. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's licensed vocational nurse (LVN) job description last revised 3/7/2024, the job description stated the facility shall prepare and pass medications as indicated. 2.During a review of Resident 52's Admission Record, the Admission Record indicated Resident 52 was admitted to the facility 4/3/2022 with diagnoses of cerebral palsy (a group of conditions that affect movement and posture), gastrostomy, tracheostomy (an opening surgically created through the neck into the trachea (windpipe) to allow air to fill the lungs), and dysphagia (problems swallowing). During a review of Resident 52's MDS dated [DATE], the MDS indicated Resident 52 was rarely or never understood. During a review of Resident 52's order summary sheet, an order was placed 1/29/2025 for Zinc Sulfate capsule 220 mg, give 1 capsule by mouth one time a day for supplement/ wound healing for 1 month. During an interview on 2/5/2025 at 9:07 a.m., licensed vocational nurse (LVN 3) stated she had not previously noticed Resident 52's physician order for Zinc Sulfate was incorrect. LVN 3 stated Resident 52 was unable to swallow anything by mouth and the order should have indicated the Zinc Sulfate was to be given by GT. LVN 3 stated nurses were to follow the medication administration rights (Right Person, Right Medication, Right Dose, Right Time, Right Route, Right Reason, and Right Documentation) when administering medications to residents and it was for resident safety. LVN 3 stated she had been giving the medication via GT because Resident 52 could not swallow but if someone did follow the order, Resident 52's safety was at risk, and he could choke and aspirate. During an interview on 2/8/2025 at 2:52 p.m., the Director of Nursing (DON) stated the medication administration route needed to be verified against physician orders, but the nurses also needed to assess the resident to see if the order was correct for their condition. The DON stated it was important for physician's orders to indicate the correct route because the medication could have accidentally been given by mouth and the resident might aspirate. The DON stated the nurses needed to take the time to get a clarification of physician's orders if something was not correct. During a review of the facility's policy and procedure (P/P) titled Medication and Treatment Orders dated 7/2016, the P/P indicated orders for medications must include the route of administration. 50144

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 45891 Based on interview and record review, the facility failed to ensure one out of three sampled residents (Resident 188) had an adequate diagnosis and did not receive unnecessary antipsychotic (altering brain chemistry to help reduce psychotic symptoms like hallucinations, delusions and disordered thinking) medications. This deficient practice placed Resident 188 at risk for harmful side effects of antipsychotic medication including sedation (a decrease in awareness and a decrease in response to external stimulation), drowsiness (sleepy), dizziness, weakness, problems with movement, and changes in weight. Findings: During a review of Resident 188's admission record, the admission record indicated Resident 188 was admitted to the facility 12/6/2024 with diagnoses of gastrostomy tube (GT, a feeding tube), muscle wasting, non-Hodgkin lymphoma (cancer), tracheostomy tube (an opening surgically created through the neck into the trachea (windpipe) to allow air to fill the lungs), and multiple pressure ulcers. Resident 188's admission record did not indicate Resident 188 had any diagnosis related to mental health issues or psychosis. During a review of Resident 188's minimum data set (MDS, a resident assessment tool) dated 12/13/2024 indicated Resident 188 had severe cognitive impairment (a significant decline in cognitive abilities that significantly impact daily functioning and independence). The MDS indicated Resident 188 did not have any indicators for psychosis nor did he exhibit any behavioral symptoms. The MDS indicated Resident 188 did not have any psychiatric or mood disorders. The MDS indicated Resident 188 was receiving antipsychotic medication. During a review of Resident 188's Order Summary Report, the report indicated an order was placed 2/3/2025 for Seroquel (antipsychotic medication) oral tablet 25 mg, give 1 tablet via GT at bedtime for anti-psychosis. During an interview on 2/8/2025 at 3:16 p.m., the Assistant Director of Nursing (ADON) stated there must be an actual diagnosis for antipsychotic usage and the physician's order needed to be full and complete including the manifestation (m/b, what symptoms is resident exhibiting. The ADON stated he reviewed Resident 188's chart and he did not have any diagnosis for psychosis or mental health issues. The ADON also stated that the order for Seroquel was not complete because it did not contain the m/b statement informing which behaviors Resident 188 had that warranted the use of Seroquel. The ADON stated Resident 188 was at risk of medication side effects and Seroquel had a black box warning (is an added label to drugs or drug products by the Food and Drug Administration (FDA) when serious adverse reactions or special problems occur, particularly those that may lead to death or serious injury) which was, increased risk of death. During a review of the facility's policy and procedure (P/P) titled Antipsychotic Medication Use dated 7/2022, the P/P indicated residents would not receive medications that were not clinically indicated to treat a specific condition. Residents who were transferred from the hospital and were already receiving antipsychotics would be evaluated for the appropriateness and indications for use.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 45891 Based on interview and record review the facility failed to follow their policy and procedure (P/P) titled Antipsychotic Medication Use by failing to ensure one out of eight sampled residents (Resident 184) had complete physicians orders for psychotropic medications (any drug that affects behavior, mood, thoughts, or perception) including a specific diagnosis. This deficient practice placed Resident 184 at risk for receiving unnecessary medications (medications without adequate indication for use). Findings: During a review of Resident 184's Admission Assessment, the Admission Assessment indicated Resident 184 was admitted to the facility 9/16/2024 with diagnoses of unspecified dementia (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain) with behavioral disturbance, unspecified mood disorder (a mental health condition that primarily affects your emotional state), and unspecified psychosis (a severe mental condition in which thought and emotions are so affected that contact is lost with external reality). During a review of Resident 184's minimum data set (MDS, a resident assessment tool) dated 12/20/2024, the MDS indicated Resident 184 had severe cognitive impairment (problems with your thinking, communication, understanding or memory). The MDS indicated Resident 184 had no behavioral symptoms or indicators of psychosis. The MDS indicated Resident 184 was receiving antipsychotics. During a review of Resident 184's Order Summary Report, orders were placed 3/4/2025 for Olanzapine (an antipsychotic medication) oral tablet 5 milligrams (mg, a unit of measurement), give 1 tablet by mouth two times a day for antipsychotics. During an interview on 3/12/2025 at 2:11 p.m., the assistant director of nursing (ADON) stated he oversaw monitoring antipsychotics for the facility and the facility was cited on their recent recertification survey (exit date 3/8/2025) for unnecessary psychotropic medications and it was part of his duty to ensure all residents had a proper diagnosis and indication for antipsychotic use. The ADON stated he reviewed Resident 184's current medication orders on 3/12/2025 and noted for antipsychotics was not a proper diagnosis to be prescribed Olanzapine and there was no indication mentioned. The ADON stated it was important to ensure residents receiving antipsychotic medications had a specific diagnosis for use and an indication as to why the resident was receiving the medication to ensure they were being monitored for the behavior. The ADON stated the potential risk of residents not having a proper diagnosis or indication for the antipsychotics was the resident does not really need the medication and they could have adverse side effects (unwanted undesirable effects that are possibly related to a drug). (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P/P titled Antipsychotic Medication Use dated 7/2022, the P/P indicated residents would not receive medications that were not clinically indicated to treat a specific condition. Residents who were transferred from the hospital and were already receiving antipsychotics would be evaluated for the appropriateness and indications for use.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50144 Based on observation, interview and record review, the facility failed to store and label medications in accordance with manufacture guidelines for the following: 1. One opened Budesonide inhalation suspension foil pack (medication used to reduce breathing problems) for Resident 152 2. Four Intravenous (IV - administered thorugh a blood vessel) Lorazepam (sedative medication used to treat anxiety or seizures) vials for Resident 87 3. One IV Torbramycin (antibiotic) bag for Resident 1 4. One opened Ipratopium Bromide foil pack (medication used to treat breathing problems) for Resident 72 5. One opened Tuberculin Purified Protein Derivative (PPD-used in the 2-step process to screen new resident for tuberculosis [TB-an infectious disease that primarily affects the lungs] solution multi-dose vial. This failure had the potential to result in Residents 152, 87, 1, and 72 receiving medications that had become ineffective or toxic due to improper storage or labeling, possibly leading to health complications or hospitalization as well as resulting in inaccurate testing for any resident requiring an initial or annual TB screening, placing all residents at risk for Tuberculosis. Findings: 1. During a review of Resident 152's Admission Record, the Admission Record indicated Resident 152 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities) and hypertensive heart disease (prolonged high blood pressure) with heart failure. During a review of Resident 152's general acute care hospital (GACH) records dated [DATE], Resident 157 was treated for acute hypoxic respiratory failure (a condition where the body does not have enough oxygen [life sustaining gas] in the blood) and pneumonia (a lung infection). During a review of Resident 152's Minimum Data Set (MDS - a resident assessment tool), dated [DATE], the MDS indicated Resident 152 had severe cognitive (ability to learn, reason, remember, understand) impairment, required supervision for eating, was required maximal (helper does more than half the effort) for toileting and bathing. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 152's Physician Order Summary printed [DATE], the Physician Order Summary indicated an order for Budesonide Inhalation Suspension 0.5 Milligrams (MG - unit of measurement)/ 2 Milliliter (ML - unit of measurement), inhale orally two times a day for shortness of breath (SOB), ordered [DATE]. During a concurrent observation and interview on [DATE] at 2:16 p.m., with Registered Nurse (RN) 4, the Station 3B medication cart was inspected. There was an opened foil pack of Budesonide for Resident 152 with no opened date. RN 4 stated the open date should have been written on the foil pack because the medication must be used within 2 weeks after foil envelope is opened per the manufacturer guidelines. If Resident 152 received expired Budesonide for SOB, there is a risk that the resident will continue to have SOB or other breathing problems due to recieving expired or ineffective medication. 2. During a review of Resident 1's Admission Record, the Admission Record, indicated Resident 1 was initially admitted to the facility on [DATE] with diagnoses of sepsis (a life-threatening blood infection) and pneumonia (an infection/inflammation in the lungs). During a review of Resident 1's MDS, dated [DATE], the MDS indicated Resident 1 had was able to understand and be understood and was dependent (required complete assistance of 2 or more helpers) for eating, hygiene, bathing, and dressing. During a review of Resident 1's Physician Order Summary printed [DATE], the Physician Order Summary indicated an order for Tobramycin Sulfate Injection Solution. Use 120 MG intravenously one time a day for leukocytosis 9the body's response to infections)/sputum infection until [DATE] 05:59 reconstitute with 100 ML Normal Saline (NS) solution, ordered [DATE]. During a concurrent observation and interview on [DATE] at 2:44 p.m., in the Station 1 medication storage room refrigerator with RN 5, there was one bag of IV Tobramycin for Resident 1 that had an expiration date of [DATE]. RN 5 stated the antibiotic was discontinued and the expired medication should have been properly disposed of. 3. During a review of Resident 72's Admission Record, the Admission Record indicated Resident 72 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including pneumonia, acute respiratory failure (a condition when the body is not able to breath to support body funtions), and chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing). During a review of Resident 72's MDS, dated [DATE], the MDS indicated Resident 1 had moderatly cognitivly impairmed with some ability to recall information, required supervision for eating and toileting, and required maximal assistance for bathing. During a review of Resident 72's Physician Order Summary printed [DATE], the Physician Order Summary indicated an order for Ipratropium-Albuterol Inhalation Solution 0XXX,d+[DATE].5 (3) MG/3ML, 1 unit inhale orally every 4 hours as needed for Wheezing (difficulty breathing); Shortness of breath, ordered on [DATE]. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on [DATE] at 2:32 p.m., with Licensed Vocational Nurse (LVN) 4, Station 1A medication cart was inspected. There was an opened foil pack of Ipratropium-Albuterol Inhalation Solution with no open date. LVN 4 stated the open date should have been written on the foil pack because the medication must be used within 2 weeks after foil envelope is opened per the manufacturer guidelines. LVN 4 stated if there is no open date, the nurse will not know when the medication expires. LVN 4 stated if Resident 72 received expired Ipratropium-Albuterol for SOB or wheezing, there is a risk that the resident will continue to have SOB, wheezing or other breathing problems. 4. During a concurrent observation and interview on [DATE] at 2:44 p.m., in the Station 1 medication storage room refrigerator with RN 5, there was one opened Tuberculin Purified Protein Derivative (PPD-used in the 2-step process to screen new resident for tuberculosis (TB-an infectious disease that primarily affects the lungs) solution multi-dose vial with the open date of [DATE]. RN 5 stated the PPD solution should be used within 30 days per manufacturer guidelines (until [DATE]). During an interview on [DATE] at 6:50 p.m. with the Director of Nursing (DON), the DON stated it is important to label medications and follow manufacturer guidelines for storage. It is important to dispose of medications when expired, because the potency of the medication will be affected. It is important to ensure that PPD solution is not expired because it can produce inaccurate TB screening readings potentially placing all residents at risk for tuberculosis. During a review of the facility's policy and procedure (P&P), titled Medication Storage in the Facility - Storage of Medications, dated [DATE], The P&P indicated Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier . Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy if a current order exists. During a review of the facility's policy and procedure (P/P), titled Preparation and General Guidelines - Vials and Ampules of Injectable Medications, dated [DATE], The P/P indicated the date opened and the initials of the first person to use the vial are recorded on multi-use vials .medication in multi-dose vials may be used until the manufacturer's expiration date or 6 months after opening unless otherwise specified.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. 46415 Based on observation ,interview and record review the facility failed to ensure they followed their own sanitation and infection control policy to work under sanitary conditions at all times. This deficient practice had the potential to result in cross-contamination (transfer of harmful substances or disease-causing microorganisms to food by hands, food contact surfaces) and increase the risk of infection for 133 of 181 residents. Findings: During a concurrent observation and interview on 2/4/2025 at 11:59a.m. with Regional Registered Dietitian (RRD), RRD was observed grabbing a food thermometer with no hand washing and gloves, grabbed an alcohol swab (clean and disinfect skin or surfaces to prevent infection), swabbed the metal part of the thermometer, and stuck the thermometer into the purred broccoli (cooked food that has been blended to the consistency of a creamy paste). RRD was observed getting another alcohol swab and wiping away the metal part of the thermometer to clean the purred broccoli and attempted to repeat the process without hand hygiene and gloves. RRD stated the cook had already taken the temperature of the food and did not wear a glove because I had asked him to take the temperature of the food. During an interview on 2/4/2025 at 12:43p.m. with RRD, RRD stated hand hygiene is performed to prevent cross contamination and indicated he was not touching the food when taking the temperature. During a review of the facility's Policies and Procedures (P&P), titled Sanitation and Infection Control, undated, the P&P indicated hand washing before and after handling foods. Hands are to be washed when entering the kitchen and before putting on disposable gloves. Disposable gloves are to be worn when handling food directly with hands when handling ready-to-eat foods.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 45891 Based on interview and record review the facility failed to ensure the registered dietician (RD) was competent regarding assessment and reassessment of residents with severe weight loss for one of ten sampled residents (Resident 188), and the RD failed to attend interdisciplinary (an approach to healthcare that integrates multiple disciplines through collaboration) team meetings at the facility. This deficient practice had the potential to cause continued weight loss for Resident 188. Resident 188 had severe weight loss (a weight loss greater than 5% in one month, greater than 7.5% in 3 months, and greater than 10% in 6 months) of 25.8 lbs. or 21.6% in 60 days since admission on 12/6/2025. This deficient practice placed all 181 Residents at risk for weight loss. Cross reference: F692 Findings: During a review of Resident 188's admission record, the admission record indicated Resident 188 was admitted to the facility 12/6/2024 with diagnoses of gastrostomy tube (GT, a feeding tube), muscle wasting, non-Hodgkin lymphoma (cancer), tracheostomy tube (an opening surgically created through the neck into the trachea (windpipe) to allow air to fill the lungs), and multiple pressure ulcers. During a review of a handwritten document titled Weekly-Weights- Station Subacute found in the RNA binder in the subacute station dated 12/2024, the handwritten document indicated Resident 188 was weighed weekly after admission with the following weights: 12/11/2024: 115 lbs. (4 lbs. weight loss in 5 days since 12/6/2024) 12/18/2024: 112 lbs. (3 lbs. weight loss in a week) 12/27/2024: 110 lbs. (2 lbs. weight loss in a week) 1/3/2024: 110 lbs. The weekly weights noted above were not identified in Resident 188's electronic medical record and the weekly weight loss was not addressed. Weekly weights were not continued when the 7.6% weight loss was identified on 1/3/2025. During a review of Resident 188's Weights and Vitals Summary, on 12/6/2025 (admission) Resident 188 weighed 119 lbs. On 1/3/2025 the Weights and Vitals Summary indicated Resident 188 weighed 110 lbs., a 9 lb. (7.6%) loss since admission 1 month prior. On 2/6/2025 the Weights and Vitals Summary indicated Resident 188 weighed 93.2 lbs., a 25.8 lb. (21.7%) loss since admission 60 days (2 months) prior. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 188's Order Summary Report, the report indicated an order was placed 12/6/2024 to monitor Resident 188's weight weekly times (x) 4 weeks and then monthly (no weekly weights were documented in Resident 188's Weight and Vital Sign Report in the electronic medical record (EMR)). The report indicated an order was placed on 12/6/2024 and discontinued 1/7/2025 for enteral feed order: Glucerna (diabetes-specific nutrition) 1.5 calorie (cal) formula at 45 cubic centimeter (cc, a unit of measurement) per hour (hr.) for 20 hrs. via pump to provide 900 cc/1350 kilocalories (kcals) per day. An order was placed 1/7/2025 to increase Glucerna 1.5 to 55 cc/ hr. for 20 hrs. via pump to provide 900 cc/ 1350 kcal (incorrect, would have provided 1100 cc/ 1650 kcal) per day, the order was discontinued 3 days later on 1/10/2025. On 1/7/2025, an order was placed for Imodium A-D (antidiarrhea medication) 2 milligrams (mg) via GT every 4 hours as needed for loose stool for 7 days. On 1/10/2025 an order was placed to decrease the Glucerna 1.5 back down to 45 cc/hr. for 20 hrs. (900 cc/1350 kcal) per day. There were no new orders placed until 2/7/2025 to increase the tube feeding. A new order was placed on 2/7/2025 for Glucerna 1.5 at 55 cc per hour for 20 hours via pump to provide 1100CC/1650 kcal) per day. During a review of Resident 188's minimum data set (MDS, a resident assessment tool) dated 12/13/2024 indicated Resident 188 had severe cognitive impairment (a significant decline in cognitive abilities that significantly impact daily functioning and independence). The MDS indicated Resident 188's current weight (taken 12/6/2024) was 119 lbs., Resident 188 was receiving a therapeutic diet (e.g., diabetic), and Resident 188 was receiving 51% or more of his total calories through a feeding tube. Resident 188's medical record did not include an updated significant change MDS containing updated information regarding his cognitive function or weight loss. During a review of Resident 188's untitled care plan initiated 12/23/2024, the care plan focus was Resident 188 had cancer with increased risk for weight loss secondary to non-Hodgkin's lymphoma. Goals included Resident 188 having weight loss that did not exceed 5% per month and interventions including RD evaluation. During a review of Resident 188's medication administration report for 1/2025, Imodium A-D was last given on 1/13/2025 for loose stool. During a review of Resident 188's Nutrition/ Dietary Note dated 1/7/2025, the RD indicated Resident 188's weight was 110 lbs. a 9-pound (8% (number documented by RD)) weight loss in 1 month. The RD indicated Resident 188's ideal body weight (IBW) was 117 to 143 lbs., and the weight loss was significant. The RD recommended to increase the Glucerna 1.5 from 45 cc/hr. to 55 cc/hr. to provide 1100cc, 1650 kcal) per day. The RD indicated to monitor weight trends (frequency not specified), and she would reassess as needed. An addendum added 1/7/2025 to this note indicated Resident 188 was able to tolerate the feeding well and had no nausea/ vomiting or diarrhea (N/V/D). During a review of Resident 188's Nutrition/ Dietary note entered later that day on 1/7/2025, the RD indicated she discussed with nurse (unknown) and the increase in tube feeding would be held due to diarrhea. The RD indicated the tube feeding would be increased once diarrhea resolved (Imodium last given 1/13/2025, 6 days later). (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 188's Nutrition/ Dietary note dated 2/6/2025, the RD indicated Resident 188 was 93 lbs., a 17 lb. (15%) weight loss in one month, 26 lb. weight loss in 3 months (these numbers are documented by RD, it appears she rounded the numbers. The RD indicated the weight loss was significant and was likely related to wound healing, diarrhea, respiratory failure (a serious condition that makes it difficult to breathe on your own), and history of sepsis (blood stream infection). The RD indicated Resident 188 was tolerating tube feeding well and was not experiencing diarrhea at the time. The RD recommended to increase the tube feeding to Glucerna 1.5 at 55cc/hr. x 20 hrs. (1100 cc, 1650 kcal). During an interview on 2/6/2025 at 12:21 p.m., the RD stated she had not reassessed Resident 188 since 1/7/2025 (30 days ago) when she evaluated him for significant weight loss and did not implement any weekly weights because she did not feel Resident 188 required weekly weights for close monitoring. The RD stated she was unable to increase tube feeding on 1/7/2025 because Resident 188 had Diarrhea. The RD stated she did not reassess Resident 188 after the diarrhea subsided on 1/13/2025 (6 days later). The RD stated she did not feel it was necessary to monitor Resident 188's significant weight loss of 7.6% more frequently than monthly. The RD stated it was important to monitor severe weight loss closely to ensure the residents health status did not decline. The RD stated the potential outcome of severe weight loss was malnutrition (condition that develops when the body is deprived of vitamins, minerals and other nutrients it needs to maintain healthy tissues and organ function). During an interview on 2/8/2025 at 1:57 p.m., the RD stated she did not attend IDT meetings for weight loss. The RD stated the IDT discussed Resident 188's case but it was not written down. The RD stated if it was not documented, it was not done. The RD stated she based her assessment of Resident 188 on the resident's chart and information obtained from nursing but did not assess or speak to the resident himself. During a review of the facility's P/P titled Weight Assessment and Intervention dated 3/2022, the P/P indicated any weight change of 5% or more since last weight assessment was retaken the next day for confirmation and if the weight is verified, the nursing team was to immediately notify the RD in writing. Residents were to be weighed at an interval determined by the IDT. The threshold for significant unplanned and undesired weight loss was to be based on the following criteria [where percentage of body weight loss = (usual weight - actual weight)/ (usual weight) x 100]: a. 1 month - 5% weight loss is significant; greater than 5% is severe. b. 3 months- 7.5% weight loss is significant; greater than 7.5% is severe. c. 6 months - 10% weight loss is significant; greater than 10% is severe. Care planning for weight loss or impaired nutrition is a multidisciplinary effort and includes the physician, nursing staff, the dietitian, the consultant pharmacist, and the resident or resident's legal surrogate (RP). Individualized care plans shall address to the extent possible: the identified causes of weight loss; goals and benchmarks for improvement; and time frames and parameters for monitoring and reassessment. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's Registered Dietician (RD) Consultant job description dated 4/2022, the job description indicated the RD was to work with the ADM, nursing, and other department heads on planning resident care issues, and quality assessment monitoring and reporting. The RD was responsible for evaluating the nutritional needs of the residents and documenting in the nutritional record.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46415 Based on observation and interview the facility failed to ensure to store food in a sanitary manner to prevent growth of microorganisms that could cause food borne illness (food poisoning: any illness resulting from the food spoilage of contaminated food, pathogenic bacteria, and viruses for 133 out of the 181 residents in the facility by not: 1. Facility failed to separately store frozen meats and veggies. 2. Facility failed to store opened sausages and croissants separately in the produce fridge. 3. Facility failed to date and label frozen items, produce, and stored goods. 4. Facility failed to date thickened milk shakes that were already thawed in the fridge. 5. Facility failed to discard molded and expired bread and expired cottage cheese. 6. Facility failed to check chloride levels and have chloride test strips available before running the dishwasher. 7. Facility failed to have a scale to weigh proper portion sizes. These deficient practices had the potential to result in pathogen (germ) exposure to residents and placed residents at risk for developing foodborne illness (food poisoning) with symptoms including upset stomach, stomach cramps, nausea, vomiting, diarrhea and fever and can lead to other serious medical complications and hospitalization . Findings: During initial kitchen tour on [DATE] at 8:23a.m. with Dietary Aid 1 (DA 1) and [NAME] 1 (CK 1), DA 1 stated in Freezer number (#) two (2): a. Potato fries in a bag and 2 pie crusts on the first shelf do not have labels and are undated. CK 1 stated a different staff had supposedly received the delivery on Saturday [DATE], however the delivery date and open date for the pie crust is not indicated. During a concurrent observation and interview on [DATE] at 8:34a.m. with CK 1 for Freezer # 2 , CK 1 stated on the first shelf: a. Opened bag of peperoni that was stored with the pie crust. Date on the opened bag of peperoni is unclear. b. Valley box crinkle fries, cut carrots, and green peas has no date on the boxes. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	c. Frozen pork loin and zucchini crinkle fries are stored together undated. d. Cut corn and frozen beef are stored together undated. e. Frozen broccoli florentine and ground pork are stored together undated. CK 1 stated veggies and meat are supposed to be stored separately and is not supposed to be like this in the freezer. f. Cookie box is stored on top of the meat box. CK 1 indicated the cookie and meat are not supposed to be stored together and the received date is supposed to be on the box. During a concurrent observation and interview on [DATE] at 8:44a.m. with CK 1 in the produce fridge, CK 1 stated Top shelf on Left side of Produce Fridge: g. Opened sausages are stored with croissant (baked margarine). h. Opened tartar sauce dated [DATE]. i. One (1) opened and 2 unopened cottage cheese. Produce original expiration date [DATE]. j. Three (3) non-dairy almond milk stored with ground beef with no received date. k. Opened box of health shake with Keep Frozen on box. Thickened milk shake has no thaw date. Bottom shelf on left side of Produce Fridge: Produce box had a label pepper, but had onions stored in the bin. CK 1 stated labels are required to know when the items expire, and without the label, they will not know when the food will go bad and the residents can get sick. During a concurrent observation and interview on [DATE] at 8:59a.m. with Dietary Aid 2 (DA 2), DA 2 stated the chloride strips are usually located on the top of the dishwashing machine, but indicated he does not know where they are. DA 2 stated they check twice a day but do not have the strips today. Cups were noted drying at the end of the dishwasher. During a concurrent observation and interview on [DATE] at 9:16a.m. with Registered Dietitian (RD) in pantry room, RD stated the opened peanut kids (peanut butter) with an unclear date is based on the delivery date. During a concurrent observation and interview on [DATE] at 9:20a.m. with Dietary Manager (DM) in pantry room. DM stated: Salt packets-does not know delivery date (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Canned cranberry dated ,d+[DATE] but does not know the year Sweet Relish-undated 12 boxes of perfect moist angel food boxes-no delivery date, Vanilla wafers-undated. Tea bags-no received dated. DM stated they would normally write the receive date to know if more orders need to be placed and the best by date. Swiss miss (hot chocolate) no sugar-opened box undated. Polenta-no received date 2 [NAME] tomato ketchup-undated Five (5) Sunrise brand canned mushrooms-undated. DM stated they are supposed to have labels on it. 5 unopened dry pasta-one unclear date and the rest undated. Ziti noodles-undated. Unopened bread [eight (8) hamburger enriched bun dated [DATE]] four (4) hamburger buns molded. 1 expired hamburger enriched bun dated [DATE]. 4 loafs of bread expired: [DATE], [DATE], [DATE], and [DATE]. During a concurrent observation and interview on [DATE] at 9:47a.m. with RD and DM, DM stated the health shakes in the produce fridge that have been thawed are good for 2 weeks but does not any dates. DM stated the onions in the produce bin does not have a date. During a concurrent observation and interview on [DATE] at 9:39a.m. with DM for Freezer # 2, DM stated the zucchini box is undated, and the pork loin, broccoli florentine, and zucchini are stored together. DM stated they are supposed to be stored separately as the meat can leak onto the veggies and the residents can get sick. During a concurrent observation and interview on [DATE] at 9:52a.m. with DM of dishwasher machine, DM stated the chlorine test strips would normally be on top of the dishwasher, but it was not there prior and did not observe a test strip near the dishwasher. DM stated they check the chemical (chlorine) and if there are no chlorine test strips, they run the dishwasher a few times. DM stated they check to ensure all of the germs come off after the dishes are returned to the kitchen. DON stated if they do not check the chloride level, residents can get sick, can contaminate from dirty and clean dishes. DM stated they check the chlorine level before every meal service. (continued on next page)

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	056043	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Care Center	1913 E 5th Street Long Beach, CA 90802

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent observation and interview with Regional Registered Dietitian (RRD) and CK 1 by ready-to-serve food, RRD stated for the pork that was being served for lunch on [DATE], a small portion is usually 2 to 3 ounces (oz: unit of weight) and indicated they do not have a food scale, and stated by the looks of it, the small portion of pork was 2oz. RRD stated they measure weight if the recipe requires measurement. During an interview on [DATE] at 12:41p.m. with RRD, RRD stated the kitchen used to have a scale but has not had a scale since [DATE]. RRD stated 3 oz is the size of the palm, and a scale ensures the residents get the recommended serving. RRD stated he knows the pork being served for lunch for a regular portion (3 oz) is 3 oz as the meat was the size of the palm. RRD stated there was nothing that needed to be weighed. During a review of the Dry Goods Storage Guidelines, dated 2018, the dry goods storage guidelines indicated: 1.Mayonnaise, salad dressing, tater sauce: opened-refrigerated 2 months. 2.Bread: unopened on shelf-five (5) to seven (7) days During a review of the facility's Policy and Procedure (P&P), titled Refrigerator/Freezer Storage undated, the P&P indicated all meat and perishable food, e.g. milkshakes, pies, etc. placed in the refrigerator for thawing must be labelled and re-dated with the date the item was transferred to the refrigerator. All items should be properly covered, dated, and labeled. Food items should have the following appropriate dates: Delivery date-upon receipt Open date-opened containers of PHF Thaw date-any frozen items. No food items that is expired of beyond the bed buy date are in stock. Dry goods storage guidelines to be followed unless manufacture recommendation showing it can be kept longer. Food items will be stored according to this order: a) Cooked and ready-to-eat, produce, leftovers b) Whole raw beef, pork, fish, eggs c) Raw ground meat/fish d) Raw poultry and ground turkey During a review of the facility's P&P, titled Dish Washing Procedures-Dish Machine undated, the dish washer will run the dish machine before washing of dishes until temperature and chlorine level is within manufacturer's guidelines. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the facility's P&P, titled Storage of Canned and Dry Goods undated, the P&P indicated new stock must be placed behind the old stock so oldest items will be used first. Products should be dated to ensure FIFP-First -in-First-out. All foods will be dated according to -month, day, and year. Plastic or metal contained (with fitting lids and NSF approved_, or re-sealable plastic bags will be used for staples and opened packages (like pasta, rice, cereal, flour, etc.). Food items will be dated and labeled when placed in containers.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 46415 Based on observation, interview, and record review, the facility failed to dispose garbage and refuse properly by not completely covering two (2) of three (3) blue dumpster (a large trash container designed to be emptied into a truck) for unknown amount of time. This deficient practice had a potential to attract flies, insects, cats, and other animals to the dumpster area placing 180 of 196 facility residents getting food from the kitchen cross-contamination (a transfer of harmful bacteria from one place to another). Findings: During a concurrent observation of the garbage area located outside the facility near the kitchen and interview with Dietary Manager (DM) at 2/3/2025 on 9:43a.m., 2 of 3 blue dumpsters were not completely closed and covered. There were 3 black trash bags between two dumpsters on the floor. DM stated the trash bin lids were not completely closed, and it could attract pests. During a concurrent observation of the garbage area located outside the facility near the kitchen and interview with the Maintenance Supervisor (MS) at 2/7/2025 on 12:20 p.m., 1 of 3 blue dumpsters was open. There was 1 black trash bag, flattened cardboard boxes, and soiled diapers in the walkway next to the dumpsters. During a review of Food Code 2017, indicated, 5-501.113 Covering Receptacles and waste handling units for refuse, recyclables, and returnable shall be kept covered: (A) Inside food establishment if the receptacles and units: (1) Contain food residue and are not in continuous use; or (2) After they are filled; and 174 (B) With tight-fitting lids or doors if kept outside the food establishment. During a review of the facility's Policies and Procedures (P&P), titled Waste Control and Disposal, undated, the P&P indicated trash bins should be covered at all times. Outside garbage bin should be kept closed at all times and surrounding area must be kept clean. Dispose garbage in a timely manner to prevent build up. All cardboard boxes will be broken down and disposed of timely. 50144

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 45382 Based on observation, interview, and record review, the facility failed to ensure the Physical Therapy Joint Mobility Screenings (PT JMS, a brief assessment of a resident's range of motion of both legs completed by a Physical Therapist [PT, profession aimed in the restoration, maintenance, and promotion of optimal physical function]), dated 8/19/2024 and 10/15/2024, for one of seven sampled residents (Resident 19) were accurately completed and documented. This deficient practice had the potential to negatively impact the provision of necessary care and services, portray an inaccurate reflection of assessment results, cause miscommunication among staff, and result in missed opportunities to detect declines in joint range of motion (ROM, full movement potential of a joint). Findings: During a review of Resident 19's Admission Record, the Admission Record indicated the facility initially admitted Resident 19 on 9/10/2003 and readmitted Resident 19 on 5/20/2023 with diagnoses including C1-C4 quadriplegia (spinal cord injury in the neck region causing weakness or paralysis in both arms and both legs), polyneuropathy (damage of the nerves that can cause weakness, numbness, and burning pain) and chronic obstructive pulmonary disease (lung disease that causes obstruction of airflow and can limit normal breathing). During a review of Resident 19's PT JMS, dated 8/19/2024, the PT JMS indicated Resident 19 had full passive range of motion (PROM, movement at a given joint with full assistance from another person) in both hips and both knees and had minimal (less than 25% loss) ROM loss in both ankles. The PT JMS indicated Resident 19 maintained the ROM of both hips, both knees, and both ankles (from previous JMS). The PT JMS comment section indicated patient did not let therapist manually test PROM, screening was done based on visual observation. During a review of Resident 19's PT JMS, dated 10/15/2024, the PT JMS indicated Resident 19 had full PROM in both hips and both knees and had minimal ROM loss in both ankles. The PT JMS indicated Resident 19 maintained the ROM of both hips, both knees, and both ankles (from previous JMS). The PT JMS comment section indicated patient did not let therapist manually test PROM, screening was done based on visual observation. During a review of Resident 19's Minimum Data Set (MDS, a federally mandated assessment tool), dated 1/22/2025, the MDS indicated Resident 19 was cognitively (ability to think, understand, learn, and remember) intact. The MDS indicated Resident 19 was dependent in eating, hygiene, toileting, bathing, dressing, and rolling to both sides. The MDS indicated Resident 19 had functional ROM limitations (limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk of injury) in both arms (shoulder, elbow, wrist, hand) and both legs (hip, knee, ankle, foot). (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 2/6/2025 at 11:57 am, Physical Therapist 1 (PT 1) stated the facility monitored for changes in joint ROM by JMS screens conducted by licensed PTs and Occupational Therapists (OT, profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) upon a resident's admission, re-admission, quarterly, and upon a change of condition (significant alteration in a patient's physical, mental, or emotional status that deviates from their baseline health). PT 1 stated the purpose of the JMS was to assess for any changes, declines, or improvements in a resident's joint ROM to ensure the appropriate interventions and services were provided. PT 1 stated the assessment of a resident's ROM in the JMS indicated a resident's PROM, which meant the therapist provided total assistance while moving the joint through the available ROM. PT 1 reviewed Resident 19's PT JMS evaluations, dated 8/19/2024 and 10/15/2024, and confirmed the PT JMS evaluations indicated Resident 19 had full PROM of both hips and both knees and minimal ROM loss of both ankles. PT 1 confirmed Resident 19's PT JMA evaluations indicated in the comment section that the evaluation of Resident 19's ROM was based on visual observation only because Resident 19 refused the PROM assessment. PT 1 stated he did not perform a physical assessment of Resident 19's ROM of both legs since Resident 19 refused. PT 1 stated it was impossible to perform a PROM assessment by visual observation only since PROM required the therapist to move the resident's legs with hands on total physical assistance through the available ROM. PT 1 stated Resident 19's PT JMS evaluations, dated 8/19/2024 and 10/15/2024, were inaccurate. PT 1 stated he should have documented Resident 19's refusal of PROM of both legs under the comment section of each joint and/or been more specific when documenting observations such as the position of Resident 19's legs instead of providing an inaccurate PROM value to joints that were not assessed. PT 1 stated the PT JMS evaluations were contradictory and confusing since it appeared as though he assessed Resident 19's PROM of both legs when he did not. PT 1 stated it was important JMS evaluations were documented accurately to avoid confusion and miscommunication among staff. During a concurrent interview and record review on 2/7/2025 at 11:39 am, the Assistant Director of Nursing (ADON) stated the facility monitored for changes in joint ROM by JMS evaluations conducted by the Rehabilitation Department (Rehab) and nursing. The ADON reviewed Resident 19's PT JMA evaluations, dated 8/19/2024 and 10/15/2024, and stated both PT JMS evaluations were confusing, contradictory, and inaccurate. The ADON stated the PT JMS evaluations indicated Resident 19 had full PROM of both hips and both knees and minimal ROM loss of both ankles but later indicated in the comment section that the PROM assessment was done by observation only since Resident 19 refused the PROM assessment. The ADON stated PROM assessments could not be done by visual observation since PROM required the evaluating person to provide total physical assistance of the resident's body part through the available range to assess his or her ROM. The ADON stated it was important JMS evaluations were documented accurately to avoid missed opportunities to identify declines in ROM and to ensure residents received the appropriate treatment and services to maintain function. During an interview on 2/7/2025 at 5:52 pm, the Director of Nursing (DON) stated the facility monitored for changes in joint ROM by JMS evaluations conducted by Rehab and MDS assessments conducted by nursing. The DON stated it was important JMS evaluations were completed and documented accurately to ensure the facility did not miss any opportunities to detect declines in a resident's ROM and to ensure residents received the appropriate treatment and services to maintain and improve ROM and function. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's undated Policy and Procedure (P/P) titled Joint Mobility Assessment, the P/P indicated the purpose of the Joint Mobility Assessment was to determine a resident's ROM for all major joints and to implement plans of care to increase, maintain or reduce a decline in joint mobility. The P/P indicated all residents shall be assessed for joint mobility limitations upon admission and reviewed every three months thereafter. The P/P indicated the PT and//or OT shall assess each joint for ROM and document findings on the Joint Mobility Assessment sheet. The P/P indicated the information was used to assist in developing or modifying a plan of care, especially in area of physical function such as positioning, locomotion, and activities of daily living (dressing, grooming, eating). During a review of the facility's P/P, titled Charting and Documentation, revised July 2017, the P/P indicated all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The P/P indicated documentation in the medical record would be objective, complete, and accurate.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45891 Based on interview and record review, the facility's Quality Assessment and Assurance committee ([QAA] a group of facility staff who identifies, evaluates, and implements measures to improve the quality care and life for the residents in the facility) and 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, and all nursing home caregivers in practical and creative problem solving) committee failed to identify concerns related to cardio-pulmonary resuscitation (CPR, it can help save a life during cardiac arrest, when the heart stops beating or beats too ineffectively to circulate blood to the brain and other vital organs) and weight loss in the facility. This deficient practice had the potential for continued weight loss and improper assessment skills for when initiating CPR is indicated for full code (when your heart stops, and you have died , medical professionals will do everything medically possible to try and restart your heart) residents. (Cross reference: F678 and F692) Findings: During an interview on [DATE] at 7:42 p.m., the administrator (ADM) stated CPR and weight loss were not part of their current QAPI plan and the issues were not identified prior to the recertification survey [DATE]-[DATE]. The ADM stated these issues should have been caught via training and follow through, but they were not. During a review of the facility's policy and procedure (P/P) titled, Quality Assurance and Performance (QAPI) Program, revised ,d+[DATE], indicated the facility implements and maintains an ongoing, facility-wide Quality Assurance and Performance Improvement (QAPI) Program focused on the indicators of the outcomes of care and quality of life for our residents. The P/P indicated the objective of the QAPI program was to provide a means to measure current and potential indicators for outcomes of care and quality of life and establish a system through which to monitor and evaluate corrective actions.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45382 45891 46415 Based on observation, interview, and record review, the facility failed to observe infection control measures on 5 of 37 sampled residents (Resident 19, 87,343,16) by failing to: 1. Ensure Restorative Nursing Aide 2 (RNA 2) wore an isolation gown (protective apparel used to protect the wearer from the transfer of microorganisms and body fluids) while providing range of motion (ROM, full movement potential of a joint) exercises to Resident 19 who was on Enhanced Barrier Precautions (EBP, infection control intervention using gown and gloves during high contact resident care activities designed to reduce the transmission of multi-drug resistant organisms). 2. Ensure padded side rails (a padded side fitted to a bed for safety) were not wrapped with foam and paper tape for one of 10 sampled residents (Resident 87). 3. Ensure Resident 343 had an Enhanced Barrier Precaution (EBP: infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) signage posted for having a gastrostomy tube (g-tube: a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), foley catheter (a hollow tube inserted into the bladder to drain or collect urine), and a nephrostomy bag (urine drain from the kidney through an opening in the skin on the back). 4. Ensure staff wore proper Personal Protective Equipment (PPE: equipment worn (gown, gloves, goggles) to help create a barrier between a healthcare worker and germs, bodily fluids) when touching the foley catheter of Resident 343 and staff wore PPE while doing care for Resident 16 who is on EBP. The deficient practice of using a foam and paper tape prevented staff for proper cleaning and disinfection (the process of cleaning something, especially with a chemical, to destroy bacteria) of the padded side rails and could lead to the spread of infection to all other residents and staff. The failure of RNA 2 not wearing isolation gown had the potential to transmit infectious microorganisms and increase the risk of infection among the residents and staff members. The deficient practice of not following the proper usage of PPE while providing care put Residents, staff, visitors or vendors at risk for spread of infection. Findings: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. During a review of Resident 19's Admission Record, the Admission Record indicated the facility initially admitted Resident 19 on 9/10/2003 and readmitted Resident 19 on 5/20/2023 with diagnoses including C1-C4 quadriplegia (spinal cord injury in the neck region causing weakness or paralysis in both arms and both legs), polyneuropathy (damage of the nerves that can cause weakness, numbness, and burning pain) and chronic obstructive pulmonary disease (lung disease that causes obstruction of airflow and can limit normal breathing). During a review of Resident 19's Order Summary Report, the Order Summary Report indicated a physician's order, dated 12/24/2024, for Resident 19 to be placed on EBP precautions. During an observation on 2/4/2025 at 3:32 pm, in the resident's room, Resident 19 was lying in bed with both shoulders elevated on pillows to the side to shoulder height, both elbows bent, and the neck and upper body hunched forward. Resident 19 had a tracheostomy (a tube placed into a surgically created hole through the front of the neck and into the windpipe-trachea) tube. A sign that indicated Resident 19 was on EBP precautions was posted on the back wall behind Resident 19's bed. RNA 2 was standing next to Resident 19's bed wearing gloves on both hands and no isolation gown. RNA 2 stated she just completed passive range of motion (PROM, movement at a given joint with full assistance from another person) to Resident 19's left arm and was about to start ROM to Resident 19's right arm. RNA 2 picked up Resident 19's right arm and provided PROM to Resident 19's shoulder, elbow, wrist, and hand. Once RNA 2 completed exercises to Resident 19's right arm, RNA 2 removed both gloves, washed hands, and exited the room. During an interview on 2/4/2025 at 3:45pm, RNA 2 stated she did not wear an isolation gown while providing PROM exercises to Resident 19 because she did not know Resident 19 was on EBP precautions. RNA 2 stated she did not see a sign indicating Resident 19 was on EBP precaution upon entrance to Resident 19's room and did not see the sign posted on the wall behind Resident 19's bed. RNA 2 stated she should have worn an isolation gown while providing PROM to Resident 19 because she provided direct care to Resident 19 who was on EBP precautions. RNA 2 stated it was important to follow infection control protocols to prevent the spread of infection. During an interview on 2/6/2025 at 11:05 am, the Infection Preventionist Nurse (IPN) stated the purpose of EBP was to reduce the transmission of infections for residents with tracheostomies, gastronomy tubes (a tube placed directly into the stomach for long-term feeding), catheters (thin, flexible rube inserted into the bladder to drain urine), and open wounds. The IPN stated all staff must wear the appropriate personal protective equipment (PPE, equipment worn to minimize exposure to hazards that can cause serious injuries and illnesses) which included an isolation gown and gloves during high contact activities such as providing PROM exercises to residents on EBP precautions to prevent the spread of infection. During an interview on 2/7/2025 at 5:52 pm, the Director of Nursing (DON) stated it was important all staff followed the proper infection control protocols to prevent the spread of infection and cross contamination. During a review of the facility's Policy and Procedure (P/P) titled, Enhanced [NAME] Precautions, revised 6/5/2024, the P/P indicated EBP precautions were used as an infection prevention and control intervention to reduce the spread of MRDO to residents. The P/P indicated EBP precautions required the use of gowns and gloves during high contact resident care activities. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a review of Resident 87's Admission Record, the Admission Record indicated Resident 87 was admitted to the facility on [DATE] with diagnoses of epilepsy (a neurological disorder marked by sudden recurrent episodes of sensory disturbance, loss of consciousness, or convulsions, associated with abnormal electrical activity in the brain) and encephalopathy (a change in how your brain functions). During a review of Resident 87's Minimum Data Set (MDS- a resident assessment tool) dated 11/6/2024, the MDS indicated Resident 87 was rarely or never understood. During a review of Resident 87's Order Summary Report, an order was placed 12/27/2024 for low bed with bilateral upper padded half side rails up to decrease potential injury. During an observation on 2/4/2025 at 9:05 a.m., Resident 87's bilateral upper side rails on his bed were wrapped in black foam and white paper tape. During an interview on 2/7/2025 at 4 p.m., the infection prevention nurse (IPN) stated the facility used Diversey Oxivir 1 Disinfectant Cleaner on the padded side rails in the subacute unit (where Resident 87 resided) and Diversey Virex Plus- One Step Disinfectant Cleaner and Deodorizer for all other units in the facility. The IPN stated that the manufactures instructions on both products indicated they were to be used on hard, nonporous (does not allow liquid or air to pass through it) surfaces. The IPN stated the foam and tape wrapped on the bedrails was not appropriate because they were porous and could cause the surface to not be cleaned properly and also break down the foam and tape. During a review of the product label for Diversey Oxivir 1 Disinfectant Cleaner sku 100850916, the label indicated the product was an effective cleaner, disinfectant, and deodorizer for hard, nonporous inanimate (not alive) surfaces. During a review of the product label for Diversey Virex Plus-One Step Disinfectant Cleaner and Deodorizer, the label indicated the product worked as a disinfectant on hard, non-porous surfaces. 3. During a review of Resident 343's Admission Record, the Admission Record indicated Resident 343 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including g-tube, hydronephrosis (kidney swelling due to urine building up) with renal (kidney: organs that filter waste materials out of the blood) and ureteral calculous obstruction (blockage in the tube that carries urine from bladder caused by a kidney stone), and artificial opening of urinary tract status (conditions affecting the urinary system). During a review of Resident 343's H&P dated 1/29/2025, the H&P indicated Resident 343 does not have the capacity to understand and make decisions. During a review of Resident 343's MDS dated [DATE], the MDS indicated Resident 343's cognitive skills were severely impaired. The MDS indicated Resident 343 is dependent on bathing, chair/bed-to-chair transfer, personal hygiene, toileting hygiene, oral hygiene, and required maximal assistance (helper supports more than half the effort required) for eating. The MDS indicated Resident 343 is impaired on both side of the upper and lower extremities. During a review of the Order Summary (physician notes) dated 2/6/2025, the order summary indicated an active order for enhance barrier precautions related to (r/t) g-tube on 1/29/2025. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Care Center	1913 E 5th Street Long Beach, CA 90802

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 2/3/2025 at 10:51a.m. in Resident 343's room, Resident 343 had a g-tube, foley catheter, and a nephrostomy bag. Resident 343's room did not have any indication of EBP signage above the head of her bed or on the outside of the door or the hallway. During a concurrent observation and interview on 2/5/2025 at 11:27a.m. with Infection Preventionist Nurse (IPN), IPN stated EBP was implemented in 2019 and is used for extra protection for residents who have g-tubes, open wounds, indwelling catheters as they are prone to getting infections, so it is imperative to protect the residents as much as possible. IPN stated Resident 343 has a g-tube, so the EBP sign would be placed on top of where the head of the bed is. IPN stated upon observation of Resident 343's room, indicated Resident 343 is supposed to have a EBP signage and does not have one. IPN stated hand hygiene is done as much as possible and is done before and after patient care. IPN stated if the staff is answering the call light and does not touch the resident, they do not have to do hand hygiene. IPN however stated it is common practice to do hand hygiene when leaving the residents room even if the staff did not touch the resident. During a concurrent observation and interview on 2/5/2025 at 11:13a.m. with Certified Nursing Assistant 3 (CNA 3), CNA 3 was observed entering Resident 343's room with no PPE lifted the blanket that was covering the foley catheter, reached her hand inside the dignity bag (bag covering the foley catheter for privacy) to slightly expose the foley bag. CNA 3 stated she would wear a gown for precautions and if a resident has an infection, they are mandated to wear a gown. CNA 3 stated not wearing PPE can transmit the infection to another resident. CNA 3 stated even with or without a precautionary sign on the wall, they are trained to wear PPE if they have a resident with a g-tube. CNA 3 stated she wears gloves for everything, however she indicated she did not wear gloves this time since she was requested to show the foley catheter for observation. CNA 3 was observed touching her mask with the same hand she touched the foley bag without performing hand hygiene. CNA 3 stated hand hygiene is performed before and after working with residents and before entering the resident's room. During a review of Resident 16's Admission Record , the Admission record indicated Resident 16 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including gastrostomy, chronic obstructive pulmonary disease (COPD: a chronic lung disease causing difficulty in breathing), gastroesophageal reflux disease (GERD: stomach acid that flows back from the stomach into the tube that connects the mouth and stomach), and chronic kidney disease (moderate damage to the kidneys). During a review of Resident 16's H&P dated 6/15/2024, the H&P indicated Resident 16 does not have the capacity to understand and make decisions. During a review of Resident 16's MDS dated [DATE], the MDS indicated Resident 16's cognitive skills were severely impaired. The MDS indicated Resident 16 is dependent on all aspects of activities of daily living (ADL: bathing, sit to lying, personal, toileting, oral hygiene, and eating. The MDS indicated Resident 16 is impaired on both the upper and lower extremities. During a review of Resident 16's Order Summary dated 2/5/2025, the order summary indicated (Nepro: therapeutic nutrition designed for people who have reduced kidney function) at 50 cubic centimeter (cc: unit of volume that measures space occupied by solid or liquid) per hour (hr.) for 20 hours (hrs.) via pump to provide 1000CC/1800 kilocalories (kcals: unit measurement of energy used to describe calorie content of food) per day with an active date of 6/12/2024. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 2/5/2025 at 1:26p.m. with Registered Nurse 1 (RN 1), RN 1 was observed lifting up Resident 16's blanket to show the location of Resident 16's g-tube without wearing a gown when there was an EBP signage posted on top of Resident 16's head of the bed. RN 1 stated Resident is on EBP precautions since she has a g-tube and will wear a gown and gloves as it can get on her clothes. RN 1 stated unless direct patient care is being provided, it is not necessary to wear a gown. During a review of the facility's P&P, titled Enhanced Barrier Precautions revised 6/5/2024, the P&P indicated enhanced barrier precautions are used as an infection prevention and control intervention to reduce the spread of multi-drug-resistant organisms (MDROs) to residents. EBPs employ targeted gown and glove use 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 gown and gloves for EBPs include dressing, bathing/showering, transferring, provide hygiene, changing linens, device care or use (urinary catheter, feeding tube), and wound care. EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless or MDRO colonization. EBPs remain in place for the duration of the resident's stay or until resolution of the wound or discontinuation of the indwelling medical device that places them at increased risk. Standard precautions apply to the care of all residents regardless of suspected or confirmed infection or colonization status. Signs are posted outside of resident's room or head of the bed indicating the type of precautions and PPE required. During a review of the facility's P&P, titled Handwashing/Hand Hygiene undated, the P&P indicated this facility considers hand hygiene that primary means to prevent the spread of healthcare-associated infections. Hand Hygiene is indicated after contact with blood, body fluids, or contaminated surfaces, after touching the resident's environment. Single-use disposable gloves should be used when anticipating contact with blood or body fluids and when in contact with a resident. 50144

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50144 Based on interview and record review, the facility failed to implement the antibiotic stewardship program policy when the antibiotic (a substance used to kill bacteria and to treat infections) did not meet Loeb's or McGeer's Criteria (criteria used to determine appropriate use of antibiotics) for two of three sampled residents: 1. Resident 154 for ceftriaxone (antibiotic used to treat bacterial infections) 2. Resident 29 for cephalexin (another antibiotic used to treat bacterial infections). These deficient practices had the potential to increase antibiotic resistance and provide antibiotics without justification. Findings: 1. During a review of Resident 154's Admission Record, the record indicated Resident 154 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including respiratory failure with hypoxia, tracheostomy (an opening surgically created through the neck into the trachea [windpipe] to allow direct access to the breathing tube), and gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During a review of Resident 154's Minimum Data Set (MDS-a resident assessment tool) dated 11/25/2024 indicated Resident 154's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was not intact and was dependent (required complete assistance of 2 or more helpers) for hygiene, bathing, and dressing. During a review of Resident 154's physician order summary printed on 2/7/2025, the order indicated Ceftriaxone Sodium Solution Reconstituted 1 GRAM (GM-unit of measurement) Inject 1 GRAM intramuscularly every 24 hours for urinary tract infection (UTI - an infection in any part of the urinary system, the kidneys, bladder or urethra) for 5 days. 2. During a review of Resident 29's Admission Record, the record indicated Resident 29 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including dementia and hypertension (HTN-high blood pressure). During a review of Resident 29's MDS dated [DATE] indicated Resident 29's was not intact, required supervision for eating, and required moderate assistance (helper provided less than half of effort) for hygiene, bathing, and dressing. During a review of Resident 29's Medication Administration Record (MAR) printed on 2/7/2025, the MAR indicated Cephalexin Oral Tablet Give 500 Milligrams(MG-unit of measurement) by mouth four times a day for possible UTI for 7 days. The MAR indicated Resident 29 completed the ordered Cephalexin. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 02/06/25 at 2:50 p.m. with the Infection Preventionist Nurse (IPN), Resident 154 and Resident 29's charts: 1. Resident 154's Infection Screening Evaluation dated 12/21/2024 was reviewed and indicated, No IPC Case Triggered. The IPN stated Resident 154's symptoms did not meet criteria, and there is no documentation indicating the physician was notified. The IPN stated Resident 154 completed the ordered ceftriaxone. 2. Resident 29's Infection Screening Evaluation dated 1/17/2025 was reviewed. The Infection Screening Evaluation indicated, No IPC Case Triggered. The IPN stated Resident 29's symptoms did not meet criteria, and there is no documentation indicating the physician was notified. The IPN stated the physician the physician should be notified if a resident does not meet Loeb's or Mc Geer's criteria. During an interview on 2/8/2025 at 6:50 p.m. with the Director of Nursing (DON), the DON stated the purpose of the antibiotic stewardship program is to ensure antibiotics are used appropriately and prevent overuse or incorrect use of antibiotics. The DON stated the physician must be notified if a resident does not meet criteria. During a review of the facility's Infection Control Preventionist Job Description dated 3/19/2024, the job description indicated, the IPN reviews every antibiotic order in the facility to ensure that each medication has proper indication for use and is appropriate for the residents and is responsible for sharing feedback to the physicians.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 50144 Based on observation, interview and record review, the facility failed to offer, educate, and track coronavirus vaccinations for staff per facility's policy. This failure had the potential to place all residents at risk for infection of coronavirus. Findings: During an interview on 2/6/2025 at 2:50 p.m. with the Infection Preventionist Nurse (IPN), the IPN stated the facility does not have a tracking log or retain records of vaccination education, proof of vaccination, or declinations for coronavirus vaccination of facility staff. During an interview on 2/8/2025 at 6:50 p.m. with the Director of Nursing (DON), the DON stated it is important to educate and document staff coronavirus vaccinations in order to protect residents and staff from the coronavirus. During a review of the facility's policy and procedure (P/P), titled Covid-19 Policy, dated 8/26/2024, the P/P indicated: A. The facility will continue to educate residents, responsibility parties, and staff about the benefits of receiving the vaccination and risks of refusals. B. Covid-19 2024-2025 vaccination will be offered to residents and staff based on recommendations by Long beach Health Department (LHD) and California Department of Health (CDPH). C. The facility will keep copies of the proof of vaccinations. E. The facility will continue to educate the resident, responsible party, and employees regarding the benefits of COVID-19 vaccination to keep their vaccination up to date unless it is contraindicated, refused by resident or refused by employees. G. If am employee chooses not to be vaccinated, they must provide a written declination that he or she has declined the vaccination.

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. 45891 Based on interview, and record review, The facility failed to provide Effective Communications training for direct care staff, including 18 of Registered Nurse (RN), 50 of Licensed vocational nurse (LVN), and 20 of Respiratory Therapist (RT) as required by the facility's policy and procedure (H&P). This deficient practice had the potential to miscommunication, unmet resident needs, and compromised care, particularly for residents who rely on alternative communication methods. Findings: During an interview on 2/8/2025 at 6:56 p.m. with the Administrator, the ADM stated that currently, there were 18 of RN, 50 of LVN, 20 of RT, and 100 of CNA in the facility. During a concurrent interview and record review on 2/8/2025 at 7:55 p.m. with the Director of Staff Development (DSD), the facility's in-service logs, for the year of 2024. The DSD stated that she was unaware that Effective Communications was a mandatory training for direct care staff and stated that the training was not provided in 2024. The DSD also stated that Effective Communications is important to ensure that staff can communicate effectively with residents, without this training, staff may lack the necessary skills to communicate properly with residents. During an interview on 2/8/2025 at 8:05 p.m. with the Director of Nursing (DON), the DON stated that effective communication is essential to meet resident's need, particularly for Non-English speaking residents and those requiring specialized care, such as individuals with dementia, traumatic brain injury (TBI), or stroke, who rely on specific communication methods. The DON also stated that the training should be provided to ensure staff can effectively communicate with these residents, without proper training, resident's needs may not be met, affecting their care. During a review of the facility's policy and procedure (H&P) titled, In-Service Training, All Staff, revised August 2022, indicated the all staff are required to participate in regular in-service education and primary object of the in-service training is to ensure that staff are able to interact in a manner that enhances the resident's quality of life and quality of care and can demonstrate competency in the topic areas of the training. The P&P also indicated 'Effective communication with residents and family as a required training topic for direct care staff. The P&P indicated that training requirement are met prior to staff providing services to residents, annually, and as necessary based on the facility's assessment.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 45891 Based on interview, and record review, The facility failed to provide Quality assurance and performance improvement (QAPI) training for direct care staff, including 18 of Registered Nurse (RN), 50 of Licensed vocational nurse (LVN), and 20 of Respiratory Therapist (RT) as required by the facility's policy and procedure (H&P). This deficient practice had the potential to result in poor communication among staff, lack of awareness of facility updates, lack of collaborative work, and compromised resident care. Findings: During an interview on 2/8/2025 at 6:56 p.m. with the Administrator, the ADM stated that currently, there were 18 of RN, 50 of LVN, 20 of RT, and 100 of CNA in the facility. During a concurrent interview and record review on 2/8/2025 at 7:55 p.m. with the Director of Staff Development (DSD), the facility's in-service logs, for the year of 2024, were reviewed. The DSD stated that she was unaware that QAPI was a mandatory training for direct care staff, and she did not provide the training to direct care staff in 2024. The DSD also stated that QAPI training is important for staff to stay informed what was going on in the facility and could not answer the potential outcomes of not providing the training. During an interview on 2/8/2025 at 8:05 p.m. with the Director of Nursing (DON), the DON stated that QAPI is ongoing process used to address issues, improve communication among staff, ensure proper resident care. Without this training, staff may not be aware of updated facility procedures, proper communication protocols, or how to assist residents effectively, potentially impacting resident care and teamwork within the facility. During a review of the facility's policy and procedure (H&P) titled, In-Service Training, All Staff, revised August 2022, indicated the all staff are required to participate in regular in-service education and primary object of the in-service training is to ensure that staff are able o interact in a manner that enhances the resident's quality of life and quality of care and can demonstrate competency in the topic areas of the training. The P&P also indicated 'Elements and goals of the facility QAPI program as a required training topic. The P&P indicated that training requirement are met prior to staff providing services to residents, annually, and as necessary based on the facility's assessment.