STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056074	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chico Heights Rehabilitation & Wellness Centre, L	587 Rio Lindo Avenue Chico, CA 95926

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43739 Based on interview and record review, the facility failed to ensure that a direct care staff interacted and communicated in a manner that promoted the mental and psychosocial well-being for one of three sampled residents (Resident 9) when the Certified Nursing Assistant (CNA) G said to Resident 9 Don't be a smartass . This failure resulted in upsetting Resident 9 and Resident was crying. Findings: During a review of Resident 9's clinical record, the record indicated, Resident 9 was originally admitted to the facility on [DATE] with diagnoses which included diabetes (high blood glucose), difficulty in walking, and need for assistance with personal care. Resident 9 was her own health care decision maker. During a review of Resident 9's Minimum Data Set (MDS - an assessment and care screening tool), dated 4/17/2024, the MDS indicated that Resident 9 had a brief interview for mental status (BIMS) score of 15, at section C Cognitive Patterns indicating that her cognition was intact. During a review of the facility's document titled, Abuse Investigation Summary Form , the form indicated that the date of the incident occurred on 4/13/2024, time of the incident occurred at 5 am, and the incident was reported at 8 am. Two CNAs, CNA G and CNA T were interviewed. The form indicated that CNA G was the perpetrator, and CNA T was the witness. 1. During a review of the investigation interview statement, made by CNA G, CNA G stated, at 5 am, I went into the room with CNA T to help with Resident 9's roommate, when Resident 9 heard us, Resident 9 started making comments like can I go to the bathroom? Do I need permission for that? It's like - I am in a prison . I frowned and looked at her, and told her, Stop being a smartass . 2. During a review of the investigation interview statement, made by CNA T, CNA T stated, at approx. 5:30 am in Resident 9's room, me and CNA G went in to do patient care. Resident 9 asked if she could use the restroom. CNA G answered Resident 9 and told Resident 9, yes, she could . CNA G then asked Resident 9 why she would ask. Resident 9 stated that we were treating her like a prisoner .CNA G told her not to be a smartass, then Resident 9 got upset and stopped talking to CNA G. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. During a review of the investigation interview statement, Resident 9 was interviewed. Resident 9 stated, . As I was coming out of the restroom, both CNA G and CNA T were helping a roommate. CNA G asked Resident 9 to lay back in her bed, Resident 9 said I was just using the restroom, CNA G proceeded to say, stop being a dumbass , and CNA T said It's better to be a dumbass than a stupid ass . During an interview on 4/19/2024, at 10:30 am, with the administrator (ADMIN), ADMIN admitted that CNA G called Resident 9, smartass . ADMIN stated, we felt that it's inappropriate, it's more of dignity, not verbal abuse . During an interview on 4/19/2024, at 1:43 pm, with Resident 9, in Resident 9's room, Resident 9 stated, they called me a stupid dumbass! They actually called dumbass ! It was CNA G. On a Wednesday, I put myself on restriction, CNA G came in here and said that I was acting like a 2-year-old and said that I was throwing a fit. I cried . Resident 9's eyes turned red and had tears coming down her face. Resident 9 frowned her face and said the man who abused me used to call me stupid ., that brought back the bad memory .

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F 0580 Level of Harm - Actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43739 Based on observation, interview and record review, the facility failed to promptly notify the Medical Director (MD), who was the attending physician, for one of three residents sampled for change of condition (Resident 1), when Resident 1 was experiencing signs and symptoms of stroke (a life-threatening medical emergency, when the blood supply to part of the brain is blocked or reduced) on [DATE], he was transferred to the Acute Hospital on [DATE]. This failure resulted in a three-day delay in transferring Resident 1 to the hospital for treatment, and increased Resident 1's pain and discomfort. Resident 1 suffered significant declines on his functional abilities: slurred speech, left-sided weakness, inability to swallow. Resident 1 died on [DATE], within a month of his initial admission ([DATE]). Findings: During a review of the facility's policy titled, Change of Condition, revised [DATE], indicated: A. The Facility will promptly inform the Resident, consult with the Resident's primary care physician, and notify the Resident's legal representative or an interested family member when the Resident experiences a significant change in their condition caused by a significant change in the Resident's physical mental or psychosocial status . B. The Facility will ensure Residents, family, legal representatives, and physicians are informed of changes in the Residents' condition in a timely manner. C. Any Facility staff member who observes a Change of Condition will report the change to the Med Tech or Licensed Nurse. The Med Tech or Licensed Nurse will assess the Change of Condition and determine what interventions are appropriate. 1. In the event of any of the following conditions, 911 will be notified immediately. a. Change in level of consciousness. b. Weakness. c. Signs and symptoms of stroke or heart attack. During a review of U.S. Center for Disease Control and Prevention (CDC) website page titled, Stroke, dated , d+[DATE], indicated: 1. The key points During a stroke, every minute counts. Fast treatment can lessen the brain damage that stroke can cause. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	2. Signs and Symptoms Sudden numbness or weakness in the face, arm, or leg, especially on one side of the body. Sudden confusion, trouble speaking, or difficulty understanding speech. Sudden trouble seeing in one or both eyes. Sudden trouble walking, dizziness, loss of balance, or lack of coordination. Sudden severe headache with no known cause. 3. Call [DATE] right away if you or someone else has any of these symptoms. 4. The stroke treatments that work best are available only if the stroke is recognized and diagnosed within 3 hours of the first symptoms. Stroke patients may not be eligible for these treatments if they don't arrive at the hospital in time. During a review of [NAME] Journals (a leading global publisher of current and influential medical, nursing, and allied health research) titled, Acute Ischemic Stroke: The Golden Hour, published in Nursing 2016 Critical Care, Volume 11, Number 3, indicated: 1. Stroke continues to be the leading cause of disability in the United States, contributing to poor quality of life and billions of dollars in health care cost. 2. A door-to-treatment time of 60 minutes or less is the goal. This 60-minute period is often referred to as the Golden Hour of acute ischemic stroke treatment . 3. Appropriate evaluation and treatment can make a critical difference between independence and disability for a patient with acute ischemic stroke. Rapid evaluation and treatment within the golden hour of acute ischemic stroke requires a coordinated, multidisciplinary approach and knowledge of the best practices, therapies, and available management techniques. During a review of Resident 1's admission record, the record indicated, Resident 1 was initially admitted to the facility on [DATE] with diagnoses which included cellulitis (bacterial skin infection that causes redness, swelling, and pain in the infected area of the skin) of left lower limb, difficulty in walking, and high blood pressure. Resident 1 was his own health care decision maker. During a review of Resident 1's clinical record titled, Physician Orders for Life-Sustaining Treatment (POLST), dated [DATE], the record indicated, Resident 1 chose to have Comfort-Focused Treatment - primary goal of maximizing comfort. Relieve pain and suffering with medication by any route as needed, use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatment listed in Full and elective Treatment unless consistent with comfort goal. Request transfer to hospital only if comfort needs cannot be met in current location. During a review of Resident 1's Admission progress note, dated [DATE] at 7:23 pm, by Licensed Nurse (LN) B, the note indicated, Resident 1 was alert and oriented to person, place, and time. Resident 1's speech was clear and able to understand and be understood when speaking. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's Minimum Data Set (MDS - an assessment and care screening tool) at section C - Cognitive Pattern, section GG - Functional Abilities and Goals, and section J - Health Conditions, Pain Management, dated [DATE], the MDS indicated, 1. Resident 1 had a brief interview for mental status (BIMS) score of 12, suggesting that Resident 1's cognition was moderately impaired. 2. Resident 1 was independent at self-care (the need for assistance with bathing, dressing, using the toilet, or eating prior to the current illness .). 3. Resident 1 was Independent at indoor Mobility (ambulation - need for assistance with walking from room to room, with or without a device such as cane, crutch, or walker) prior to the current illness . 4. Resident 1 had no impairment, no limitation in his range of motion (the extent or limit to which a part of the body can be moved around a joint or a fixed point). 5. Resident 1 had no pain. During a review of Resident 1's progress note, dated [DATE] at 5:41 pm, by LN C, the note indicated, Resident 1 was noted to be pale, sleeping most of shift Noted little motivation this shift to participate (to take part in self-care) . During a review of Resident 1's progress note, dated [DATE] at 11:03 pm, by Registered Nurse (RN) D, the note indicated, Resident aware, mumbling but able to follow simple commands. Able to swallow medications well but in a slow manner . There's no note indicating that the MD was notified of Resident 1's change of condition. During a review of Resident 1's Social Services progress note, dated [DATE] at 2:02 pm, by the Social Services Director (SSD), the note indicated, unable to do care conference related to resident not feeling well . During a review of Resident 1's Social Services progress note, dated [DATE] at 5:21 pm, by RN E, the note indicated, Resident assessed and noted with decline in Level of Consciousness per Social Services Worker, Vital sign score and resident with tired appearance and increased difficulty with oral intake. The Physician was notified with orders received/noted to monitor at this time . Do-Not-Resuscitate (DNR- means that a person has decided not to have cardiopulmonary resuscitation attempted in the event their heart or breathing stops.) with comfort focused care During a review of Resident 1's progress note, dated [DATE] at 11:06 pm, by RN D, the note indicated, Resident 1 was alert to drowsy, awake and needs verbal cues to take medications and fluids in a slow manner . (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's progress note, dated [DATE] at 11:37 am, by the Director of Nursing (DON), the note indicated, A staff reported to the DON that Resident 1 was unable to work with Occupational Therapy (OT) and could not move his left arm. The DON went to assess and found Resident 1's head leaning on his left, some drooling, Resident 1 was able to squeeze right hand, however, weakness on the left hand was noted, unable to move and wiggle left toes. The MD was notified and ordered to get Resident 1 sent out. The DON wrote, Resident 1 was his own responsible party (RP) and explained that nurse suspect stroke. He is DNR, comfort care, however, okay to get sent out for further evaluation and treatment. Emergency Medical Services (EMS) came and transported Resident 1. During a review of Resident 1's progress note, dated [DATE] at 11:43, by LN B, the note indicated, Resident 1 got sent out at approximately 11:40 am due to change in mental status and increased need for help with Activities of Daily Living (ADLs). Resident 1 presented with slurred speech and left sided weakness. Patient is own RP and told RN that he would like to be sent out to get checked out EMS arrived at 11:30 am, report given to EMS. Patient taken out of facility and sent to scute . During a review of Resident 1's Acute Hospital's Emergency Department (ED) Provider note, dated [DATE] at 11:59 am, the note indicated, the ED Provider received report from EMS, and was told that Patient was last seen well 4 days ago, patient had normal movement of all extremities and was conversant ., and Patient currently has no movement of the left side as well as slowed and garbled speech . Resident 1 was found to have cerebrovascular accident (CVA - stroke), Acute renal failure (sudden loss of the ability of the kidneys to excrete wastes, concentrate urine, conserve electrolytes, and maintain fluid balance), and Chronic cellulitis. During a review of Resident 1's Acute Hospital Clinical Notes, titled, Case Management Discharge Planning Note, dated [DATE] at 4:16 pm, by the Acute Hospital Medical Social Worker (MSW) G, the note indicated, MSW G followed the request from the acute hospital medical doctor to locate Resident 1's Next of Kin. The MSW G completed Resident 1's Chart review and found names of Resident 1's friends and neighbors. MSW G contacted Friend H. Friend H told MSW G that she spoke to Resident 1 four days ago and Resident 1 said he was getting better and hope to discharge soon from Skill Nursing Facility. Per note, Friend H shared she is willing to talk with the medical doctor so Resident 1 does not go without treatment. During a review of Resident 1's Acute Hospital Speech Therapy Treatment note, dated [DATE] at 10:55 am, the note indicated, Resident 1 was seen by the Speech Therapy (ST) for swallow treatment, Resident 1 was noted to have eggs from breakfast drooling from left side of mouth when the ST entered ., and Resident 1 was high likelihood of aspiration (accidentally inhaling the food or liquid through the vocal cords into the airway) even with use of precautions . During a review of Resident 1's Clinical Admission record, dated [DATE], at 9:04 pm , the record indicated, Resident 1 was readmitted to the Skill Nursing Facility with diagnoses which included Right ischemic stroke (the blood supply to part of the right side of the brain is blocked or reduced) with left hemiparesis (weakness on the left side of the body), and urinary retention (the bladder doesn't empty completely). Resident 1 was still his own health care decision maker. During a review of Resident 1's MDS at section C - Cognitive Pattern, section GG - Functional Abilities and Goals, and section J - Health Conditions, Pain Management, dated [DATE], the MDS indicated, 1. Resident 1's BIMS score was 14, suggesting that Resident 1's cognition was intact. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	2. Resident 1 had impairment on one side of his upper and lower extremities. 3. Resident 1 was completely dependent (the helper does all the effort), on toileting hygiene, shower/bath, and lower body dressing. 4. Resident 1 had generalized pain. During an interview on [DATE], at 2:05 pm, with LN L, LN L stated, I was really upset. They kept saying Resident 1 was on comfort care, comfort care is to make the patient as comfortable as possible, it's not to let them lay there and die. They should have sent him out earlier . During an interview on [DATE], at 4:14 pm, with SSD, SSD stated, I met Resident 1 on Friday, [DATE], in Resident 1's room. I scheduled his care conference. He answered his question completely. He completed his BIMs, he got 12. On Monday ([DATE]), I tried to interview him for care conference, he started talking gibberish. This is not him; he was alert and had a clear speech when I talked to him on Friday. I reported it to LN F. LN F was covering the Station 4 for the nurse, LN F usually worked at the Station 1 and was not familiar with the residents at the Station 4, so I also reported to the Assistant Director of Nursing (ADON)/RN E. Both LN F and ADON went into Resident 1's room and assessed the resident. They took his vital sign; LN F said his vitals were fine. I am not a nurse; I left the issue with them. However, I told them that he acted differently than how I saw him on Friday During an observation and interview on [DATE], at 3:16 pm, with Resident 1, in Resident 1's room, Resident 1 had his eyes closed, his head turned left, and appeared to be pale. During an interview with Resident 1, Resident 1 was struggling to raise his left hand, but it was unsuccessful. Resident 1 then tried to speak several times, but most of it was slurred and unable to be understood. When asked how was the facility treating you?, Resident 1 stated, not very good! Resident 1 confirmed his answer by nodding his head. When asked what you mean by not very good? Resident 1 stated, I can't tell you. During an interview on [DATE], at 3:24 pm, with RN J, RN J stated, Resident 1 needed 1:1 feeder (assisted feeding - the action of a person feeding another person who cannot otherwise feed themselves), he was not eating well. Food was coming out of his mouth. He had to use a straw to drink the food, he wasn't doing well, the food was drooling down from his mouth. During an interview on [DATE] at 3:41 pm with LN B, 1. LN B stated, she admitted and interviewed Resident 1 on [DATE], LN B said, Resident 1 was alert, he could eat, he could hold a normal conversation, he could move himself in the bed. 2. LN B stated, I was his nurse on [DATE]. When I went into his room in the morning, noticed he had a change of condition. I asked his name, he could not respond, his speech was slurred, he showed slow movement, I reported it to the DON right away. 3. LN B stated, Resident 1 now was a completely different person. He could not talk well; he could not eat and move like he used to when he first got here. During an interview on [DATE], at 4:01 pm, with DON, (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	1. The DON stated, Comfort care is to keep them comfortable, it doesn't mean not to treat. 2. The DON stated, Resident 1 had a change of condition on [DATE]. I told him, he had symptoms of stroke, that he could not lift his left arm and left leg, he had slurred speech. As a nurse, I wound be the patient advocate. I notified the doctor and Resident 1 agreed to be sent out to the Acute Hospital. 3. The DON stated that she did not know what happened on [DATE], however, she confirmed that the facility should have sent Resident 1 to the Acute Hospital earlier. 4. The DON stated that the licensed nursing staff should have known the signs and symptoms of stroke, we had an in-service for it. The DON said, they [licensed nursing staff] did not know what comfort care was. If you are on comfort care, it doesn't mean that I won't treat you. During a review of Resident 1's progress note, dated [DATE], at 6:10 pm, by LN K, the note indicated, Resident 1 struggled with sucking honey thick liquids through a straw throughout the shift . Resident 1 had elevated blood pressure and temperature . During a review of Resident 1's clinical record titled, Interdisciplinary Team (IDT - a group of dedicated healthcare professionals who work together to provide the care the patient needs) Progress Notes - Weight Variance & Nutritional condition, dated [DATE], at 3:50 pm, the note indicated, Resident 1 had significant weight loss of 12.8 pounds in a week. Resident 1 requested to be referred to the Gastrointestinal (GI) specialist to have a Gastrostomy tube (also called a G-tube, is a tube inserted through the belly that brings nutrition directly to the stomach) During a review of Resident 1's progress note, dated [DATE], at 3:54 pm, by LN M, the note indicated, Resident 1 was seen by the speech therapist. Resident 1 noted to be having difficulty swallowing. Resident 1 was aspirating. Resident 1 decided he does want a G-tube. MD notified. Referral for GI consult. During a review of Resident 1's IDT skin progress note, dated [DATE], at 1:40 pm, by Treatment Nurse (TN) Q, the note indicated, Resident 1 has been very lethargic and at risk for malnutrition. Resident 1 was noted to have shearing on left upper back related to being bedbound and immobile (Shearing wounds occur when forces are applied to body tissues or parts that cause these tissues to move in opposite directions. Shearing forces can put pressure on blood vessels, causing them to be closed off, resulting in reduced blood flow to an area). During a review of Resident 1's nursing progress note, dated [DATE], at 1:16 pm, by LN C, the note indicated, Resident 1 continued to be unable to take in meals, food rolls out of mouth, unable to swallow. Taking Honey thickened fluids by spoon, and most of the fluids also rolled out of his mouth . During a review of Resident 1's progress note, dated [DATE], at 6:05 pm, by LN S, the note indicated, Resident 1 was accepted to Hospice P services (a type of care that focuses on the care, comfort, and quality of life of a person with a serious illness who is approaching the end of life). Resident 1 was prescribed with Roxanol (morphine sulfate, a highly concentrated solution of the narcotic analgesic morphine sulfate for oral administration used for the treatment of severe pain) 5 milligram (mg), 10 mg, and 15 mg via mouth every one hour, as needed (PRN), for mild to severe pain. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's Wound care progress note, dated [DATE], at 12:19 pm, by RN J, the note indicated, Resident 1 was in such pain and refused to have skin care, and the nurse was unable to console with touch or other non-pharmaceutical interventions. PRN pain medication administered. During a review of Resident 1's progress note, dated [DATE], at 11:06 am, by LN O, the note indicated, Hospice P notified LN O that Resident 1 had Deep Tissue Pressure Injury (DTPI) to right buttock and abrasion (scrape) to left side (DTPI - intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler as compared to adjacent tissue. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface). Resident 1 did not have any skin issue on both his buttocks noted while he was readmitted to the facility on [DATE]. During a review of Resident 1's IDT skin progress note, dated [DATE], at 2:59 pm, by TN Q, indicated Resident 1 had continued to refuse meal and medications. Resident 1 had a referral for G-tube placement, no updates for it at this time. TN Q was notified by the nurse and the nursing aids that Resident 1 was non-complaint with rotating a repositioning, and Resident 1 got aggressive and physically tried to prevent himself from being repositioned. Even after receiving pain medication still refused to turn . During a review of Resident 1's progress note, dated [DATE], at 12:51 pm, by Nursing Unit Manager (NUM) R, the note indicated, NUM R received new orders for Resident 1 from Hospice P. Resident 1 was prescribed with more routine pain medications - Norco, routine and as needed, and Morphine Sulfate, routine with one milliliter (ml) via mouth, three times a day, and continue with the previous PRN order for Morphine Sulfate for pain management. During a review of Resident 1's clinical record, the record indicated that Resident 1 had passed away on [DATE] at the facility. During an interview on [DATE], at 12:50 am, with administrator (ADMIN), ADMIN stated that she was very upset about what happened to Resident 1. ADMIN said LN B admitted Resident 1 on [DATE], and LN C took over the shift over the weekend. LN C did not know Resident 1's base line. When Resident 1 had a change of condition, LN C did not know, and LN B did not do the assessment on [DATE].

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32797 Based on observation, interview, and record review the facility failed to develop and implement safe and successful discharge plan for one of 15 residents (Resident 15) when the Interdisciplinary Team (IDT, a team composed of nursing, social work, and therapy who develop resident plan of care) did not ensure she and her family were prepared for returning home. This resulted in Resident 15 to return to the skilled nursing facility with 24 hours of discharging after falling at home. Findings: A review of a facility policy titled Discharge and Transfer of Residents , revised 02/2018, indicated To ensure that discharge planning is complete and appropriate and that necessary information is communicated to the continuing care provider. The Facility may transfer or discharge a resident with an order from the resident's physician if the resident's health has improved significantly and services provided by the facility are no longer required. A review of Resident 15's admission record indicated she was admitted to the facility on [DATE], with diagnoses which included history of falling, muscle weakness, morbid obesity, and heart disease. Resident 15 was able to make her own health care decisions. A review of a Minimum Data Set (MDS, resident assessment) dated 2/13/24, indicated Resident 15 Sit to lying: was a maximum assist, Lying to sitting on side of bed: partial to moderate assist, Sit to stand:, chair to bed, and chair to toilet was refused by resident. Walking 10 feet, 50 feet or 150 feet was not attempted due to medical condition or safety concerns. A review of a social service progress note dated 3/11/24 at 10:52 am, indicated Resident 15 needed a slide board (a piece of equipment that can be used if a person is not able to use their legs to complete a transfer between surfaces or if a standing transfer is not safe to perform) to help with transfers. She was unable to stand and safely transfer without the assistance of the slide board. Resident 15 had been working with therapy and demonstrated the ability to use a slide board safely. A review of a proposed transfer and discharge form dated 3/12/24, indicated Resident 15 was going to be discharged to home, by this is Facility and is appropriate because your health has improved sufficiently so that you no longer require services. A review of a discharge planning review dated 3/15/24, indicated Resident 15 discharge goal barriers were her physical challenges. The review indicated Resident 15 did not have a caregiver when she was admitted , and her Family Members would now be the caregivers when she discharged home. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056074	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chico Heights Rehabilitation & Wellness Centre, L	587 Rio Lindo Avenue Chico, CA 95926

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a physical therapy discharge summary dated 2/9/2024 - 3/13/2024, indicated Resident 15 had exhausted benefits, she declined treatment. Resident 15 prognosis was indicated as excellent with strong family support. Resident 15's bed mobility to roll left and right = Independent, sit to lying = Independent, lying to sitting on side of bed = Independent, sit to stand = partial/moderate assistance, chair/bed-to-chair transfer = setup or clean-up assistance and toilet transfer = Not attempted due to medical conditions or safety concerns. Assistive Device During Transfers = Sliding Board. Resident 15 did not walk 10 feet =due to medical conditions or safety concerns. Resident uses a wheelchair and slide board (a board placed from surface to surface to allow sliding during transfers. Resident 15's mobility function score (ranges from 0 - 12; 12 being the highest function) was a 6. A review of a health status note dated 3/14/2024 at 1:41 pm, Resident 15 discharged to home in facility van. A review of a Health Status Note 03/15/2024 8:17 pm, indicated Resident 15 arrived from home via our facility van. She was alert, oriented, and cooperative. Resident 15 denied any pain from a fall at home. During a concurrent observation and interview on 4/28/24 at 3:45 pm, Resident 15 was observed in her bed. She stated, I recently went home then had to come back via ambulance Resident 15 stated I cannot walk, need an extra-large bed, had my right knee replaced, and needs another surgery on her left knee. Resident 15 stated I need a brace to be able to stand. During an interview 5/9/24 12:30 pm, Resident 15 stated her husband was older and her daughter lives with her in a mobile home. Resident 15 stated her family was not trained on how to assist her and that they really cannot help her. Resident 15 stated her family can just help getting her things. Resident 15 stated Prior to discharge, she was unable to walk or stand, and she was working with physical therapy to learn how to use transfer board. Resident 15 stated she was never able to do it independently and always had stand by assistance from staff in the facility. Resident 15 explained I came back in 24 hours later, after I could not get out of bed and got stuck on the toilet had to call 911 and went back to facility. I am a high risk for falls. I have pain in my left knee which needs a knee replacement, but I have to lose 40 pounds before they will do it. I have just been lying in bed after the last hospitalization for my urinary kidney issues, I am deconditioned. My new knee on my right side is now bothering me since I cannot use my left leg after the last readmission, I was walking when I was first admitted back in October 2023. I did want to go home. It was really hard to work with physical therapy and really had not progressed. During aconcurrent interview and record review on 5/9/24 at 1:45 pm, the Director of Therapy (DT) who participated in the discharge planning for Resident 15, stated this was an unsafe discharge. DT stated Resident 15 was still a maximum assist with walking and transferring. He confirmed there was nothing in the record to indicate family members were instructed how to assist resident at home. DT confirmed the words unsafe were not mentioned to Resident 15 during meetings nor Against Medical Advice (AMA) about going home before she was ready. DT stated Resident 15 wanted to go home. DT stated she had not really progressed since admission due to her left knee and pain. DT stated sometimes she refused to participate due to pain and frustration. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During and interview on 5/9/24 at 2pm, with Business Office (BO) and Social Service Assistant (SSA) and Administrator (ADMIN), BO stated resident was informed that her days had run out, and she would need to pay share of cost and apply for assistance. Family member was on the phone during the discharge planning and stated Resident 15 could not afford to stay. BO stated found out later Family Member had applied for further assistance in the home and not yet approved. SSA stated Resident 15 was informed that she needed to stay but wanted to go home. ADMIN, BO and SSA confirmed AMA was not discussed nor the risks and benefits of returning home. ADMIN confirmed Resident 15 should have been an AMA discharge.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32797 Based on observation, interview and record review, the facility failed to provide sufficient nursing staff in the facility to meet the need of the residents' acuity (the level of severity of residents' illnesses, physical, mental, and cognitive limitations and conditions) when: 1. Facility failed to sufficiently staff multiple nursing Stations during the week of 3/30/2024 through 4/5/2024. 2. Residents 14, 2, 3, 4, 5, 6, and 8 did not receive showers as scheduled. This failure resulted in long wait times for call lights to be answered (average 30 minutes) and residents not receiving Activities of Daily Living (ADLs) including hydration and shower assistance. This had the resulted in residents to feel neglected and affected their dignity. Findings: 1. During a concurrent observation on 4/12/2024 at 11:15 am, a call light was initiated in room [ROOM NUMBER]A. Call light was not answered by a direct care staff member until 11:45 am. During a concurrent observation and interview on 4/12/2024 at 11:18 am, Resident 14 stated call light had been unanswered for five minutes. Resident 14's colostomy bag needed to be emptied. She stated she had already ambulated to the office down the hall in her wheelchair to ask for help. Certified Nursing Assistant (CNA E) was witnessed entering Resident 14's room, turned off the call light and exited the room. CNA E and asked if she was going to assist Resident 14. CNA E went back into Resident 14's room and emptied her colostomy bag. During a concurrent observation and interview on 4/12/2024 at 11:33 am, Resident 2 stated that her call light had been on for five minutes. Resident 2 needed a boost in her bed. During an interview on 4/12/2024 at 11:21 am, Licensed Vocational Nurse (LVN A) stated that low staffing has continued to be an issue at the facility. LVN A stated that there were only two staff on Station 3 and 4 that morning. LVN A stated she helped Station 3 and 4 as much as possible. This led to multiple late resident medication administrations by 30 minutes (best practice medication administration time is one hour before to one hour after ordered time). LVN A stated that her understanding of the shower team is that it is supposed to be comprised of 4-5 CNAs. She stated that two CNAs walked out two weeks ago, and two recently quit. LVN A stated it was her understanding that there was only one staff member currently on the shower team. During a concurrent observation and interview on 4/12/2024 at 11:37 am, Resident 3 stated that he had been waiting in the hallway in his wheelchair needing to be wiped for over 30 minutes. He stated that it happens all the time where he must use his wheelchair to ambulate to the hallway to get staff assistance. Resident 3 stated that he wants to leave the facility. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 4/12/2024 at 11:39 am, Resident 4 stated that he does not use his call light because he does not expect anything. Resident 4 stated he has waited up to 2 hours to have staff answer his call light. Resident 4 preferred to sit in the hallway in his wheelchair to get staff assistance. Resident 4 stated hydration is not adequate at facility and prefers to sit by the hydration cart when staff get around to giving residents water. During a concurrent observation and interview on 4/12/2024 at 11:39 am, Resident 5 stated that he received one shower per week. Resident 5 stated that he preferred to sit by the hydration cart to access liquids when the CNAs get around to it, but they're never around. Resident 5 has a history of below the knee amputation and requires hands on assistance for ADLs. During a concurrent observation and interview on 4/12/2024 at 11:39 am, Resident 6 stated that she became nauseated due to limited access to hydration. She stated she did not have access to receiving medications on time. Resident 6 stated when she has a headache, she must ambulate in wheelchair down to nurse's Station to request pain medication. During a record review of staff schedules, AM shift is defined as 7:00 am - 3:30 pm, PM shift is defined as 3:00 pm - 11:30 pm, and NOC shift is defined as 11:00 pm - 7:30 am. During an interview on 4/15/2024 at 10:46 am, CNA A stated that she is not aware of a shower team at the facility. She is a registry employee with outside agency. CNA A stated that she had one CNA staff member to help her between two Stations on her most recent NOC shift. CNA A stated that on the morning of 4/8/2024, there were lots of call outs, and there was only 1 CNA for Station 2 that day. During an interview on 4/15/2024 at 10:57 am, Registered Nurse (RN A) stated that she has been pulled onto the floor to help staff. RN A stated, call offs happen often. She felt this was due to a general overwhelming feeling among staff. RN A stated that NOC staff are given additional tasks. RN A stated she is not sure how many showers residents are receiving, but stated they should receive two a week. She was not aware of expectations or duties of shower team. RN A stated she raised staffing concerns with Admin. Admin frequently asked staff to do a double shift. Admin has utilized outside registry, but registry employees regularly do not show up for scheduled shifts. RN A stated that there was one direct care staff member at Station 4 on 4/14/2024. During an interview on 4/15/2024 at 11:17 am, Nursing Assistant (NA A) stated facility is chaotic most of the time. NA A voiced concerns to management of not feeling comfortable managing a Station on her own since she is new. NA A stated it is difficult to get staff to come in and help. NA A stated staff is calling off due to being overworked. During March 2024, NA A worked 10 days in a row due to feeling pressured to work because of the low staffing issues at facility. NA A is not familiar with the shower team. NA A has not seen any staff operating shower team. She stated that residents are supposed to receive 2-3 showers a week, and was unsure if they were receiving them. NA A is aware of resident complaints regarding not receiving showers. NA A stated that management does not come help on the floor is there is low staffing during a shift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/15/2024 at 1:45 pm, CNA B stated that she has witnessed staff take 40-60-minute breaks even when there is low staffing. CNA B spoke to management regarding short staffing issues. CNA B is fearful of retaliation. She stated there is a culture of retaliation at facility. CNA B felt license at risk due to workload and emotionally stressed after witnessing staff members be mean to residents. CNA B stated comfort care residents requested pain medication and are ignored due to staff feeling overwhelmed with workload. CNA B visited a mental health crisis center after a recent shift at facility due to feeling stressed. CNA B told management that she needed time to recover, and felt they were not receptive when they asked her to return to work the following day. CNA B witnessed CNA D handle 50 residents on a shift because another CNA left their shift. No other staff were called to assist CNA D. In regard to the shower team, CNA B stated, Forget that. That's nonexistent. Residents and family members tell her that they are not receiving showers. CNA B stated that her understanding is that residents are supposed to receive 2-3 showers a week. During an interview on 4/15/2024 at 3:55 pm, CNA C stated facility felt like a roller coaster. CNA C acknowledged staffing issues and that staffing comes and goes. She felt management was working on it. CNA C believed staff is feeling pressure and overwhelmed. She stated there is resistance to change amongst the staff, and this is why staff was quitting without notice, not showing up for shifts, etc. Regarding shower team, CNA C stated there should be 4 CNAs to assist with showers Monday through Friday for an 8-hour shift. She stated that the shower team was a trial idea and not necessarily permanent. CNA C stated residents should have 2 showers every week. She stated that expectation is inconsistent, and that residents are not receiving showers mostly due to refusal. During an interview on 4/16/2024 at 11:40 am, CNA D stated that she felt there were not enough staff assigned to the Stations. She has not gone to management to discuss her concerns because she felt that she would not be heard. CNA D stated residents are supposed to receive 3 showers a week. She is not familiar with the shower team, or how it is supposed to operate. CNA D stated NOC shifts are very short-staffed and there are not enough employees. During an interview on 4/28/2024 at 3:20 pm, CNA F stated staffing is horrible on Station 4. She stated we only usually have 2 CNAs on Station 3, and 2 on Station 4. Today, we have 3 and 3. We have a shower team during the week. CNA F stated there are no showers on the weekend. CNA B stated the shower team operates only if no other CNAs call out. CNA F stated call light wait times are 30-40 minutes long when there are 2 CNAs at a Station. During an interview on 4/28/2024 at 3:30 pm, RN B stated they are short CNAs on the weekend and day shift. She stated CNAs do not have enough time to deliver meal trays and feed dependent residents. RN B stated Station 1 and 2 have Hoyer lift and dependent residents. During a record review of document titled Resident Council Meeting Minutes dated 2/27/2024, it was noted Residents concerned about slow call light response time. They feel it is ' all shifts and all Stations.' During a record review of staff schedule dated 3/30/ 2024, it was noted that Station 3 on NOC shift did not have any CNAs, and Station 4 had one CNA. During a record review of staff schedule dated 3/31/2024, it was noted that AM Station 2 had one CNA, PM Station 3 had two CNAs, and NOC Station 2 and 3 each had one CNA. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review of staff schedule dated 4/1/2024, it was noted that NOC Station 1 had one CNA. During a record review of staff schedule dated 4/2/2024, it was noted that AM Station 2 had two CNAs, Station 3 had one CNA, and Station 4 had one CNA. During a record review of staff schedule dated4/3/2024, it was noted that AM Station 2 and 3 both had one CNA, PM Station 1 and 4 had one CNA, and NOC Station 3 had one CNA. During a record review of staff schedule dated 4/4/2024, it was noted that AM Station 1 had one CNA, PM Station 4 had one CNA, NOC Stations 2, 3 and 4 each had one CNA. During a record review of staff schedule dated 4/5,/2024, it was noted that AM Station 2 had one CNA, PM Station 2 and 3 had one CNA each, and NOC Station 2 and 3 had one CNA each. 2. During a record review of document titled Showering and Bathing dated January 1, 2012, indicated that A tub or shower bath is given to the residents to provide cleanliness, comfort and to prevent body odors. It further states that Residents are given tub or shower baths unless contraindicated. A record review of documents titled ADL Lookbacks from 3/30/2024 to 4/12/ 2024 for seven out of fifteen sampled residents (Resident 14, Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, and Resident 8) indicated: - Showers normally occur on day shift and early evening hours. - Resident 14 was scheduled for 4 showers and received 1. - Resident 2 was scheduled for 4 showers and received 1. - Resident 3 was scheduled for 4 showers and received 1. - Resident 4 was scheduled for 4 showers and received 3. - Resident 5 was scheduled for 4 showers and received 3. - Resident 6 was scheduled for 4 showers and received 1. - Resident 8 was scheduled for 4 showers and received 1. During a record review of staff schedule dated 4/1/2024, it was noted there were no direct care staff working on the shower team. During a record review of staff schedule dated 4/2/2024, it was noted that shower team had one direct care staff member present. During a record review of staff schedule dated 4/3/2024, it was noted there were no direct care staff working on the shower team. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review of staff schedule dated 4/4/2024, it was noted there were no direct care staff working on the shower team. During a record review of staff schedule dated 4/5/2024, it was noted there were no direct care staff working on the shower team. During a concurrent observation and interview on 4/12/2024 at 11:33 am, Resident 2 stated that she received one shower a week. Resident 2 stated that she used to receive two showers a week on Monday and Wednesdays. She stated her showers are now on Mondays only. Resident 2 stated this has been going on for four weeks now. During an interview on 4/12/2024 at 11:49 am, Administrator (ADMIN) stated facility used an outside registry for staffing. Regarding answering call lights, ADMIN stated residents' perceptions are different, we all know this. ADMIN stated her expectation for answering call lights is get there as soon as they can. Regarding the shower team, ADMIN stated I have four people Monday through Friday that do the whole building. All they do is shower residents. ADMIN stated that staff calls off all the time. ADMIN stated a CNA clocked out at 3:00 am and never returned to their shift. ADMIN stated this was a common occurrence. During an interview on 4/28/2024 at 4:02 pm, Director of Nursing (DON) stated that ADMIN has tried to weed out CNAs that do not perform and call out chronically. DON stated staffing should be 3 CNAs and 3 LVNs .on Station 3 and 4 with a split nurse in the middle and 1 on each 3 and 4.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43739 Based on observation, interview, and record review, the facility failed to provide nursing staff with necessary competencies and skill sets to meet the care and services for residents' need for one of three sampled residents (Resident 1) when a change of condition was not promptly identified and reported to the physician. Resident 1 was experiencing signs and symptoms of stroke (a life-threatening medical emergency, when the blood supply to part of the brain is blocked or reduced) on [DATE], he was transferred to the Acute Hospital on [DATE]. This failure resulted in a three-day delay in transferring Resident 1 to the hospital for proper treatment, and increased Resident 1's pain and discomfort. Resident 1 suffered significant declines on his functional abilities: slurred speech, left-sided weakness, inability to swallow. Resident 1 died on [DATE], within a month of his initial admission ([DATE]). Findings: During a review of the facility's policy titled, Change of Condition , revised [DATE], indicated: A. The Facility will promptly inform the Resident, consult with the Resident's primary care physician, and notify the Resident's legal representative or an interested family member when the Resident experiences a significant change in their condition caused by a significant change in the Resident's physical mental or psychosocial status . B. The Facility will ensure Residents, family, legal representatives, and physicians are informed of changes in the Residents' condition in a timely manner. C. Any Facility staff member who observes a Change of Condition will report the change to the Med Tech or Licensed Nurse. The Med Tech or Licensed Nurse will assess the Change of Condition and determine what interventions are appropriate. 1. In the event of any of the following conditions, 911 will be notified immediately. a. Change in level of consciousness. b. Weakness. c. Signs and symptoms of stroke or heart attack. During a review of U.S. Center for Disease Control and Prevention (CDC) website page titled, Stroke , dated , d+[DATE], indicated: 1. The key points During a stroke, every minute counts. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Fast treatment can lessen the brain damage that stroke can cause. 2. Signs and Symptoms Sudden numbness or weakness in the face, arm, or leg, especially on one side of the body. Sudden confusion, trouble speaking, or difficulty understanding speech. Sudden trouble seeing in one or both eyes. Sudden trouble walking, dizziness, loss of balance, or lack of coordination. Sudden severe headache with no known cause. 3. Call [DATE] right away if you or someone else has any of these symptoms. 4. The stroke treatments that work best are available only if the stroke is recognized and diagnosed within 3 hours of the first symptoms. Stroke patients may not be eligible for these treatments if they don't arrive at the hospital in time. During a review of [NAME] Journals (a leading global publisher of current and influential medical, nursing, and allied health research) titled, Acute Ischemic Stroke: The Golden Hour , published in Nursing 2016 Critical Care, Volume 11, Number 3, indicated: 1. Stroke continues to be the leading cause of disability in the United States, contributing to poor quality of life and billions of dollars in health care cost. 2. A door-to-treatment time of 60 minutes or less is the goal. This 60-minute period is often referred to as the Golden Hour of acute ischemic stroke treatment . 3. Appropriate evaluation and treatment can make a critical difference between independence and disability for a patient with acute ischemic stroke. Rapid evaluation and treatment within the golden hour of acute ischemic stroke requires a coordinated, multidisciplinary approach and knowledge of the best practices, therapies, and available management techniques. During a review of Resident 1's clinical record, the record indicated, Resident 1 was initially admitted to the facility on [DATE] with diagnoses which included cellulitis (bacterial skin infection that causes redness, swelling, and pain in the infected area of the skin) of left lower limb, difficulty in walking, and high blood pressure. Resident 1 was his own health care decision maker. During a review of Resident 1's clinical record titled, Physician Orders for Life-Sustaining Treatment (POLST), dated [DATE], the record indicated, Resident 1 chose to have Comfort-Focused Treatment - primary goal of maximizing comfort. Relieve pain and suffering with medication by any route a needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatment listed in Full and elective Treatment unless consistent with comfort goal. Request transfer to hospital only if comfort needs cannot be met in current location. (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 1's Admission progress note, dated [DATE] at 7:23 pm, by Licensed Nurse (LN) B, the note indicated, Resident 1 was alert and oriented to person, place, and time. Resident 1's speech was clear and able to understand and be understood when speaking. During a review of Resident 1's MDS at section C - Cognitive Pattern, section GG - Functional Abilities and Goals, and section J - Health Conditions, Pain Management, dated [DATE], the MDS indicated, 1. Resident 1's BIMS score was 14, suggesting that Resident 1's cognition was intact. 2. Resident 1 had impairment on one side of his upper and lower extremities. 3. Resident 1 was completely dependent (the helper does all of the effort), on toileting hygiene, shower/bath and lower body dressing. 4. Resident 1 had generalized pain. During a review of Resident 1's progress note, dated [DATE] at 5:41 pm, by LN C, the note indicated, Resident 1 was noted to be pale, sleeping most of shift Noted little motivation this shift to participate . During a review of Resident 1's progress note, dated [DATE] at 11:03 pm, by Registered Nurse (RN) D, the note indicated, Resident aware, mumbling but able to follow simple commands. Able to swallow medications well but in a slow manner . There's no note indicated that the MD was notified. During a review of Resident 1's Social Services progress note, dated [DATE] at 2:02 pm, by the Social Services Director (SSD), the note indicated, unable to do care conference related to resident no feeling well . During a review of Resident 1's Social Services progress note, dated [DATE] at 5:21 pm, by RN E, the note indicated, Resident assessed and noted with decline in Level of Consciousness per Social Services Worker, Vital sign score and resident with tired appearance and increased difficulty with oral intake. The Physician was notified with orders received/noted to monitor at this time . Do-Not-Resuscitate (DNR- means that a person has decided not to have cardiopulmonary resuscitation attempted in the event their heart or breathing stops.) with comfort focused care During a review of Resident 1's progress note, dated [DATE] at 11:06 pm, by RN D, the note indicated, Resident 1 was alert to drowsy, awake and needs verbal cues to take medications and fluids in a slow manner . During a review of Resident 1's progress note, dated [DATE] at 11:37 am, by the Director of Nursing (DON), the note indicated, A staff reported to the DON that Resident 1 was unable to work with Occupational Therapy (OT) and could not move his left arm. The DON went to assess and fund Resident 1's head leaning on his left, some drooling, Resident 1 was able to squeeze right hand, however, weakness on the left hand was noted, unable to move and wiggle left toes. The MD was notified and ordered to get Resident 1 sent out. The DON wrote, Resident 1 was his own responsible party (RP) and explained that nurse suspect stroke. He is DNR, comfort care, however, okay to get sent out for further evaluation and treatment. Emergency Medical Services (EMS) came and transported Resident 1. (continued on next page)

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	056074	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chico Heights Rehabilitation & Wellness Centre, L	587 Rio Lindo Avenue Chico, CA 95926

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 1's progress note, dated [DATE] at 11:43, by LN B, the note indicated, Resident 1 got sent out at approximately 11:40 am due to change in mental status and increased need for help with Activities of Daily Living (ADLs). Resident 1 presented with slurred speech and left sided weakness. Patient is own RP and told RN that he would like to be sent out to get checked out EMS arrived at 11:30 am, report given to EMS. Patient taken out of facility and sent to scute . During a review of Resident 1's Acute Hospital's Emergency Department (ED) Provider note, dated [DATE] at 11:59 am, the note indicated, the ED Provider received report from EMS, and was told that Patient was last seen well 4 days ago, patient had normal movement of all extremities and was conversant . , and Patient currently has no movement of the left side as well as slowed and garbled speech . Resident 1 was found to have cerebrovascular accident (CVA - stroke), Acute renal failure (sudden loss of the ability of the kidneys to excrete wastes, concentrate urine, conserve electrolytes, and maintain fluid balance), and Chronic cellulitis. During a review of Resident 1's Clinical Admission record, dated [DATE], at 9:04 pm , the record indicated, Resident 1 was readmitted to the Skill Nursing Facility with diagnoses which included Right ischemic stroke (the blood supply to part of the right side of the brain is blocked or reduced) with left hemiparesis (weakness on the left side of the body), and urinary retention (the bladder doesn't empty completely). Resident 1 was still his own health care decision maker. During a review of Resident 1's MDS at section C - Cognitive Pattern, section GG - Functional Abilities and Goals, and section J - Health Conditions, Pain Management, dated [DATE], the MDS indicated, 1. Resident 1's BIMS score was 14, suggesting that Resident 1's cognition was intact. 2. Resident 1 had impairment on one side of his upper and lower extremities. 3. Resident 1 was completely dependent (the helper does all of the effort), on toileting hygiene, shower/bath and lower body dressing. 4. Resident 1 had generalized pain. During an interview on [DATE], at 2:05 pm, with LN L, LN L stated, I was really upset. They kept saying Resident 1 was on comfort care , comfort care is to make the patient as comfortable as possible, it's not to let them lay there and die. They should have sent him out earlier . During an interview on [DATE], at 4:14 pm, with SSD, SSD stated, I met Resident 1 on Friday, [DATE], in Resident 1's room. I scheduled his care conference. He answered his question completely. He completed his BIMs, he got 12. On Monday ([DATE]), I tried to interview him for care conference, he started talking gibberish. This is not him; he was alert and had a clear speech when I talked to him on Friday. I reported it to LN F. LN F was covering the Station 4 for the nurse, LN F usually worked at the Station 1 and was not familiar with the residents at the Station 4, so I also reported to the Assistant Director of Nursing (ADON)/RN E. Both LN F and ADON went into Resident 1's room and assessed the resident. They took his vital sign; LN F said his vial was fine. I am not a nurse; I left the issue with them. However, I told them that he acted differently and how I saw him on Friday (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 observation and interview on [DATE], at 3:16 pm, with Resident 1, in Resident 1's room, Resident 1 had his eyes closed, and his head turned left, appeared to be weak, and pale. During an interview with Resident 1, Resident 1 was struggling to raise his left hand, but it was unsuccessful. Resident 1 then tried to speak several times, but most of it was slurred and unable to understand. When asked how was the facility treating you? , Resident 1 stated, not very good! Resident 1 confirmed his answer by nodding his head. When asked what you meant by not very good ? Resident 1 stated, I can't tell you. During an interview on [DATE], at 3:24 pm, with RN J, RN J stated, Resident 1 needed 1:1 feeder (assisted feeding - the action of a person feeding another person who cannot otherwise feed themselves), he was not eating well. Food was coming out of his mouth. He had to use a straw to drink the food, he wasn't doing well, the food was drooling down from his mouth. During an interview on [DATE] at 3:41 pm with LN B, 1. LN B state, she admitted /interviewed Resident 1 on [DATE], LN B said, Resident 1 was alert, he could eat, he could hold a normal conversation, he could move himself in the bed. 2. LN B stated, I was his nurse on [DATE]. When I went into his room in the morning, noticed him had a change of condition. I asked his name, he could not respond, he couldn't make common, he was slurred, he showed slow movement, I reported it to the DON right away. 3. LN B stated, Resident 1 now was a completed different person. He could not talk well; he could not eat and move like he used to when he first got here. During an interview on [DATE], at 4:01 pm, with DON, 1. DON stated, Comfort care is to keep them comfortable, it doesn't mean not to treat ! 2. DON stated, Resident 1 had a change of condition on [DATE]. I told him, he had symptoms of stroke, that he could not lift his left arm and left leg, he had slurred speech. As a nurse, I wound be the patient advocate. I notified the doctor and Resident 1 agreed to be sent out to the Acute Hospital. 3. DON stated that she did not know what happened on [DATE], however, she admitted that the facility should have sent Resident 1 to the Acute Hospital earlier. 4. DON stated that the staff should have known the sign and symptoms of stroke, we had in-service for it . DON said, they did not know what comfort care is. Your understanding is different from the resident. If you are on the comfort care, it doesn't mean that I won't treat you! During a review of Resident 1's progress note, dated [DATE], at 6:10 pm, by LN K, the note indicated, Resident 1 struggled with sucking honey thick liquids through a straw throughout the shift . Resident 1 had elevated blood pressure and temperature . (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 1's clinical record titled, Interdisciplinary Team (IDT - a group of dedicated healthcare professionals who work together to provide the care the patient needs) Progress Notes - Weight Variance & Nutritional condition , dated [DATE], at 3:50 pm, the note indicated, Resident 1 had significant weight loss of 12.8 pounds in a week. Resident 1 requested to be referred to the Gastrointestinal (GI) specialist to have a Gastrostomy tube (also called a G-tube, is a tube inserted through the belly that brings nutrition directly to the stomach) During a review of Resident 1's progress note, dated [DATE], at 3:54 pm, by LN M, the note indicated, Resident 1 was seen by the speech therapist. Resident 1 noted to be having a difficulty swallowing. Resident 1 aspirating. Resident 1 decided he does want a G-tube. MD notified. Referral for GI consult. During a review of Resident 1's IDT skin progress note, dated [DATE], at 1:40 pm, by Treatment Nurse (TN) Q, the note indicated, Resident 1 has been very lethargic and at risk for malnutrition. Resident 1 was noted to have shearing on left upper back related to being bedbound and immobile (Shearing wounds occur when forces are applied to body tissues or parts that cause these tissues to move in opposite directions. Shearing forces can put pressure on blood vessels, causing them to be closed off, resulting in reduced blood flow to an area). During a review of Resident 1's nursing progress note, dated [DATE], at 1:16 pm, by LN C, the note indicated, Resident 1 continued unable to take in meals, rolls out of mouth, unable to swallow. Taking Honey thickened fluids by spoon and most of the fluids also rolled out of his mouth . During a review of Resident 1's progress note, dated [DATE], at 6:05 pm, by LN S, the note indicated, Resident 1 was accepted to Hospice P services (a type of care that focuses on the care, comfort, and quality of life of a person with a serious illness who is approaching the end of life) . Resident 1 was prescribed with Roxanol (morphine sulfate, a highly concentrated solution of the narcotic analgesic morphine sulfate for oral administration used for the treatment of severe pain) 5 milligram (mg), 10 mg, and 15 mg via mouth every one hour, as needed (PRN), for mild to severe pain. During a review of Resident 1's Wound care progress note, dated [DATE], at 12:19 pm, by RN J, the note indicated, Resident 1 was in such pain and refused to have skin care, and the nurse was unable to console with touch or other non-pharmaceutical interventions. PRN pain medication administered. During a review of Resident 1's progress note, dated [DATE], at 11:06 am, by LN O, the note indicated, Hospice P notified LN O that Resident 1 had Deep Tissue Pressure Injury (DTPI) to right buttock and abrasion (scrape) to left side (DTPI - intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler as compared to adjacent tissue. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface). Resident 1 did not have any skin issue on both his buttocks noted while he was readmitted to the facility on [DATE]. (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 1's IDT skin progress note, dated [DATE], at 2:59 pm, by TN Q, indicated Resident 1 had continued to refuse meal and medications. Resident 1 had a referral for G-tube placement, no updates for it at this time. TN Q was notified by the nurse and the nursing aids that Resident 1 was non-complaint with rotating a repositioning, and Resident 1 got aggressive and physically tried to prevent himself from being repositioned. Even after receiving pain medication still refused to turn . During a review of Resident 1's progress note, dated [DATE], at 12:51 pm, by Nursing Unit Manager (NUM) R, the note indicated, NUM R received new orders for Resident 1 from Hospice P. Resident 1 was prescribed with more routine pain medications - Norco, routine and as needed, and Morphine Sulfate, routine with one milliliter (ml) via mouth, three times a day, and continue with the previous PRN order for Morphine Sulfate for pain management. During a review of Resident 1's clinical record, the record indicated that Resident 1 had passed away on [DATE] at the facility. During an interview on [DATE], at 12:50 am, with administrator (ADMIN), ADMIN stated that she was very upset about what happened to Resident 1. ADMIN said LN B admitted Resident 1 on [DATE], and LN C took over the shift over the weekend. LN C did not know Resident 1's base line. When Resident 1 had a change of condition, LN C did not know, and LN B did not do the assessment on [DATE]!

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32797 Based on observation, interview, and record review the facility failed to ensure equipment in the facility was maintained when: 1. The Central Air Conditioning (AC) system and Packaged Terminal Air Conditioners (PTAC, a standalone AC/heater, self-contained, meaning they do not rely on ducts to operate) on Station 3 and 4 were not working. This resulted in an uncomfortable temperature during the warmer months and resident discomfort. 2. A resident rooms lights did not work. This put two residents at risk for falls. Findings: During an observation on 5/9/2024 at 2 pm, the outside temperature was 83 degrees Fahrenheit (F). During a concurrent observation and interview with Maintenance Tech (MT A) on 5/9/2024 at 2:27 pm, the following room temperatures were observed in resident rooms that did not have working fans and chilling coils: - room [ROOM NUMBER]A: 76.7 F at wall thermometer - room [ROOM NUMBER]A: 76.7 F at wall thermometer -room [ROOM NUMBER]A: 79.3 F at wall thermometer During an interview with Resident 16 on 5/9/2024 at 2:35 pm, she stated that she was feeling warm and hot in her Room, 36A. MT A stated that Resident 16's PTAC fan had not been fixed yet. 2. During a concurrent observation and interview on 5/9/24 12:30 pm, room [ROOM NUMBER] was dark. Resident 15 requested a Certified Nursing Assistant to turn Bed B's light on, since Bed A and C lights did not work. Resident 15 used Bed B's light to see in the room. During a concurrent observation and interview with MT A on 5/9/2024 at 2:15 pm, he confirmed room [ROOM NUMBER] did not have working lights above Bed A and B. MT A stated he was not aware of them not working. At 2:46 pm.MT A confirmed room [ROOM NUMBER]'s window air conditioning unit needed to be pulled out and reinstalled, but had not been completed. MT A stated that Station 2 had PTAC units were not scheduled to be serviced. MT A stated that maintenance is replacing motors of all of the fans in rooms on Station 1 and 2 week by week. MT A stated that maintenance had replaced six AC fan motors that week. PT A further explained that the facility had issues with chilling coils for the AC units that were not working at Nursing Station 2.C units that were not working at nursing Station 2 on 5/9/2024.