STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056079	A. Building B. Wing	08/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glendora Grand, Inc	805 W. Arrow Hwy. Glendora, CA 91740

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40438 Based on observation, interview, and record review, the facility failed to ensure call lights were within reach for two of two sampled residents (Residents 81 and 25). These deficient practices had the potential to result in Residents 81 and 25 to not receive the necessary care or receive delayed services to meet the residents' needs that could result in a fall and accident. Findings: a. During a review of Resident 81's Admission Records (AR), the AR indicated Resident 81 was initially admitted to the facility on [DATE] and Resident 81 was readmitted to the facility on [DATE] with diagnoses that included osteoarthritis (occurs when flexible tissue at the ends of bones wears down), muscle weakness (decreased strength in the muscles) and dementia (loss of cognitive functioning-thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities). During a review of Resident 81's Care Plan (CP), dated 4/18/2024, the CP indicated, Resident 81 needed assistance with activity of daily living (ADLs, refer to an individual's daily self-care activities) and Resident 81 was at risk for fall/injuries related to impaired cognition (ability to understand), impaired mobility and transfer, poor impulse control, and lack of safety awareness. Resident 18 had a fall risk assessment score of 18. The CP interventions included to provide frequent assistance of needs and maintain a call light within easy reach and answer promptly. During a review of Resident 81's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 5/20/2024, the MDS indicated, Resident 81 had severely impaired cognition and required supervision or touching assistance (helper provided verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with oral and toileting hygiene, upper and lower body dressing, and personal hygiene. During a review of Resident 81's Fall Risk Assessment (FRA), dated 7/30/2024, the FRA indicated, Resident 81 had a score of 18 indicating Resident 81 was a high risk for potential falls. (continued on next page)

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

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview, on 7/30/2024 at 10:22 am, with certified nurse assistant (CNA) 3 while inside Resident 81's room, Resident 81's call light was dangling on the side of the bed and situated up high on the head of the bed. Resident 81 stated she could not reach the call light. Resident 81 stated, I need to go around the bed to get the call light and I could not walk on my own. CNA 3 stated the call light should be clipped on the bed next to the resident for the resident to call for help when they needed help and for staff to be able to assists the residents promptly. During an interview on 7/30/2024 at 11:15 a.m. with the licensed vocational nurse (LVN) 5, LVN 5 stated, call lights should be pinned on top of the bed by the pillow where the resident could grab and see the call light and prevent the call light from falling off the bed. This is so the residents could call the staff and the staff could address the residents' needs. During an interview on 8/1/2024 at 10:51 am with the director of nursing (DON), the DON stated, the call light should be clipped or pinned on the bed, close to the strong side of the resident, this way the resident could call the staff for help and the staff could assist the resident. During a review of the facility's policy and procedure (P&P) titled, Call Lights: Accessibility and Timely Response, revised 2023, the P&P indicated, Staff will ensure the call light is within reach of the resident and secured, as needed. b. During a review of Resident 25's Admission Record (AR), the AR indicated Resident 52 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included muscle weakness and unspecified dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning). During a review Resident 25's History and Physical (H&P), dated 2/7/2024, the H&P indicated, Resident 25 did not have the capacity to understand and make decisions. During a review of Resident 25's Fall Risk Care Plan, dated 2/7/2024, the Care Plan indicated Resident 25 was at risk for falls related to impaired cognition, impaired mobility, and transfer. The Care Plan interventions indicated the nursing staff would do the following: 1. To ensure Resident 25's call light is within easy reach. 2. Staff to answer call light promptly. 3. Remind Resident 25 to always ask for help or assistance. During a review of Resident 25's Fall Risk Assessment (method of assessing a patient's likelihood of falling), dated 5/10/2024, indicated Resident 25 was assessed as at high risk for falls due to the following: 1. Intermittent confusion. 2. Required regular assistance with elimination. 3. Balance problem while standing and walking. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Decreased muscular coordination. 5. Required use of an assistive device, such as wheelchair. 6. Took three to four medications currently. 7. The presence of predisposing disease condition. During a review of Resident 25's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 6/27/2024, the MDS indicated, Resident 25 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated, Resident 25 required substantial/maximum assistance (helper did more than half the effort and lifted or held trunk or limbs) for toileting hygiene, shower, lower body dressing, putting on and taking off footwear. The MDS indicated, Resident 25 required partial to moderate assistance (helper did less than half the effort and lifted or held trunk or limbs) with oral hygiene, upper body dressing and personal hygiene. During an observation on 7/30/2024 at 9:53 a.m. Resident 25 was lying on his bed. Resident 25's call light was observed on the floor next to Resident 25's roommate's bed. During a concurrent observation and interview on 7/30/2024 at 9:54 am, with Licensed Vocational Nurse 4 (LVN 4), the LVN 4 pulled the call light with force below the bedside table next to Resident 25's roommate's bed. LVN 4 stated, Resident 25's call light needed to be in reach for Resident 25 to use it to communicate and call the staff if Resident 25 needed assistance. During an interview on 7/30/2024 at 12:20 pm with Registered Nurse 1 (RN 1), RN 1 stated, Resident 25 was a high risk for falls. RN 1 stated the call light needed to be within reach for Resident 25 to receive assistance immediately and to maintain residents' safety. During an interview on 8/1/2024 at 3:47 p.m., with the facility's Director of Nursing (DON), the DON stated the call light needed to be always within reach to address Resident 25's needs in a timely manner.

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F 0578 Level of Harm - Potential for minimal 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** 42781 Based on interview and record review, the facility failed to provide information regarding an Advance Directive (AD, a written preferences regarding treatment options, a process of communication between individuals and their healthcare agents to understand, reflect on, discuss, and plan for future healthcare decisions for a time when individuals are not able to make their own healthcare decisions) for one of one sampled resident (Resident 252) in accordance to the facility's policy titled Advance Directives. This failure had the potential to result in the facility staffs to provide medical or surgical treatment against Resident 252's will. Findings: During a review of Resident 252's Admission Record, the admission record indicated Resident 252 was admitted to the facility on [DATE] with diagnoses that included schizophrenia (mental disorder characterized by abnormal social behavior and failure to understand what is real) and anxiety disorder (group of mental disorders characterized by feelings of anxiety [an unpleasant state of inner turmoil] and fear). During a review of Resident 252's History and Physical (H&P), dated 4/22/2024, the H & P indicated, Resident 252 had fluctuating capacity to understand and make decisions for activities of daily living. During a review of Resident 252's AD Acknowledgement form, signed on 4/24/2024, the AD acknowledgement form was not filled out completely. During a review of Resident 252's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 4/28/2024, the MDS indicated, Resident 252 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated, Resident 252 required supervision or touching assistance (helper provided verbal cues and/or touching/steadying and/or contact guard assistance as resident completed the activity) for eating, oral hygiene, and upper body dressing. The MDS further indicated, Resident 252 required partial/moderate assistance (helper did less than half the effort and lifted or held trunk or limbs) with toileting hygiene, shower, lower body dressing and putting on/taking off footwear. During an interview and concurrent record review, on 7/30/2024 at 12:29 pm, with Registered Nurse 1 (RN 1) of Resident 252's medical record (chart), RN 1 stated the AD Acknowledgement Form was not filled up completely. The RN 1 stated AD Acknowledgement Form needed to be filled up completely to know Resident 252's wants in case of emergency. During an interview and concurrent record review on 7/31/2024 at 9:02 am, (continued on next page)

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F 0578 Level of Harm - Potential for minimal harm Residents Affected - Some	with the Social Services Designee (SSD) of Resident 252's chart, the SSD stated the AD Acknowledgement Form was not filled up completely to indicate whether Resident 252 wanted to formulate an advance directive or not. The SSD stated, Resident 252's AD Acknowledgement Form needed to be filled out completely to know Resident 252's wants and wishes and should be in the chart for easy access. During an interview on 8/1/2024 at 3:45 pm, with the facility's Director of Nursing (DON), the DON stated the AD needed to be filled out completely by the Social Services Designee to know Residents 252's wants in case of an emergency. During a review of the facility's undated Policy and Procedure titled, Advance Directives, the P&P indicated, prior to or upon admission of a resident to our facility, the Social Services Director or Designee will provide written information to the resident concerning medical care, including the right to accept or refuse surgical treatment and the right to formulate advance directives. The P&P indicated prior to or upon admission of a resident, the Social Services Director or Designee will inquire of the resident, and/or his/her family members, about the existence of any written advance directives.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45064 Based on observation, interview and record review, the facility failed to ensure residents were provided a homelike environment for one of one sampled resident's room (Resident 209) by failing to ensure the room did not have peeling paint on the walls and stain on the floor. This failure had the potential for unsafe and unclean resident's environment. Findings: During a review of Resident 209's Face Sheet (FS), the FS indicated Resident 209 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included muscle weakness, anxiety disorder (group of mental disorders characterized by feelings of anxiety [an unpleasant state of inner turmoil] and fear) and insomnia (inability to sleep). During a review of Resident 209's History and Physical Examination (H&P) dated 2/13/2024, the H&P indicated Resident 209 does not have the capacity to understand and make decisions. During a review of Resident 209's Minimum Data Set (MDS-a standardized assessment and care planning tool) dated 5/13/2024, the MDS indicated Resident 209 had moderately impaired cognition (ability to think and process information). During a concurrent observation and interview on 7/30/2024 at 10: 16 am with Director of Nursing (DON) in Resident 209's room, paint was coming off the wall and black stain was noted on the floor located near the head of Resident 209's bed. The DON stated the paint was peeling off the wall and the floor had black stain and was not clean. The DON stated, DON will notify Maintenance Department to fix the wall and clean the floor immediately. Resident 209 refused to speak to the surveyor when attempted to interview the resident. During an interview on 8/1/2024 at 12:16 pm with the DON, the DON stated staff needed to report to the Maintenance Supervisor if there were any issues with the environment such as peeled paint and stain on the floor. The DON stated, it's the facility's policy to provide a clean and homelike environment for the residents. During an interview on 8/1/2024 at 12:50 pm with Director of Maintenance (DM), DM stated each nurses' station had a maintenance logbook where the nurses would write down if there was any issue with the environment. DM stated, DM was not aware of any issue in Resident 209's room and no one had reported until 7/30/2024 when the DON informed him about the paint peeled off of the wall and the floor had black stain in Resident 209's room. DM stated, it was important to provide a clean and homelike environment for the residents to feel safe and comfortable. During a review of the facility's Policy and Procedure titled, Safe and Homelike Environment, revised 2023, the P&P indicated In accordance with resident's rights, the facility will provide a safe, clean, comfortable and homelike environment The facility will maintain a clean environment.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42781 Based on interview and record review, the facility failed to develop an individualized/person- centered care plan for one of one sampled resident (Resident 22), who was on Ativan, (medication used to treat anxiety [group of mental disorders characterized by feelings of anxiety [an unpleasant state of inner turmoil] and fear]) in accordance to the facility's policy titled Comprehensive Care Plans. This deficient practice had the potential to result in Resident 22 not receiving appropriate care treatment and/or services. Findings: During a review of Resident 22's Admission Record (AR), the AR indicated Resident 22 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included anxiety and dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning). During a review of Resident 22's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 6/5/2024, the MDS indicated, Resident 22 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated, Resident 22 required supervision or touching assistance (helper provided verbal cues and/or touching/steadying and/or contact guard assistance as resident completed the activity) for eating, oral hygiene, and upper body dressing. The MDS further indicated, Resident 22 required partial/moderate assistance (helper did less than half the effort and lifted or held trunk or limbs) with toileting hygiene, shower, lower body dressing and putting on/taking off footwear and personal hygiene. During a review of Resident 22's Physician Order (PO) dated 7/16/2024, the order summary report indicated to administer Ativan 1 milligrams (mg) tablet by mouth every eight hours for anxiety manifested by (m/b) yelling/screaming for no reason. During a concurrent interview and record review on 7/30/2024 at 1:05 pm with the facility's Registered Nurse Supervisor (RN Sup 1) Resident 22's medical record was reviewed. The RN Sup 1 stated there was no other clinical documentations that a CP was developed for Resident 22 who was on Ativan use. The RN Sup stated a care plan needed to be developed and implemented for the management of Ativan to ensure Resident 22 received the proper care and effective interventions from the nursing staff as needed. During an interview on 8/1/2024 at 3:38 pm with the facility's Director of Nursing (DON), the facility DON stated a comprehensive care plan needed to be developed and implemented to provide proper intervention which was specific and individualized to the resident. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's undated Policy and Procedure (P&P) titled, Comprehensive Care Plans, revised 3/2023, the policy indicated the facility is to develop and implement a person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives, and timeframes to meet a residents medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. The P&P indicated, the comprehensive care plan will be developed within seven days after completion of the comprehensive MDS assessment.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48905 Based on interview and record review, the facility failed to revise one of one sampled resident (Resident 228) care plan (CP) when Resident 228's scratch (skin injury from something sharp or rough) on the right hip changed in color on 7/24/2024. This failure had the potential to delay the provision of care and treatment for Resident 228' injury and cause Resident 228's skin injury to worsen. Cross reference F686 Findings: During a review of Resident 228's Admission Record (AR), the AR indicated, the facility originally admitted Resident 228 to the facility on [DATE], and readmitted Resident 228 on 5/30/2024, with diagnoses that included but are not limited to type two diabetes mellitus (T2DM, occurs when there is too much sugar in the blood), end stage renal disease (occurs when kidneys are unable to filter blood properly), and dependence on renal dialysis (procedure to remove waste products and excess fluid from the blood when kidneys are not working). During a review of Resident 228's Minimum Data Set (MDS, a standardized comprehensive assessment of each resident's functional capabilities and identifies health problems), dated 3/4/2024, the MDS indicated, Resident 228 had mild cognitive (ability to think, learn, and understand) impairments. During a review of Resident 228's Short Term Problems CP for the right hip open scratches, dated 6/22/2024, the CP indicated, a goal for Resident 228 to have a decrease in risk for further problems. The CP intervention included for staff to notify the Medical Doctor (MD) if treatment was not effective. During a review of Resident 228's Non-Pressure Sore Skin Problem Report (NPSSPR) for the right hip dated 6/22/2024, the NPSSPR indicated, Resident 228 had open red and moist scratches on the right hip. The NPSSPR indicated, on 7/24/2024, Resident 228's scratches on the right hip appeared macerated (skin is soft and breaking down) and white in color. During a concurrent interview and record review on 8/2/2024 at 11:40 AM with the Director of Nursing (DON), Resident 228's NPSSPR dated 7/24/2024 was reviewed. The DON stated the CP was not revised when Resident 228's scratch on the right hip turned white and was macerated (on 7/24/2024). The DON stated the CP should have been revised to ensure the resident received proper treatment. During a review of the facility's policy and procedure (P&P) titled, Comprehensive Care Plans, undated, the P&P indicated, the comprehensive care plan would be reviewed and revised by the facility after each comprehensive and quarterly MDS assessment. The P&P indicated, the comprehensive care plan would include objectives and timeframes to meet the resident's identified needs. The P&P indicated, the facility would monitor the resident's progress and alternative interventions would be documented as needed.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 40037 Based on observation, interview, and record review, the facility failed to ensure safe administration of medications during a medication administration observation for one of three sampled residents (Resident 124) by failing to ensure Licensed Vocational Nurse (LVN) 6 did not administer medications that were dropped on the floor to Resident 124. This failure had the potential to result in infection for Resident 124 from consuming contaminated medications. Findings: During a medication administration observation on 7/31/2024 at 8:53 am, in Resident 124's room LVN 6 prepared 13 medications and put the medications in a medication cup for Resident 124. LVN 6 accidentally dropped three pills on the floor before giving the medication cup to Resident 124. LVN 6 looked on the floor, found the three pills, picked up the three pills, and put the three pills back into the medication cup with the rest of Resident 124's medications. LVN 6 then gave the medication cup to Resident 124. Resident 124 received the medication cup from LVN 6 and was about to put the medications from the medication cup inside Resident 124's mouth. The surveyor intervened and stopped Resident 124 from taking the medications from the medication cup. During a concurrent interview on 7/31/2024 at 8:53 am with LVN 6, LVN 6 stated LVN 6 should not have given Resident 124 the medications that dropped on the floor. LVN 6 stated the medications dropped on the floor were contaminated and resident could get sick from taking contaminated medications and could cause declination of health condition. LVN 6 stated LVN 6 needed to discard the medications that dropped on the floor. During a review of Resident 124's Face Sheet (FS- Admission Record), the FS indicated, the facility admitted Resident 124 on 5/15/2024, with diagnoses including heart failure (a lifelong condition in which the heart muscle can't pump enough blood to meet the body's needs for blood and oxygen) and malignant neoplasm (cancerous [a disease in which abnormal cells divide uncontrollably and destroy body tissue] kidney tumor) of right kidney. During a review of Resident 124's Minimum Data Set (MDS, a standardized resident assessment and care screening tool), dated 5/21/2024, the MDS indicated, Resident 124 had clear speech and the ability to understand others and make self-understood. Resident 124 required partial/moderate assistance (helper did less than half the effort, helper lifted, held, or supported trunk or limbs) for personal hygiene and chair/bed-to-chair transfer. During an interview on 7/31/2024 at 10:41 am with the Director of Nursing (DON), the DON stated when medications were dropped on floor, nurses needed to discard the medications right away and not pick up the medications from floor to give to the residents. The DON stated this was for the residents' safety. The DON stated it was part of professional standard of practice to not give patients contaminated medications. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled Medication Administration, revised 2023, the P&P indicated, Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48905 Based on observation, interview, and record review, the facility failed to provide care and services for three of three sampled residents (Residents 228, 231 and 80) to prevent the development of a pressure ulcer (PU, localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device) and failed to provide treatment to the PU. 1. For Resident 228 who was assessed as at risk for developing PU, the facility failed to: a. Ensure Treatment Nurses (TXN 1 and TXN 3) provided treatment to Resident 228's right hip opened scratches (areas of damage on the surface of the skin)/open wounds (injuries that involve a break in the skin and leave the internal tissue exposed) on 7/6/2024, 7/20/2024, 7/21/2024, 7/25/2024 as ordered by Resident 228's Medical Doctor (MD) 1. b. Ensure TXN 1 and TXN 3 provided treatment to Resident 228's right and left hips' unstageable PU (full thickness tissue loss where the depth of the wound was covered by eschar [collection of dry, dead tissue within a wound]) on 7/29/2024 as ordered by MD 1. c. Ensure TXN 3 notified MD 1 of Resident 228's development of the avoidable (able to be prevented) unstageable PU on the right and left hips when Physician Assistant 1 (PA 1) identified those PUs on 7/24/2024. d. Ensure TXN 3 carried out PA 1's verbal order to clean Resident 228's unstageable PU on Resident 228's right and left hips with Normal Saline (NS, mixture of water and salt) and Betadine (medication used to prevent infection in wounds), and to cover (the PU) with dressing (unspecified) on 7/24/2024. e.Ensure TXN 1 and TXN 3 implemented Resident 228's Care Plan (CP) dated 5/30/2024 for impaired skin integrity and risk of worsening of a PU and to provide wound care treatment to Resident 228 as ordered by MD 1 and to report further skin breakdown to MD 1. As a result, on 7/24/2024, Resident 228 developed an avoidable unstageable PU on the right hip and worsened left hip unstageable PU. The unstageable PU on the right hip measured 5.5-centimeter (cm, measurement unit in length) length by 5 cm width with a depth of 0.2 cm, and the unstageable PU on the left hip measured 7 cm length by 4 cm width with a depth of 0.2 cm. 2. For Resident 231, the facility staff failed to ensure the Low Air Loss mattress (LAL - tiny laser made air holes in the mattress top surface continually blow out air causing the patient to float) was set at accurate setting based on the resident's weight. Resident 231's LAL mattress was set at 325 pounds (lbs. - unit of measurement) static mode and the resident currently weighed 158 pounds. This failure had the potential for skin breakdown for Resident 231. (continued on next page)

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	056079	A. Building B. Wing	08/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glendora Grand, Inc	805 W. Arrow Hwy. Glendora, CA 91740

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F 0686 Level of Harm - Actual harm Residents Affected - Few	3. For Resident 80, the facility failed to ensure facility Treatment Nurses (TXN) provided treatment for Resident 80's Stage 4 Pressure Ulcer (Stage 4 PU, full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer; slough and/or eschar may be visible on some parts of the wound bed) on the Sacro coccyx (tailbone) from 7/25/24 to 7/30/24. This failure had the potential to delay healing of Resident 80's PU. Cross reference F657 Findings: 1. During a review of Resident 228's Admission Record (AR), the AR indicated the facility admitted Resident 228 on 2/23/2024 and readmitted on [DATE] with diagnoses that included type two diabetes mellitus (occurs when there was too much sugar in the blood), End Stage Renal Disease (ESRD- kidneys were damaged and unable to filter blood), and dependence on renal dialysis (procedure to remove waste products and excess fluid from the blood). During a review of Resident 228's Minimum Data Set (MDS, a standardized assessment and care planning tool) dated 3/4/2024, the MDS indicated Resident 228 had moderately impaired cognition (ability to think, learn, and understand). The MDS indicated Resident 228 was at risk for developing PU due to occasionally moist skin and very limited mobility (ability to change and control body position). During a review of Resident 228's Admission Body Assessment ([NAME]) dated 5/30/2024, the [NAME] indicated Resident 228 was admitted to the facility with an unstageable PU on the left hip which measured 1 cm. length by 1.5 cm width. The [NAME] indicated Resident 228 had contractures (fixed tightening of muscle, tendons, ligaments, or skin that prevents normal movement of the body part) of bilateral (both) knees, left elbow, and left wrist. During a review of Resident 228's Braden Scale (BS, tool used to assess resident's risk for developing a PU) form, dated 5/30/2024, the BS form indicated Resident 228 was at risk to develop a PU due to occasionally moist skin and very limited mobility. During a review of Resident 228's untitled CP for impaired skin integrity and risk of worsening of a PU dated 5/30/2024, the CP indicated for staff to provide treatment to Resident 228's PU as ordered by MD 1 and to report further skin breakdown to MD 1. During a review of Resident 228's Non-Pressure Sore Skin Problem Report (NPSSPR) of the right hip dated 6/22/2024, the NPSSPR indicated there was open red and moist scratches on Resident 228's right hip. During a review of Resident 228's Physician's Order (PO) dated 6/22/2024, the PO indicated for licensed staff (TXN 1 and TXN 3) to cleanse Resident 228's right hip open scratches/wounds with NS, pat (the wounds) dry and apply calmoseptine (moisture barrier) and cover (the wound) with Optifoam (non-adhesive dressing to create a proper environment for wound healing) every day for 14 days and re-evaluate. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 228's PO dated 7/22/2024, the PO indicated for licensed staff (TXN 1 and TXN 3) to paint Resident 228's right hip's open wounds with Betadine and cover (the wound) with Optifoam every day for 14 days and re-evaluate. During a review of Resident 228's Physician's Assistant Wound Assessment Notes (PAWAN) dated 7/24/2024 at 3:06 PM, the PAWAN indicated the following: Resident 228's left hip had one unstageable PU, which measured 7 cm length by 4 cm width with a depth of 0.2 cm. Resident 228's right hip had one unstageable PU which measured 5.5 cm length by 5 cm width with a depth of 0.2 cm. Resident 228's PAWAN indicated PA 1 recommended for licensed staff (TXN 1 and TXN 3) to cleanse Resident 228's right and left unstageable PU with NS and Betadine, cover the PUs with dry dressing (wound dressing make of dry material such as gauze or absorbent cotton), offload (relieve the PU from pressure) and reposition. During a review of Resident 228's PO dated 7/26/2024, the PO indicated for licensed staff (TXN 1 and TXN 3) to clean Resident 228's left hip red scab (unstageable PU) with NS, paint (the unstageable PU) with Betadine, and cover (the unstageable PU) with Optifoam for 14 days. During a review of Resident 228's PO, dated 7/27/2024, the PO indicated for licensed staff (TXN 1 and TXN 3) to clean Resident 228's right hip PU with NS, apply Santyl ointment (ointment used to remove damaged tissue) daily, and cover (the right hip PU) with Optifoam for 14 days. During a review of Resident 228's Skin and Wound Progress Report (SWPR) for the right hip dated 7/27/2024, the SWPR indicated Resident 228 had an unstageable PU on the right hip. The SWPR indicated unstageable PU on Resident 228's right hip had increased in size and color. During a concurrent observation of Resident 228 in Resident 228's room and an interview with Resident 228 on 7/31/2024 at 9:15 AM, Resident 228 was lying on Resident 228's right side with bilateral (both) knees, left elbow, and left wrist contracted (tissue shortened). Resident 228 stated Resident 228 did not know how Resident 228 developed the unstageable PU on Resident 228's right and left hips. During an interview on 7/31/2024 at 10:49 AM with Registered Nurse 3 (RN 3), RN 3 stated the unstageable PU on Resident 228's right hip was a new PU, and the PU was developed in the facility. RN 3 stated the right hip unstageable PU started as a scratch on 6/22/2024. RN 3 stated Resident 228 was admitted with a left hip PU. During a concurrent interview with TXN 1 on 7/31/2024 at 3:58 PM and record review of Resident 228's Treatment Administration Record (TAR) dated from 7/26/2024 to 7/31/2024 for the left hip, Resident 228's TAR indicated missing treatment for the unstageable PU on 7/29/2024. TXN 1 stated the TAR for 7/29/2024 was blank. TXN 1 stated TXN 1 was unsure if Resident 228 received treatment for the unstageable PU on 7/29/2024. TXN 1 stated there was no documented evidence on Resident 228's clinical record to indicate why the treatment was missed. TXN 1 stated missing the treatment would result in worsening of Resident 228's left hip unstageable PU. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview with TXN 1 on 7/31/2024 at 4 PM and record review of Resident 228's TAR dated from 6/1/2024 to 7/31/2024 for the right hip and the CP for impaired skin integrity and risk of worsening of PU dated 5/30/2024, Resident 228's TAR for the right hip indicated blank spaces on 7/6/2024, 7/20/2024, 7/21/2024, 7/25/2024 and 7/29/2024. TXN 1 stated Resident 228 missed five days of treatment (7/6/2024, 7/20/2024, 7/21/2024, 7/25/2024 and 7/29/2024). The CP indicated for licensed staff (TXN 1 and TXN 3) to provide wound care treatment as ordered and to report further skin breakdown to MD 1. TXN 1 stated Resident 228's right hip started as a scratch on 6/22/2024. TXN 1 stated not providing treatment as ordered would cause the right hip unstageable PU to worsen. TXN 1 stated Resident 228's CP was not implemented because treatment for the open wound on the right hip was not provided to Resident 228 as per MD 1's order. TXN 1 stated missing treatments would contribute to the development of an avoidable PU. During a concurrent observation of Resident 228's right and left hip unstageable PU in Resident 228's room and interview with the facility's Director of Nursing (DON) and RN 3 on 8/1/2024 at 10:32 AM, the DON and RN 3 assessed Resident 228's right and left unstageable PUs. The DON stated the wound bed (base of the wound) for the left hip unstageable PU was moist, pink, and purple with yellow slough (yellow or white material which consist of dead cells that accumulate in the wound) surrounded the PU. The DON stated the left hip unstageable PU had no tunneling (narrow opening that extends from the wound's surface into deeper tissue). The DON stated Resident 228's left hip PU had gotten worse because there was drainage and slough on the wound bed. The DON stated the wound bed for Resident 228's right hip unstageable PU was pale, red, moist, and surrounded with yellow slough. The DON stated the right hip unstageable PU had gotten worse due to the slough on the wound bed. During a concurrent interview with RN 3 and record review of Resident 228's TAR on 8/1/2024 at 2:34 PM, Resident 228's TAR for the right hip dated from 6/1/2024 to 7/31/2024 was reviewed. Resident 228's TAR indicated blank spaces on 7/6/2024,7/20/2024,7/21/2024,7/25/2024 and 7/29/2024. RN 3 stated Resident 228 missed treatment for the right hip open wound on 7/6/2024, 7/20/2024, 7/21/2024, 7/25/2024, and for unstageable PU on 7/29/2024. RN 3 stated five days of missed treatments would result in worsening of the PU. During a concurrent interview with the DON on 8/2/2024 at 8:14 AM and record review of Resident 228's PAWAN dated 7/24/2024, the DON stated the DON received the PAWAN dated 7/24/2024 from PA 1 in the morning of 8/2/2024. The DON stated PA 1 determined the PUs on Resident 228's left, and right hip were unstageable on 7/24/2024. The DON stated, TXN 1 notified MD 1 on 7/27/2024 (three days after the PA 1 assessed the PU on 7/24/2024) regarding Resident 228's right hip because the right hip PU had increased in size. The DON stated, not having the PAWAN for Resident 228 in Resident 228's medical record timely (assessment date) resulted in the delay in treatment for Resident 228's right and left hip unstageable PU and the PU got worsen. During a concurrent interview with the DON on 8/2/2024 at 11:40 AM, and record review of Resident 228's TAR for the right hip wound dated from 6/1/2024 to 7/31/2024 indicated blank spaces on 7/6/2024, 7/20/2024, 7/21/2024, 7/25/2024 and 7/29/2024. The DON stated, unfilled boxes on the TAR indicated treatment for the right hip open wound was not done on 7/6/2024, 7/20/2024, 7/21/2024, 7/25/2024, and 7/29/2024. The DON stated not providing treatment as ordered would result in the development of new PU and worsening of the current PU. The DON stated the DON was made aware of Resident 228's right unstageable PU on 7/29/2024 but was not aware the left hip unstageable PU worsened. The DON stated, the right hip PU could have been prevented by providing the wound treatment as ordered and implementing the CP. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview with TXN 3 on 8/2/2024 at 1:03 PM, TXN 3 stated TXN 3 accompanied PA 1 on 7/24/2024. TXN 3 stated orders were not initiated because staff were waiting for PA 1 to fax or email the PAWAN to the facility. TXN 3 stated the PA 1's notes should have been in Resident 228's chart. TXN 3 stated it was not acceptable for the TXNs (TXN 1 and TXN 3) to not provide treatment for three days. TXN 3 stated she did not follow up with PA 1 for the PAWAN when she did not receive the PAWAN from PA 1. TXN 3 stated the risk of delaying treatment would result in the development of new PU and or worsening of the current PU. During an interview with PA 1 on 8/2/2024 at 3:10 PM, PA 1 stated PA 1 assessed Resident 228 for treatment for the left and right hip wounds on 7/24/2024. PA 1 stated PA 1 was accompanied by TXN 3 and stated Resident 228 had an unstageable PU on the left and right hip. PA 1 stated PA 1 gave verbal orders to TXN 3 for repositioning Resident 228, cleaning the PUs with NS and Betadine, cover the PU with dry dressing. PA 1 stated the expectation for staff when receiving a verbal order was to implement the order as soon as possible (the same day). PA 1 stated PA 1 had computer glitches/email problems, so facility staff (DON) did not receive PA 1's PAWAN of Resident 228's PUs on the right and left hips until 8/2/2024. During a review of the facility's Policy and Procedure (P&P) titled, Pressure Injury Prevention and Management, the P&P indicated the facility will establish and utilize a systematic approach for pressure ulcer prevention and management, starting with a prompt assessment and treatment. The P&P indicated the attending physician will be notified of the presence, progression towards healing, or lack of healing upon identification of injuries. The P&P indicated interventions will be documented in the care plan and communicated to all relevant staff. 45064 2. During a review of Resident 231's AR, the AR indicated Resident 231 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnosis that included spinal stenosis (a tightening of the spinal canal that causes nerve pain), muscle weakness and cellulitis (infection of the skin and tissues) of the right and left lower extremities. During a review of Resident 231's Physician Orders (PO) dated 6/14/24, the PO indicated for Resident 231 to have LAL mattress for skin integrity maintenance. During a review of Resident 231's MDS dated [DATE], the MDS indicated the resident had severely impaired cognition. The MDS indicated, the resident was at risk of developing pressure ulcer (PU). The MDS indicated, Resident 231 required substantial/maximal assistance (helper did more than half the effort and lifted or held trunk or limbs) for toileting hygiene, showering/bathing self, upper and lower body dressing, putting on/taking off footwear, and personal hygiene. During a review of Resident 231's Monthly Weight Record (MWR) for the month of July 2024, the MWR indicated Resident 231 weighed 158 lbs. During an observation on 7/30/24 at 10:46 am in Resident 231's room, Resident 231's LAL mattress was set at 325 lbs. and in static mode. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an observation and interview on 7/30/24 at 10:48 am with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated Resident 231 was at high risk for PU and that the resident was unable to move independently in bed. LVN 1 stated, the current LAL mattress setting was set at 325 lbs. in static mode which was inaccurate setting for Resident 231 that could potentially cause PU for the resident. LVN 1 stated the LAL mattress setting needed to be set according to Resident 231's current weight of 158 lbs. During an interview on 8/2/24 at 10:35 am with the Director of Nursing (DON), the DON stated licensed nurses were responsible to check the LAL mattress setting every shift to ensure accurate setting for the residents. The DON stated the setting of the LAL mattress was based on the resident's current weight. The DON stated, static mode means the maximum firmness of the mattress, and only used during resident care such as transfer, or repositioning. The DON stated, inaccurate setting of the LAL mattress could potentially cause the resident to develop PU. During a review of the undated manufacturer's manual titled Alternating Pressure and Low Air Loss Mattress System, the manual indicated it was recommended to turn the pressure-adjust knob . adjust the air mattress to a desired firmness according to the patient's weight .In static mode, the mattress provides a firm surface that make it easier for the patient to transfer or reposition. During a review of the facility's undated P&P titled Use of Support Surfaces the P&P indicated, Support surfaces will be utilized in accordance with manufacturer recommendation. 40913 3. During a review of Resident 80's Face Sheet, the face sheet indicated the facility initially admitted the resident on 4/4/15 and readmitted the resident on 6/6/24, with diagnoses that included dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning) and dysphagia (difficulty swallowing.) During a review of Resident 80's MDS dated [DATE], the MDS indicated the resident had severe cognitive impairment. The MDS indicated Resident 80 was dependent with all activities of daily living. During a review of Resident 80's Skin and Wound Progress Notes indicated on 6/6/24, Resident 80 was readmitted to the facility with unstageable (Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar) wound on the sacrococcyx area and on 6/8/24, Resident 80's was assessed by the Wound Consultant and the wound was identified as a Stage 4 PU measuring 1 centimeter (cm) in length, 1 cm in width and 0.1 cm depth. During a review of Resident 80's TAR for the month of July 2024, the TAR indicated treatment order dated 7/17/24 to cleanse Resident 80's Stage 4 PU with normal saline, to pat dry and apply a wound gel and then cover with bordered gauze daily for 14 days. The TAR indicated from 7/17/24 to 7/24/24, the TAR was signed off, and treatment was provided. The TAR was blank from 7/25/24 to 7/30/24. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 8/1/24 at 3:45 pm, LVN 9 stated she did not remember performing wound care treatment to Resident 80. During a concurrent review of the TAR, LVN 9 stated she worked in the Red Zone (area of facility for residents on isolation precautions for COVID-19 [an illness caused by a virus that can spread from person to person]) on 7/31/24 but did not know about the pressure ulcer treatment for Resident 80. LVN 9 stated the signature on TAR would indicate the treatment was provided and if not signed the PU treatment was not provided. During a wound care observation on 8/1/24 at 4:12 pm, Treatment Nurse 3 (TXN 3) measured Resident 80's Stage 4 sacrococcyx PU which measured 0.5 cm in length, 0.5 cm in width and 0.6 cm in depth. During an interview on 8/2/24 at 10:00 am, LVN 7 stated she worked in the Red Zone on 7/30/24. LVN 7 stated she did not remember performing wound care treatment to Resident 80 when she was at the Red Zone. During a concurrent review of the TAR, LVN 7 stated she did not sign the TAR because she missed the wound care treatment for Resident 80. During an interview on 8/2/24 at 10:45 am, the Director of Nursing (DON) stated licensed staff (TXNs) needed to continue PU treatment in the Red Zone.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45064 Based on observation, interview and record review, the facility failed to ensure one of one sampled resident (Resident 42) received foot care in a timely manner. Resident 42's had unclean, yellow, and long toenails for both feet. This failure placed Resident 42 at risk for complications such as infection or injuries of the feet. Findings: During a review of Resident 42's Face Sheet (FS), the FS indicated, Resident 42 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included Chronic Kidney Disease (CKD- a condition characterized by a gradual loss of kidney function over time), dementia (progressive brain disorder that slowly destroys memory and thinking skills), and schizophrenia (a chronic and severe mental disorder that affects how a person thinks, feels, and behaves). During a review of Resident 42's History and Physical Examination (H&P) dated 6/21/2023, the H&P indicated Resident 42 had fluctuating capacity to understand and make decisions. During a review of Resident 42's Minimum Data Set (MDS-a standardized assessment and care planning tool) dated 5/4/2024, the MDS indicated, the resident had moderately impaired cognition (mental action or process of acquiring knowledge and understanding). The MDS indicated, the resident required set-up or clean up assistance (helper sets up or clean up; resident completes activity) for eating, oral hygiene, toilet hygiene, shower, upper/lower body dressing and personal hygiene. During a review of Resident 42's Comprehensive Podiatric Care, Inc. (CPC), the CPC indicated Resident 42 was seen by a Podiatrist on 5/21/2024. During a concurrent observation in Resident 42's room and interview on 7/30/2024 at 11:07 am, Resident 42 had yellow, unclean, long toenails on both feet. Resident 42 stated, Resident 42 wanted her toenails to be shorter, but no one trimmed her toenails. During an interview with LVN 1 in Resident 42's room, LVN 1 described Resident 42's toenails as yellow, thick, long and had dry skin around the toenails on both feet. LVN 1 stated, Resident 42's toenails needed to be shorter because ong toenails may potentially lead to injury or infection for the resident. During an interview on 8/1/2024 at 8:06 am with Social Services Designee 1 (SSD 1), SSD 1 stated, the maintenance for residents' toenails by the podiatrist was every three months and/or as needed. SSD 1 stated, the licensed nurses will inform SSD 1 if licensed nurses observe the residents' toenails were long and needed to be trimmed, so that SSD 1 would contact the podiatrist's office. The Director of Social Services (DSS) stated, Resident 42's last podiatry consult was done on 5/21/2024. DSS stated, Social Services was not notified by nursing staff about Resident 42's long toenails until 7/30/2024. During a review of facility's undated Policy and Procedure (P&P), titled, Nail Care, the P&P indicated, Nail care will be provided between scheduled occasions as the need arises.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40438 Based on observation, interview, and record review, the facility failed to ensure residents had an environment free from accident hazards (risks) for two of five sampled residents (Resident 80 and 100) by failing to: a. Implement the facility's Policy and Procedure (P&P) for smoking when Resident 100 was observed with a pack of cigarettes on 7/30/2024. b. Ensure proper positioning for Resident 80 during meals to prevent aspiration (when food/liquid accidentally enters a person's airway). These failures had the potential to result in accidents and hazards for Residents 80 and 100. Findings: a. During a review of Resident 100's Admission Records (AR), the AR indicated, Resident 100 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that included schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), schizoaffective disorder (a mental health condition including schizophrenia and mood disorder symptoms) and anxiety (a feeling of worry, nervousness or unease). During a review of Resident 100's Care Plan (CP), dated 4/4/2024, the CP indicated, Resident 100 was at risk for self-injury related to smoking. The CP interventions included to explain to the resident the facility's policy and procedures regarding smoking. The CP goals indicated Resident 100 would have minimal injuries to self and others, would be able to smoke safely and abide by house rules for smoking safely. During a review of Resident 100's Resident Smoking Assessment Form (RSAF), dated 4/4/2024, the RSAF indicated, Resident 100 was an unsafe smoker and must be supervised at all times when smoking. During a review of Resident 100's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 5/18/2024, the MDS indicated, Resident 100 had moderately impaired cognition (ability to understand) and required supervision or touching assistance (helper provided verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with oral hygiene, shower, upper and lower body dressing and moderate assistance (helper did less than half the effort) with toileting and personal hygiene. During a concurrent observation and interview on 7/30/2024 at 9:52 am with the licensed vocational nurse (LVN) 5 while inside Resident 100's room, Resident 100 was coming out of her room with a pack of cigarettes in her hands. LVN 5 stated residents were not allowed to have cigarettes in their possession and at the bedside because cigarettes were a fire risks and for the safety of the residents in the facility. LVN 5 stated the LVNs kept the cigarettes and passed to the CNAs when it was time for smoking. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/1/2024 at 10:55 am with the director of nursing (DON), the DON stated, cigarettes should stay with the LVNs, and given to the residents and lighted during smoking schedules in the designated place for smoking only for the safety of the residents in the facility. During a review of the facility's policy and procedure (P&P) titled, Resident Smoking Policy, revised date 5/5/2023, the P&P indicated, Smoking materials of residents requiring supervision with smoking will be maintained by nursing staff. 40913 b. During a review of Resident 80's AR, the AR indicated the facility initially admitted the resident on 4/4/2015 and readmitted the resident on 6/6/2024, with diagnoses that included dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning) and dysphagia (difficulty swallowing.) During a review of Resident 80's MDS dated [DATE], the MDS indicated the resident had severely impaired cognition. The MDS indicated Resident 80 was dependent with all activities of daily living. During an observation on 8/1/2024 at 12:30 pm, Certified Nursing Assistant 5 (CNA 5) was assisting Resident 80 with lunch. Resident 80 coughed twice. Resident 80 was positioned slightly above 45 degrees and the neck was hyperextended (leaning backwards). During an interview on 8/1/2024 at 12:35 pm, Registered Nurse 3 (RN 3) stated Resident 80's neck should not be hyperextended while eating. RN 3 assisted CNA 5 to reposition Resident 80 and adjusted the bed slightly higher and positioned the pillow to position the neck in the neutral position (normal head posture - head's weight is naturally balanced on the neck.) During an interview and record review on 8/2/2024 at 10:30 am, Resident 80's Physician Orders for July 2024 indicated an order for aspiration precautions and to elevate the head of the bed at 90 degrees during feeding. RN 3 stated this order was still active. RN 3 stated CNA 5 was a registry staff and was not aware about keeping the head of the bed at 90 degrees for Resident 80. RN 3 stated all staff is responsible to ensure residents were positioned correctly and safely during meals. During a concurrent review and interview on 8/2/2024 at 10:32 am, Resident 80's care plan for dysphagia dated 6/6/24 was reviewed. The care plan did not indicate proper positioning during meals for dysphagia. RN 3 stated proper positioning was important for residents with dysphagia. RN 3 stated the interventions regarding positioning needed to be included in Resident 80's plan of care for dysphagia and needed to be communicated to all the staff including registry staff. During a review of the facility's undated Policy and Procedure (P&P) titled Dysphagia - Clinical Protocol, the P&P indicated the Attending Physician and staff will carefully review all pertinent finding, including the resident's overall condition, prognosis, wishes, and nutritional status. The physician will address underlying conditions causing or contributing directly or indirectly to cough or difficulty eating, chewing, or swallowing; for example, treat esophagitis, address conditions affecting mental status or ability to eat appropriately, or reduce, change, or stop medications associated with dyspepsia, coughing, or dysphagia.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14330 Based on observation, interview and record review, the facility failed to provide necessary care to prevent Urinary Tract Infection ([UTI] an infection in any part of the urinary system [kidneys, bladders, ureters and urethral]) for two of two four residents (Residents 214 and 236) who had Foley catheter (a thin, sterile tube inserted into the bladder to drain urine), by failing to ensure: a. Licensed staff monitored Residents 214's urine output and notified the physician promptly for signs and symptoms of UTI. b. Licensed staff and/or Certified Nursing Assistant (CNA) positioned Resident 236's urine bag above the floor to prevent contamination of the urine. These deficient practices placed Residents 214 and 236 at risk for infection due to delayed treatment and contaminated urine when the urine bag was on the floor. Findings: a. During a review of Resident 214's Face Sheet (FS), the FS indicated the facility admitted Resident 214 on 6/10/24, with diagnoses that included diabetes mellitus (a condition that happens when the blood sugar is too high) and urinary retention. During a review of Resident 214's Physician Order Sheet (POS) dated 7/23/24, the POS indicated an order for Foley catheter attached to bedside drainage bag for urinary retention. During a review of Resident 214's Care Plan for the use of Foley catheter dated 7/24/24, the CP indicated nursing staff were to observe Resident 214's urine output for signs of UTI (cloudy or discolored urine, sediments, foul odor) and report changes in urine output to the physician. During observations on 7/30/24 at 10:45 a.m., and on 7/31/24 at 10:12 a.m., Resident 214 was lying on his back in bed, alert and coherent. Resident 214's Foley catheter was connected to a urine bag that contained slightly cloudy yellow urine output with moderate amount of urine sediments in the catheter tubing. Registered Nurse 2 (RN2) was present in Resident 214's room and RN2 also observed Resident 214's urine sediments. During a concurrent interview and record review on 7/31/24 at 2:43 p.m., there was no documented evidence that licensed staff monitored Residents 214's urine output and the physician was promptly notified for signs and symptoms of UTI. RN2 stated the physician was to be notified for any signs of UTI such as cloudy urine and/or urine sediments but she failed to do so. RN2 stated she got busy attending to other residents that she forgot to inform the physician of Resident 214's cloudy urine with sediments. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 7/31/24 at 3:01 p.m., CNA 6 stated he was only focused on checking the amount of Resident 214's urine output when he emptied the urine bag on 7/30/24 and 7/31/24. CNA 6 stated he did not check Resident 214's urine output for any changes in color or presence of sediments until RN2 instructed him to check the urine for sediments after lunch today (7/31/24). CNA 6 stated the Charge Nurse should be notified for any changes in Resident 214's urine output so that the physician would be informed immediately to prevent delayed treatment for Resident 214. 48905 b. During a review of Resident 236's Admission Record (AR), the AR indicated Resident 236 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included obstructive (back up of urine to the kidneys due to a blockage) and reflux uropathy (damage of kidneys from backward flow of urine) and benign prostatic hyperplasia (BPH-enlargement of the prostate gland blocking the flow of urine). During a review of Resident 236's History and Physical (H&P) dated 4/22/2024, the H&P indicated Resident 236 did not have the capacity to understand and make decisions. During a review of Resident 236's MDS dated [DATE], the MDS indicated Resident 236 had an indwelling/foley catheter. During a review of Resident 236's CP for foley catheter use dated 4/20/2024, the CP indicated to position the urinary bag below the level of the bladder to facilitate adequate drainage. During a concurrent observation and interview on 7/31/2024 at 8:45 AM with Certified Nursing Assistant 9 (CNA 9) in Resident 236's room, Resident 236's foley catheter bag and tubing was observed on the floor. CNA 9 stated the foley catheter bag and tubing were on the floor and was unsure if it should be on the floor. During an interview on 7/31/2024 at 8:46 AM with LVN 8, LVN 8 stated the foley catheter bag and tubing should not be on the floor because it would not be following infection prevention practices. LVN 8 stated having the foley catheter bag on the floor can put the resident at risk for bacteria to enter the bag and travel up the tubing or it could get caught on something and be accidentally pulled out. During an interview on 8/1/2024 at 7:56 AM with the Infection Prevention Nurse 2 (IPN 2- a nurse who helps prevent and identify the spread of infectious disease in the healthcare environment), IPN 2 stated foley catheter bags or tubing should not be on the floor because it would put the resident at risk of infection. During an interview on 8/2/2024 at 8:35 AM with Registered Nurse 3 (RN 3), RN 3 stated the foley catheter bag and tubing should not be touching the floor because the floor was dirty. RN 3 stated the resident would be at risk for infection because the foley catheter bag would be contaminated with what was on the floor. During a review of the facility's P&P titled, Catheter Care, Urinary revised 2023, the P&P indicated for staff to ensure the catheter bag and drainage bag are kept off the floor.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48905 Based on observation, interview, and record review, the facility failed to follow its policies and procedures (P&P) titled, Oxygen Administration, and Oropharyngeal Suction, for two of two sampled residents (Resident 67 and 653) by failing to: 1. Remove and/or replace the suction canister after use for Resident 67 when the suction canister contained moderate amount of thick, yellow sputum (secretion, a mixture of saliva and mucus produced by the lungs). 2. Date (label with a date) Resident 653's humidifier (used to increase the level of moisture for supplemental oxygen) when Resident 653 had an oxygen machine at the bedside. These findings had the potential to result in the use of expired respiratory items for Resident 653 and result in inaccurate monitoring of sputum/secretion for Resident 67. Findings: 1. During a review of Resident 67's Admission Record (AR), the AR indicated, the facility admitted Resident 67 to the facility on [DATE], and readmitted Resident 67 on [DATE], with diagnoses that included but were not limited to respiratory failure (condition where this is not enough oxygen in the body) and dysphagia (difficulty in swallowing). During a review of Resident 67's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated [DATE], the MDS indicated, Resident 67's cognitive abilities (ability to think, learn, and process information) were severely impaired. The MDS indicated, Resident 67 was dependent on staff for oral hygiene. During a review of Resident 67's Physician Telephone Orders (PTO), dated [DATE], the PTO indicated, Resident 67 had an order for suctioning for secretion build up as needed for 14 days. During a review of Resident 67's short term care plan (CP) titled, Secretion Build Up dated [DATE], the CP interventions included for staff to monitor Resident 67 for congestion/secretion buildup and suction as needed. During a concurrent observation and interview on [DATE] at 11:28 AM with Licensed Vocational Nurse (LVN) 6, in Resident 67's room, the suction canister bottle was observed with moderate amount of thick, yellow sputum at the bedside. LVN 6 stated the suction canister needed to be emptied after use. LVN 6 stated LVN 6 was unsure how long the sputum had been in the suction canister. LVN 6 stated the risk of not removing the used suction canister after use was inaccurate monitoring because staff would not know how long the sputum had been in the container. During an interview on [DATE] at 8:36 AM with Registered Nurse (RN) 3, RN 3 stated the suction canister needed to be removed and replaced as soon as it was used. RN 3 stated it (the suction canister with sputum) could place the resident at risk for infection because staff would not know how long the sputum had been there. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled, Oropharyngeal Suction, revised 2023, the P&P indicated, the suction bottle was cleaned every shift as well as changed every week and as needed. 2. During a review of Resident 653's AR, the AR indicated, the facility originally admitted Resident 653 to the facility on [DATE], and readmitted Resident 653 on [DATE], with diagnoses that included but are not limited to chronic obstructive pulmonary disease (COPD, obstructed airflow in the lungs) and asthma (airway becomes inflamed which makes it difficult to breathe). During a review of Resident 653's History and Physical (H&P, formal document of a medical provider's examination of a patient), dated [DATE], the H&P indicated, Resident 653's cognitive abilities were intact. During a review of Resident 653's Admission Orders (AO), dated [DATE] at 4:26 PM, the AO indicated, Resident 653 had an order for oxygen (O2, a treatment that provides extra oxygen to breathe in) two (2) liters (L, unit of measurement) via nasal cannula (NC, thin flexible tube that delivers oxygen through two prongs that go inside the nostrils) for 14 days as needed for shortness of breath or low oxygen level. During a review of Resident 653's short term CP for SOB and wheezing dated [DATE], the CP interventions included for staff to provide O2 as needed. During a concurrent observation and interview on [DATE] at 10:37 AM with LVN 8, in Resident 653's room, the oxygen machine was observed at the bedside with no date listed on the humidifier bottle. LVN 8 stated the humidifier bottle needed to be dated and stated the risk of the humidifier bottle being undated was that the resident could have an old humidifier bottle and would not receive the full benefit of O2 therapy. LVN 8 stated when the humidifier bottle was undated, staff would not know how long the bottle had been used and the date when the bottle would need to be changed. During an interview on [DATE] at 8:37 AM with RN 3, RN 3 stated when there was no date on the humidifier bottle, staff would not know how long the bottle had been used. RN 3 stated the resident would be at risk for inhaling old items. During a review of the facility P&P titled, Oxygen Administration the P&P indicated, oxygen was administered to residents who needed it, consistent with professional standards of practice. The P&P indicated, change the humidifier bottle when empty, every 72 hours or per facility policy, or as recommended by the manufacturer.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 40037 Based on observation and interview, the facility failed to post nursing staff data (the total number and actual hours worked by Registered Nurses, Licensed Vocational Nurses, and Certified Nurse Aides) on a daily basis at a place that was easy accessible for public review as required for one of six nursing stations (Station 1), at the beginning of each shift, which made the data unavailable to residents and visitors. This failure had the potential to give residents/visitors inaccurate staffing information and potentially affect the quality of care provided to the residents. Findings: During a facility tour and concurrent interview on 7/30/2024 at 11:59 am, with Director of Staff Development (DSD), there was no nursing staff data posted in Station 1, including its hallway. The DSD stated, the DSD did not post the nursing staff data in Station 1 and residents and visitors for Station 1 may review the facility's staffing information upon request only. The DSD stated residents and family members for Station 1 would not be able to see the posting in other nursing stations because it was in a separated area. The DSD stated, posting nursing staff data was important so residents and family members knew if the facility was staffing properly and if staffing was adequate. During an interview on 8/2/2024 at 9:48 am, the Administrator (ADM) stated staffing information should be posted daily at all nursing stations or hallway for easy public review including residents and family members. The ADM stated residents and family had the right to know the facility's staffing numbers each shift to determine if the facility had enough staff providing necessary care to all residents. The ADM stated this was a regulation requirement. During a review of the facility's undated Policy and Procedure titled Nurse Staffing Posting Information, the P&P indicated the information posted will be clear, readable and in a readily accessible area to residents and visitors.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. 40913 During an observation, interview, and record review, the facility failed to provide necessary interventions for one of one sampled resident (Resident 80) who had dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning). Resident 80 was calling out repeatedly from 8:30 am to 11:36 am on 8/1/24 without any help from staff. This deficient practice had the potential to not meet Resident 80's need such as pain, discomfort, hunger, thirst, or frustration. Findings: During a review of Resident 80's Face Sheet, the face sheet indicated the facility initially admitted the resident on 4/4/15 and readmitted the resident on 6/6/24, with diagnoses that included dementia and dysphagia (difficulty swallowing.) During a review of Resident 80's Minimum Data Set (MDS - a standardized assessment and care planning tool) dated 6/21/24, the MDS indicated the resident had severe cognitive (ability to understand) impairment. The MDS indicated Resident 80 was dependent with all activities of daily living. During an observation on 8/1/24 at different times: At 8:30 am and 9:10 am, Resident 80 was lying supine in bed, awake calling out and saying random words. At 9:29 am, Resident 80 was lying supine in bed, awake, calling out and saying random words. Licensed Vocational Nurse 10 (LVN 10) was standing in the hallway outside another resident's room where Resident 80 could be heard from where LVN 10 was standing. At 9:37 am, Resident 80 was calling out and saying random words. LVN 10 was outside in the hallway preparing to go inside the room across Resident 80's room. At 9:39 am, Resident 80 was calling out louder this time, saying random words. Certified Nursing Assistant 11 (CNA 11) passed by Resident 80's room. At 9:42 am, Resident 80 was calling out in random words. LVN 10 came out of the room across Resident 80's room. Resident 80 was still calling out loud and LVN 10 went to another room. At 9:46 am, Resident 80 was calling out in random words, CNA 11 passed by Resident 80's room to answer another resident's call light. At 10:00 am, CNA 11 repositioned Resident 80. CNA 11 stated Resident 80 was on turning schedule every two hours. CNA 11 did not check Resident 80's incontinent (inability to hold urine/bowel movement) pad. CNA 11 asked Resident 80 Are you okay?. Resident 80's oxygen tubing fell on the floor. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 10:13 am, LVN 10 went inside Resident 80's room to replace the oxygen tubing, LVN 10 did not ask or assess Resident 80's reason for the constant calling out. At 10:26 am, Resident 80 was calling out loud. Activities Staff (AS) passed by Resident 80's room to hand out coffee and tea to other residents. At 10: 48 am and 10:53 am, Resident 80 continued to call out loud in random words. At 11:36 am, Resident 80 continued to call out in random words. AS passed by Resident 80's room to provide room visits to other residents. During an interview on 8/1/24 at 3:15 pm, CNA 11 stated Resident 80 would call out all the time. CNA 11 stated Resident 80 would always say Come on or Stop it. CNA 11 did not answer when asked why she did not go to check on Resident 80 when the resident was calling out multiple times today (8/1/24). During an interview on 8/1/24 at 3:55 pm, LVN 10 stated she was passing medications, so she did not check Resident 80. LVN 10 stated when residents call out, they could be in pain, or the resident needed something from staff. LVN 10 stated LVN 10 should have checked and assessed Resident 80 to determine what Resident 80 needed. During a review of Resident 80's undated Care Plan (CP) on the risk for increasing confusion due to dementia, the CP indicated for staff to provide Resident 80 a pleasant interaction which reassures the resident when confused and to reorient the resident to the facility and room. During a review of the facility's undated Policy and Procedure (P&P) titled Dementia - Clinical Protocol the P&P indicated prominent symptoms of dementia may include reduction in alertness, appetite, attention span, function, and responsiveness, alternating agitation and lethargy, fluctuation in level of consciousness, hallucinations, and delusions. The staff and physician will evaluate individuals with new or progressive cognitive impairment and help identify symptoms and findings that differentiate dementia from other causes.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14330 Based on observation, interview and record review, the facility failed to ensure three of five sampled residents (Residents 22,198 and 210) on psychotropic drugs (any drugs that affects brain activities associated with mood, emotions, and behavior) were free from unnecessary medication. a. For Resident 198, licensed staff failed to attempt a gradual dosage reduction ([GDR] a stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued) for Resident 198's Risperdal (antipsychotic drug) 1 milligram ([mg] unit of measurement) and Lexapro (antidepressant drug) 10 mg since ordered on 6/8/21. b. For Resident 210, licensed staff failed to attempt a GDR for Resident 210's Lexapro 10 mg since ordered on 3/27/23. c. For Resident 22, licensed staff failed to monitor Resident 22's target behavior symptom and side effects every shift for the use of Ativan 1 mg (antianxiety drug). These deficient practices placed Residents 22, 198 and 210 at risk for adverse drug reaction (a harmful and unintended response to a medicine). Findings: a. During a review of Resident 198's Face Sheet (FS), the FS indicated the facility readmitted Resident 198 on 6/27/24, with diagnoses that included Alzheimer's disease (a type of dementia that affects memory, thinking, and behavior, severe enough to interfere with daily tasks), hypertensive heart disease (heart problems that occur because of high blood pressure present over a long time) and schizophrenia (a serious mental health condition that affects how people think, feel, and behave). During a review of Resident 198's Physician Order Sheet (POS) dated 6/27/24, the POS indicated licensed staff to give Risperdal 1 mg through gastrostomy tube ([GT] a tube inserted through the wall of the abdomen directed into the stomach) every 12 hours for schizophrenia as manifested by delusional thoughts (false belief) that he needs to go to work, and Lexapro 10 mg through GT, daily for depression as manifested by decreased social interaction with others. During a review of Resident 198's Medication Administration Record (MAR) for 7/1/24 through 7/31/24, the MAR indicated Resident 198 received Risperdal 1 mg every 9 a.m., and 9 p.m., and Lexapro 10 mg at 9 a.m. every day. During an observation on 7/30/24 at 10:58 a.m., Resident 198 was lying on his back in low bed with non-skid mat on the floor on both sides of the bed. Resident 198 was confused. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 7/31/24 at 4:08 p.m. with Registered Nurse 2 (RN2), Resident 198 's medical record indicated Resident 198's original admitted was on 6/8/21, with medication orders of Risperdal 1 mg every 12 hours for delusional thoughts that he needs to work and Lexapro 10 mg for decreased social interactions with others. Resident 198 was readmitted on [DATE], with Physician Order for Risperdal and Lexapro to give the same dosage for the same target behavior symptom. RN 2 stated GDR of Risperdal and Lexapro was not attempted since 6/8/21. Resident 198's medical record had no documented evidence of a past or recent failed attempt of GDR for Risperdal and Lexapro to medically justify it would be clinically contraindicated for Resident 198. During a review of the facility's Policy and Procedures (P&P) titled, Gradual Dose Reduction of Psychotropic Drugs dated as Revised 2023,the P&P indicated a resident who was admitted on a psychotropic medication or after the prescribing practitioner had initiated a psychotropic medication , the facility will attempt a GDR within the first year in two separate quarters (with at least one month between the attempts) unless clinically contraindicated. The P&P also indicated after the first year, the facility shall attempt GDR at least annually, unless clinically contraindicated. b. During a review of Resident 210's FS, the FS indicated the facility readmitted Resident 210 on 3/27/23, with diagnoses that included dementia (a general term for the impaired ability to remember, think, or make decisions that interferes with doing everyday activities) and diabetes mellitus (a condition that happens when the blood sugar is too high). During a review of Resident 210's POS dated 3/27/23, the POS indicated licensed staff to give Lexapro 10 mg for depression as manifested by decreased social interaction with others. During a review of Resident 210's MAR for 7/1/24 through 7/31/24, the MAR indicated Resident 210 received Lexapro 10 mg at 9 a.m. every day. During an observation on 7/30/24 at 10:50 a.m., Resident 210 was on left side lying position in low bed. Resident 210 was confused. During a concurrent interview and record review on 8/1/24 at 11:26 a.m. with RN2, RN 2 stated she was responsible for monitoring residents on psychotropic medications had GDR unless clinically contraindicated. RN 2 thought GDR of Lexapro was not indicated after several psychotropic medications had been discontinued for Resident 210. RN 2 stated GDR was necessary to determine if Resident 210's target behavior symptom could be managed by a lower dosage to prevent adverse drug reaction. RN 2 further stated limited interaction of Resident 210 with other residents was not an adequate indication for the continued use of an antidepressant drug (Lexapro) because it was Resident 210's preference not to socialize by staying in his room to watch television. 42781 c. During a review of Resident 22's Admission Record (AR), the AR indicated Resident 22 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included anxiety and dementia (long term and often gradual decrease in the ability to think and remember and severe enough to affect a person's daily functioning). (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 22's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 6/5/2024, the MDS indicated, Resident 22 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated, Resident 22 required supervision or touching assistance (helper provided verbal cues and/or touching/steadying and/or contact guard assistance as resident completed the activity) for eating, oral hygiene, and upper body dressing. The MDS indicated, Resident 22 required partial to moderate assistance (helper did less than half the effort and lifted or held trunk or limbs) with toileting hygiene, shower, lower body dressing and putting on and taking off footwear and personal hygiene. During a review of Resident 22's Physician Order (PO) dated 7/16/2024, the order summary report indicated to administer Ativan 1 milligrams (mg) tablet by mouth every eight hours for anxiety manifested by (m/b) yelling/screaming for no reason. The PO indicated to monitor for adverse side effects and target behavior of Ativan use every shift. During a concurrent interview and record review on 7/30/2024 at 11:34 a.m. with the Licensed Vocational Nurse 4 (LVN 4) there was no documented monitoring for Resident 22's target behavior for yelling and screaming for no reason and adverse side effect for the use of Ativan for the following dates: 1. 7/16/2024 from 3 pm to 11 pm shift. 2. 7/17/2024 from 3 pm to 11 pm shift. LVN 4 stated there was no other clinical documentation that Resident 22's target behavior and adverse side effect for the use of Ativan was monitored on 7/16/2024 and 7/17/2024 from 3pm to 11pm shift. During a concurrent interview and record review on 7/30/2024 at 12:16 p.m., with Registered Nurse 1 (RN 1), Resident 22's medical record was reviewed. RN 1 stated there was no documented monitoring for Resident 22's target behavior for yelling and screaming for no reason and adverse side effect for the use of Ativan on 7/16/2024 to 7/17/2024 from 3 p.m. to 11 p.m. shift. RN 1 stated, target behavior needed to be monitored every shift to know if the medication was effective. RN 1 stated adverse side effects needed to be monitored every shift to know if the medication was working properly and if it caused harm to Resident 22. During a concurrent interview and record review on 8/1/2024 at 3:41 p.m. with the facility's Director of Nurses (DON) of Resident 22's Medication Administration Record (MAR) dated 7/1/2024 to 7/31/2024 was reviewed. The DON stated there was no monitoring done for Resident 22's target behavior for yelling and screaming for no reason for Ativan use on 7/16/2024 to 7/17/2024 at 3 pm to 11 pm shift. The DON stated there was no monitoring for adverse side effect for Ativan use on 7/16/2024 to 7/17/2024 at 3 pm to 11 pm shift. The DON stated Resident 22's target behavior needed to be monitored and documented every shift as ordered to know if the medication was effective or not. The DON stated, the licensed nurses need to tally by hashmark and to not leave it blank. The DON stated, medication side effects need to be monitored and documented as ordered every shift because medications have certain side effects that are harmful to the residents. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled, Antipsychotic Medication Use, revised 2023, the P&P indicated, the staff will observe, document and report to the attending physician information regarding the effectiveness of any interventions, including antipsychotic medications. The P&P indicated, based on assessing the resident's symptoms and overall situation, the physician will determine whether to continue, adjust, or stop existing antipsychotic medication. The P&P indicated nursing staff shall monitor and report any side effects to the attending physician.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 47441 Based on observation, interview, and record review the facility failed to ensure kitchen staff were routinely trained and evaluated for competency skills when: a. Two of two staff (Dietary Aide 1 [DA 1] and the Dietary Account Manager [DAM]) failed to follow the manufacturer's guidelines for chlorine paper (a type of test strip) testing when checking the chlorine (a chemical used to disinfect dishes) sanitizer concentration. b. Staff failed to follow manufacturer's guidelines of smartpower sink and surface cleaner sanitizer (a solution used to sanitize kitchen surfaces) in two of two kitchens (Kitchen 1 and 2) by not checking temperature for testing solution. These failures had a potential to result to cross-contamination (a transfer of bacteria from one object to another), unsanitized dishware and bacterial growth on food that could lead to food borne illness (an illness caused by contaminated food and beverages) in 297 of 308 medically compromised residents who received food and ice from the kitchen. Findings: a. During a concurrent observation and an interview with DA 1 on 7/31/2024 at 8:40 am, DA 1 demonstrated chlorine testing and got a chlorine test strip from the container, dipped the test strip in the dish machine water, and shook the strip for 4 seconds then compared it to the color chart on the container. DA 1 stated the strip was 50 parts per million (ppm, describes concentration strength) and it was a good concentration. During concurrent observation and an interview with the DAM on 7/31/2024 at 8:52 am, the DAM demonstrated chlorine testing and got a chlorine test strip from the container then placed the test strip on the surface of the trays. The DAM struggled to get liquid solution for testing. The DAM stated the DAM needed to put the test strips directly on the wet plates or trays and not dip the strip on the water to follow the instructions of the DAM's boss. During a concurrent review of the chlorine test paper manufacturer's guidelines and interview with the DAM on 7/31/2024 at 8:55 am, the chlorine test paper indicated LOT 209224 (1) dip and remove, blot immediately with paper towel. Compare to the color chart. The DAM stated the facility did not follow the manufacturer's guidelines and it was important to follow the guidelines so that the reading of the chlorine concentration was accurate. The DAM stated the purpose of the chlorine was to disinfect the dishes and it might not be disinfecting dishes if the concentration was not accurate. The DAM stated the policy of the facility was to get the test strip and place it directly on the wet dishes and not directly in the water. The DAM stated this guideline was what the DAM used to train the staff. The DAM stated there was no difference between the water from the plate and the water in the dish machine. The DAM stated they were not dipping the strips in the water unless there were tons of water on the dishes. The DAM stated the [staff] did not follow manufacturer's guidelines or follow the facility's policy however the DAM needed to verify with her boss what the DAM needed to follow. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's job description titled Dietary Aide digitally signed by DA 1, dated 9/14/2023, indicated DA 1's essential functions of the job included, Is responsible for washing dishes after food service, as well as cleaning the kitchen to keep it sanitary and up to health standards. During an interview with the DAM on 7/31/2024 at 4:41 pm, the DAM stated there was no competency for DA 1. During review of the facility's job description titled Dining Services Director/Account Manager digitally signed by the DAM on 9/14/2023 indicated essential functions of the job included Interviews, hires, and orients dietary staff for the dietary department. Food preparation and safety. Ensures that established sanitation and safety standards are maintained. During an interview with the Registered Dietitian (RD) on 7/31/2024 at 4:41 pm., the RD stated there was no competency for the DAM because she had not been in the facility for a year. During a review of dietary in-service lesson plan and sign in sheet titled Dietary Department In-service dated July 2, 3, 5, 6, and 11 2024 indicated Testing (3). In order to test the dish machine sanitizer, dip end of strip in pool of water at end of cycle and remove quickly. Compare to chart immediately. Attendance sign in sheet indicated DA 1's signature. During a review of Food Code 2017 indicated 4-501.114 Manual and Mechanical Warewashing Equipment, Chemical Sanitation- Temperature, pH, Concentration, and Hardness. Verifying the adequacy of chlorine-based solutions can be accomplished on an on-going basis by confirming that the concentration, temperature, and pH of the sanitizing solutions comply with paragraphs 4-501.114 (A) using acceptable test methods and equipment. The manufacturer should provide methods (e.g. test strips, kits, etc.) to verify that the equipment consistently generates solution on-site at the necessary concentration to achieve sanitation. b. During an interview with the DAM on 7/31/2024 at 11:26 am, the DAM stated sanitizer was used to clean and sanitize kitchen surfaces and the facility used smart sink, surface cleaner, and sanitizer. The DAM stated they changed the red buckets (color indicates, the bucket contains sanitizing solution) every two hours, as needed, and checked the sanitizer concentration to ensure it was cleaning and sanitizing surfaces effectively. The DAM stated the potential outcome [not sanitizing effectively] would be cross-contamination to residents. During a concurrent observation and demonstration of sanitizer testing and an interview with [NAME] 2 on 7/31/2024 at 11:27 am, [NAME] 2 stated the purpose of the sanitizer was to disinfect kitchen surfaces. [NAME] 2 filled the red bucket with the sanitizing solution and dipped the test strip for 3 seconds (using a phone timer). [NAME] 2 stated [NAME] 2 dipped the test strip for 5 seconds by counting 1, 2,3,4, and 5 and compared the test strip to the color chart on the test strip canister. [NAME] 2 stated the concentration was 4. 3 and the concentration was acceptable. During a concurrent review of the smart power sink and surface cleaner sanitizer manufacturer's guidelines and interview with the DAM and the RD on 7/31/2024 at 11:30 am, the sanitizer manufacturer's guidelines posted on the wall indicated: 1. Testing solution should be above room temperature 65 F and above. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Withdrew a test strip from the canister. Dip test strip for 5 seconds in test solution. Shake off excess solution. 3. Compare colors after 10 seconds with colors on the test strip canister to determine concentration (oz/gal). Always compare against canister scale. 4. Testing solution should be between 272-700pm DDBSA. The DAM stated they did not check the testing solution temperature because maintenance staff checked the water temperature every morning hence, they do not check the temperature of the water solution. The DAM stated to talk and verify with the Director of Maintenance (DM) to verify water temperature checks. The RD stated the test strips manufacturer's guidelines did not indicate to test the temperature of the solution and the facility's vendor set up the station with a water temperature that was 65 F or above. The RD stated staff did not check the water temperature of the testing solution each time they check the sanitizer concentration. The RD stated the posted instruction of the sanitizer did not indicate to check the solution temperature when testing the sanitizer. The DAM stated they reported to maintenance when the test strips did not have the correct concentration because it meant the water temperature was not in the correct range and maintenance staff adjusted the water temperature. During an interview with the DM on 7/31/2024 at 11:48 am, the DM stated the facility checked water temperature once a month in the handwashing sink. The DM stated they checked the water temperature thoroughly only when there was a report that the water was not in the right temperature. During a concurrent review of the water temperature log and interview with the Maintenance Worker (MW) on 7/31/2024 at 12:08 pm, the MW stated the MW did not check the water temperature every day, instead the MW checked each building every other week however the MW did not record the results in the log to indicate which building the MW checked. During a review of the facility's log titled Sink and Surface Cleaner Sanitizer Solution Test for Kitchen 1 dated May 2024, June 2024 and July 2024 indicated the temperature for the testing solutions were not checked. During a review of the facility's log titled Sink and Surface Cleaner Sanitizer Solution test for Kitchen 2 dated May 2024, June 2024 and July 2024 indicated the temperature for the testing solutions were not checked. During an interview with the DAM on 7/31/2024 at 4:48 pm, the DAM stated the facility did not have a P&P for red and green buckets or for testing the sanitizer, however, the facility followed the manufacturer's guidelines. During a review of the facility's job description titled [NAME] digitally signed by [NAME] 2, dated 9/15/2023, indicated [NAME] 2's essential job functions of the job included Is responsible for washing dishes after food service, as well as cleaning the kitchen to keep it sanitary and up to health standards. During an interview with the DAM on 7/31/2024 at 4:48 pm, the DAM stated there was no competency for [NAME] 2. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of dietary in-service lesson plan and sign in sheet titled Dietary Department In-service dated July 2, 3, 5, 6 and 11 2024 indicated Testing Sanitizer Solution (4) Sanitizer solution should be at a temperature above 65 degrees Fahrenheit. Attendance sign in-sheet indicated no signature for [NAME] 2.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47441 Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices in two of two facility kitchen (Kitchen 1 and Kitchen 2) when: a. Freezer A bottom shelves had food debris, dust and gasket had dirt buildup.Freezer B vents had dust buildup. b. Reach-in refrigerator's vent had dust and dirt buildup in Kitchen 1. c. Stainless steel racks for kitchen utensil storage had rust. Stainless steel storage racks in the dry storage area had rust. Storage rack in Kitchen 2 had rust. d. Two (2) dented cans were stored with non-dented cans in Kitchen 1. One (1) dented can was stored with non-dented cans in Kitchen 2. e. The lids for the bulk container for oatmeal, thickener and flour had dirt buildup. f. Reach-in refrigerator in Kitchen 2 had ice buildup and dirt debris. g. Dry storage wooden racks in Kitchen 2 had farina cereal debris. h. [NAME] storage shelves in Kitchen 2 were not six (6) inches (in., unit of measurement) above the ground. i. Staff was wearing dangling and beaded bracelet while checking food for trayline and food handling. j. Staff were not following manufacturer's guidelines for Chlorine test paper when testing chlorine concentration for the dishmachine. k. Coffee dispenser spout (an opening where coffee was coming out) in Kitchen 1 had hard water buildup. l. Plate warmer had dirt debris. m. Juice dispenser rack had rust in Kitchen 1 n. Ten (10) resident's trays had cracked with exposed metal. o. Ice machine in Kitchen 1 had hard water buildup. Ice machine's internal parts in station 3 and 1 had slimy brownish build up and spout had dirt and hard water residues. p. Resident's refrigerator was at 42 degrees Fahrenheit (, [F] a scale of temperature). (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	q. Pans in Kitchen 2 had burned dirt debris. r. Kitchen utensils storage had food debris. s. Staff were not following manufacturer's guidelines for smartpower sink and surface cleaner sanitizer by not checking temperature for testing solution. These failures had the potential to result in harmful bacteria growth and cross contamination (transfer of harmful bacteria from one place to another) that would lead to foodborne illness (an illness caused by eating contaminated food) in 297 of 308 medically compromised residents who received food and ice from the kitchen. Findings: a. During an initial Kitchen 1 observation on 7/30/2024 at 9:34 am of Freezer A by the back area near the screen door, Freezer A bottom shelves had dust and gaskets had dirt buildup. During an initial Kitchen 1 observation on 7/30/2024 at 9:37 am of Freezer B's vents, the vents had dust and dirt buildup. During a concurrent observation of Freezers A and B and interview with the Dietary Account Manager (DAM) on 7/30/2024 at 9:56 am, the DAM stated there were a lot of food crumbs in the freezer and the vents were dusty and had black grease. The DAM stated it was important to maintain cleanliness of the freezer to prevent cross-contamination or any sickness from food, like foodborne illness. The DAM stated kitchen staff cleaned the freezer two times a week every Monday and Thursdays. During a review of facility's Policy and Procedure (P&P) titled Equipment dated 7/9/2024, the P&P indicated All food service equipment will be clean, sanitary, and in proper working order. (1) All equipment will be routinely cleaned and maintained in accordance with manufacturer's direction and training materials. (3) All food contact equipment will be cleaned and sanitized after every use. b. During an initial Kitchen 1 observation of the reach-in refrigerator where milk was stored on 7/30/2024 at 9:49 am, the reach-in refrigerator's vents had dirt buildup. During a concurrent observation of the reach-in refrigerator and interview with the DAM on 7/30/2024 at 10:04 am, the DAM stated the vent had dust buildup that would cause cross contamination and foodborne illnesses to the residents. During a review of the facility's P&P titled Equipment dated 7/9/2024, the P&P indicated (4) all non-food contact equipment will be clean and free of debris. During a review of Food Code 2017, the Food Code 2017 indicated 4-601.11 (A) Equipment Food Contact Surfaces and utensils shall be clean to sight and touch. (B) NonFood-Contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue and other debris. c. During an initial Kitchen 1 observation of the storage racks of the bowl and other utensils on 7/30/2024 at 9:52 am, two stainless steel racks and one stainless steel rack by the freezer had rust and amber discoloration. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation of the stainless-steel racks for storage and interview with the DAM on 7/30/2024 at 10:04 am, the DAM stated the racks were rusted. The DAM stated it was important to maintain the cleanliness of the rack and should be in good condition and repair of the racks to prevent foodborne illnesses that could cause the residents to get sick. During a concurrent observation of the stainless-steel racks at the dry storage area and interview with the DAM on 7/30/2024 at 10:13 am, the racks had rust. The DAM stated the racks needed to be clean and not rusted because this was associated with foodborne illnesses. During a concurrent observation of the racks in Kitchen 2 and interview with the DAM on 7/31/2024 at 11:19 am, the DAM stated the rack had rust and needed to be replaced to prevent cross-contamination. During a review of facility's P&P titled Equipment dated 7/9/2024, the P&P indicated (5) The Dinning Services Director will submit request for maintenance or repair to the Administrator and/or Maintenance Director as needed. d. During a concurrent observation of the dry storage area in Kitchen 1 and interview with the DAM on 7/30/2024 at 10:09 am, there were two dented cans found stored with undented cans. The DAM stated there was a separate area for dented cans and staff knew not to use them because it would cause infection to the residents. During a concurrent observation of the dry storage in Kitchen 2 and interview with the DAM on 7/30/2024 at 10:42 am, one white hominy can have a dent and stored with non-dented cans. The DAM stated the staff missed this (hominy can) dented can and it should be in the dented can area. During a review of the facility's P&P titled Receiving dated 7/9/2024, the P&P indicated All canned goods will be appropriately inspected for dents, rust, or bulges. Damaged cans will be segregated and clearly identified for return to vendor or disposal, as appropriate. A review of Food Code 2017 indicated 3-101.11 Safe Unadulterated, and Honestly Presented. Food shall be safe, unadulterated, and, as specified under 3-601.12, honestly presented. 3-201.11 Compliance with Food Law. A primary line of defense ensuring that food meets the requirements of S3-101.11 is to obtain food from approved sources, the implications of which are discussed below. However, it is also critical to monitor food products to ensure that, after harvesting, processing, they do not fail victim to conditions that endanger their safety, make them adulterated, or compromise their honest presentation. The regulatory community, industry, and consumers should exercise vigilance in controlling the conditions to which foods are subjected and be alert to signs of abuse. FDA considers food in hermetically sealed containers that are swelled or leaking to be adulterated and actionable under the Federal Food, Drug, and Cosmetic Act. Depending on the circumstances, rusted, and pitted or dented cans may also present a serious potential hazard. e. During an observation of the bulk condiment container and interview with the DAM on 7/30/2024 at 10:17 am, the condiment lids for flour, thickener and oatmeal had dirt buildup. The DAM stated kitchen staff cleaned the bulk condiment container every time they refill it, however, there was a buildup of dirt. The DAM stated it was important to clean the bulk condiment containers to prevent any growing bacteria and microorganisms. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	f. During an initial Kitchen 2 tour and interview with the DAM on 7/30/2024 at 10:34 am, there was an ice buildup on the freezer roof and door. The freezer bottom shelves had dirt debris. The DAM stated they cleaned the freezer and refrigerator in Kitchen 2 every Monday and Thursday and detail cleaned it once a month. The DAM stated they were having issues with the freezer as it did not meet the temperature and the ice buildup was something new to the DAM. The DAM stated it was important to have the freezer free from ice buildup due to the bacteria that would grow in it causing cross-contamination and food borne illnesses to the residents. During a review of the facility's P&P titled Environment dated 7/9/2024, the P&P indicated All food preparation areas, food service areas, and dining areas will be maintained in a clean and sanitary condition. g. During a concurrent observation of the dry storage area in Kitchen 2 and interview with the DAM on 7/30/2024 at 10:44 am, the DAM stated there was farina cereal food debris on the shelves. The DAM stated it was important to maintain the shelves clean so as not to attract rodents. During a review of the facility's P&P titled Food Storage: Dry Goods dated 7/9/2024, the P&P indicated (5) All packaged and canned food items will be kept clean, dry and properly sealed. h. During a concurrent observation of the wooden shelves in Kitchen 2 and interview with the DAM at 7/30/2024 at 10:46 am, the wooden shelves were not 6 in. off the floor. The DAM stated the shelves were wood, and it was not supposed to be wood because it was not cleanable, and it was also cracked. The DAM stated when a surface was cracked, bacteria could grow as it was not cleanable. The DAM stated shelves should be 6 in. off the floor so they could clean the bottom portion and rodents would not get to the food. The DAM stated rodents could transmit sickness to the residents. During a review of the facility's P&P titled Food Storage: Dry Goods dated 7/9/2024, the P&P indicated All items will be stored on shelves at least 6 inches above the floor. During a review of Food Code 2017, the Food Code 2017 indicated 3-305.11 Food Storage (A) Except as specified in (B) and (C) of this section, food shall be protected from contamination by storing the food: (3) at least 15 cm (6 inches) above the floor. i. During concurrent observation of the trayline on 7/30/2024 at 12:01 pm, Dietary Aide 3 (DA 3) was wearing dangling and beaded bracelets while checking food trays. During a concurrent observation of DA 3 and interview with the DAM on 7/30/2024 at 12:04 pm, the DAM stated wedding band and watches were allowed for the staff to wear in the kitchen and ensure nothing was hanging. The DAM stated it was important for the staff not to wear jewelries in the kitchen to prevent cross-contamination, as jewelries could go in the food. During an interview with the DAM on 7/30/2024 at 2:54 pm, the DAM stated kitchen staff were not allowed to wear jewelries in the kitchen. During a review of the facility's P&P titled Staff Attire, dated 7/9/2024, the P&P indicated (5) Hand jewelry will be limited to a plain band. Arm jewelry and dangling jewelry is not permitted. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Food Code 2017, the Food Code 2017 indicated 2-303.11 Prohibition. Except for a plain ring such as wedding band, while preparing food, food employees may not wear jewelry including medical information jewelry on their arms and hands. j. During concurrent demonstration of the chlorine testing and interview with DA 1 on 7/31/2024 at 8:40 am, DA 1 got a chlorine test strip from the container, dipped the test strip in the dishmachine water and shook the paper for four (4) seconds then compared it to the color chart. DA 1 stated the strip was at 50 parts per million (ppm, describes concentration strength) and it was a good concentration. During concurrent demonstration of the chlorine testing and interview with the DAM on 7/31/2024 at 8:52 am, the DAM got a chlorine test strip from the container then placed the test strip on the surface of the trays and struggled to get liquid solution for testing. The DAM stated she needed to put the test strips directly on the wet plats or trays and not dip it on the water. During a concurrent review of the chlorine test paper manufacturer's guidelines and interview with the DAM on 7/31/2024 at 8:55 am, chlorine test paper indicated LOT 209224 (1) dip and remove, blot immediately with paper towel. Compare to the color chart. The DAM stated they did not follow the manufacturer's guidelines and it was important to follow it so that the reading of the chlorine concentration was accurate. The DAM stated the purpose of the chlorine was to disinfect the dishes hence it might not be disinfecting dishes if the concentration was not accurate. k. During an observation of the coffee dispenser in Kitchen 1 on 7/31/2024 at 9:01 am, the coffee dispenser spout had dirt and hard water buildup. During an interview with the DAM on 7/31/2024 at 9:12 am, the DAM stated the coffee machine was supposed to be cleaned yesterday (7/30/2024) as they used the coffee machine daily. The DAM stated the coffee machine spout had a hard water buildup and needed to be cleaned to prevent cross-contamination. During a review of the facility's undated cleaning schedule titled Dish Cleaning Schedule the cleaning schedule indicated coffee machine was to be cleaned and sanitized in the afternoon. l. During an observation of the plate warmer on 7/31/2024 at 9:02 am, the bottom of the plate warmer where cleaned plates were stored had dirt and food debris. During an interview with the DAM on 7/31/2024 at 9:10 am, the DAM stated kitchen staff cleaned the plate warmer last week and she was aware that it was dirty. The DAM stated they needed to clean the plate warmer more often because bacteria could grow, and it could be fire hazard due to grease buildup. The DAM stated food borne illnesses could be a potential outcome for the residents. During an interview with the DAM on 7/31/2024 at 4:41 pm, the DAM stated there was no cleaning schedule for the plate warmer. m. During a concurrent observation of the juice dispenser rack and interview with the DAM on 7/31/2024 at 9:15 am. The DAM stated the juice dispenser racks had rust. The DAM stated she ordered a replacement from the vendor today as the shelves had rust and could cause bacterial growth. The DAM stated potential outcome for the residents would be foodborne illnesses. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled Environment, dated 7/9/2024, the P&P indicated The Dining Services Director will ensure that a routine cleaning schedule is in place for all cooking equipment, food storage areas, and surfaces. n. During a concurrent observation of the resident's trays used for breakfast service and interview with the DAM on 7/31/2024 at 9:17 am, ten (10) resident's tray had cracks with metal exposed. The DAM stated the tray needed replacement because bacteria could grow through the cracks and could cause food borne illnesses to the residents. During a review of Food Code 2017, the Food Code 2017 indicated 4-202.11 Food-Contact Surfaces. (A) Multiuse Food-contact surfaces shall be (1) Smooth (2) Free of breaks, open seams, cracks, chips, inclusions, pits, and similar imperfections. o. During a concurrent observation of the ice machine in Kitchen 1 and interview with the DAM on 7/31/2024 at 9:22 am, the DAM stated there was a white hard water residue in the internal parts of the ice machine and she told the Director of Maintenance (DM) however the hard water did not come off when they cleaned it. DAM stated the ice machine needed to be clean to prevent cross-contamination of ice. During an interview with the DM on 7/31/2024 at 9:25 am, the DM stated kitchen staff cleaned the ice machine on Monday (7/29/2024) however there was still hard water buildup, and it was not acceptable because bacteria could grow in the ice machine and residents consumed ice from it. During a concurrent observation of the ice machine in Station 3 and interview with Registered Nurse 3 (RN 3) on 7/31/2024 at 9:48 am, RN 3 stated the internal spout looked like rusted inside. RN 3 stated this was not acceptable as it would cause gastrointestinal ([GI], relating to stomach and intestines) symptoms like vomiting, diarrhea and upset stomach. RN 3 stated they used the ice machine for the residents who wanted ice, but they have not used it today. During an interview with the DM on 7/31/2024 at 9:52 am, the DM stated the ice machine in Station 3 was cleaned last Monday. The DM stated there was a buildup in the ice machine from the water and it could have been bacteria. The DM stated DM needed to descale and sanitize the internal parts of the ice machine. The DM stated the buildup in the ice machine was not acceptable because it could make the residents sick. The DM stated staff was supposed to report it to the DM. During an observation of the ice machine in Station 1 on 7/31/2024 at 10:18 am, the ice machine internal spout had dirt brownish debris. During an interview with Registered Nurse 4 (RN 4) on 7/31/2024 at 10:23 am, RN 4 stated the ice machine in Station 1 was for resident's use and the Certified Nursing Assistants (CNA) get ice for the residents when they needed refill of ice. During an interview with Certified Nursing Assistant 7 (CNA 7) on 7/31/2024 at 10:25 am, CNA 7 stated they got ice for the residents in the Nursing Station 1 however they have not used the ice machine this morning as the pitchers were still full of ice from last night's supply. CNA 7 stated night shift got ice from the Kitchen 1's ice machine. CNA 7 stated the inside part of the ice machine looked like it had a mildew and needed to be cleaned. CNA 7 stated it did not look sanitary and it could cause infection and residents could get sick as a potential outcome. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Certified Nursing Assistant 8 (CNA 8) on 7/31/2024 at 10:46 am in Station 3, CNA 8 stated they use Station 3's ice machine to refill the water pitchers with ice upon residents request however, he has not used the ice machine in Station 3 this morning. During a concurrent observation of the ice machine in Kitchen 2 and interview with the DAM at 7/31/2024 at 11:06 am, the ice scoop container had dust debris. The DAM stated they needed to clean the ice scoop container to prevent cross-contamination. During a review of the facility P&P titled Ice Machines and Ice Storage Chests dated 7/9/2024, the P&P indicated Ice machines and ice storage/distribution containers will be used and maintained to assure a safe and sanitary supply of ice. (f) Clean and sanitize the tray and ice scoop daily. (3) Our facility has established procedures for cleaning and disinfecting ice machines and ice storage chest which adhere to the manufacturer's instructions. The Infection Control Coordinator (or designee) maintains a copy of these procedures. p. During a concurrent observation of the resident's refrigerator in Station 3 and interview with RN 3 on 7/31/2024 at 9:34 am, the refrigerator thermometer was at 42 F. The refrigerator had dirt debris. RN 3 stated the refrigerator was not clean. RN 3 stated the resident's refrigerator temperature range was 36-46 F. RN 3 stated it was important to maintain the cleanliness of the refrigerators to prevent GI problem such as vomiting, abdominal pain for resident's storing food in the refrigerator. RN 3 stated it was important for the refrigerator temperature to be controlled so that the food would not spoil. RN 3 stated the refrigerator temperature was at the acceptable range. During a review of the facility's P&P titled Resident Refrigerator dated 7/9/2024, the P&P indicated 2) Maintenance staff shall record refrigerator temperatures weekly on a temperature log attached to the refrigerator. (b) Temperatures will be at 41 F, and freezer will be cold enough to keep foods frozen solid to touch (or in accordance with state regulations). If temperatures are out of range, maintenance staff shall notify nursing department to discard any foods that require refrigeration and take measures to remedy the problem. (3) Nursing/housekeeping staff shall clean the refrigerator weekly and discard any food that are out of compliance. Nursing staff shall clean up spills as needed or refer to housekeeping staff. During a review of Food Code 2017, the Food Code 2017 indicated 3-501.16 Time/Temperature for Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as a public health control as specified under 3-501.19, and except as specified under (B) and in (C) of this section, Time/Temperature Control for safety food shall be maintained: (2) At 5 C (41 F) or less. q. During an observation of the pans stored in Kitchen 2 and interview with the DAM on 7/31/2024 at 11:19 am, the pans had burned dirt buildup. The DAM stated they have new pans and would replace the pans with new and clean ones to prevent cross-contamination. During a review of the facility's P&P titled Equipment dated 7/9/2024, the P&P indicated All equipment will be routinely cleaned and maintained in accordance with manufacturer's directions and training materials. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Food Code 2017 the Food Code 2017 indicated 4-601.11 (A) Equipment Food Contact Surfaces and utensils shall be clean to sight and touch. 4-701.10 Food Contact Surfaces and Utensils shall be sanitized. 4-702.11 Before use After cleaning. Utensils and Food-Contact Surfaces of Equipment shall be sanitized before use after cleaning. r. During a concurrent observation of the kitchen utensils storage and interview with the DAM on 7/31/2024 at 11:25 am, the DAM stated food might have fallen during preparation of food and they needed to clean it to prevent cross-contamination. During a review of the facility's P&P titled Equipment dated 7/9/2024, the P&P indicated (4) All non-food contact equipment will be clean and free of debris. During a review of Food Code 2017, the Food Code 2017 indicated 3-307.11 Miscellaneous Sources of Contamination. Food shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301-3-306. s. During an interview with the DAM on 7/31/2024 at 11:26 AM, the DAM stated the sanitizer was used to clean and sanitize the kitchen surfaces and they used smart sink and surface cleaner and sanitizer. The DAM stated they changed the red buckets every two hours as needed and checked the sanitizer concentration to ensure it was cleaning and sanitizing surfaces effectively. The DAM stated the potential outcome to residents would be cross-contamination. During a concurrent demonstration of sanitizer testing and interview with [NAME] 2 on 7/31/2024 at 11:27 am, [NAME] 2 stated the purpose of the sanitizer was to disinfect kitchen surfaces. [NAME] 2 filled the red bucket with the sanitizing solution and dipped the test strips for three (3) seconds (using a phone timer). [NAME] 2 stated she dipped the test strip for 5 seconds by counting 1, 2, 3,4 and 5 and compared the test strip to the color chart. [NAME] 2 stated the concentration was 4.3 and it was acceptable. During a concurrent review of the smart power sink and surface cleaner sanitizer manufacturer's guidelines and interview with the DAM and RD on 7/31/2024 at 11:30 am, the sanitizer manufacturer's guidelines posted on the wall indicated: 1. Testing solution should be above room temperature 65 F and above. 2. Withdrew a test strip from the canister. Dip test strip for 5 seconds in test solution. Shake off excess solution. 3. Compare colors after 10 seconds with colors on the test strip canister to determine concentration (oz/gal). Always compare against canister scale. 4. Testing solution should be between 272-700pm DDBSA. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DAM stated they did not check the testing solution temperature as the maintenance staff checked the water temperature every morning hence, they do not check the temperature of the water solution. The DAM stated to talk and verify with the DM to verify water temperature checks. RD stated the test strips manufacturer's guidelines did not indicate to test the temperature of the solution and that their vendor set up the station with a water temperature that was 65 F or above. RD stated they did not check the water temperature of the testing solution each time they check the sanitizer concentration. RD stated the posted instruction of the sanitizer did not indicate to check the solution temperature when testing the sanitizer. The DAM stated they report to maintenance when the test strips did not test correctly because it meant the water temperature was not in the correct range and the maintenance staff then adjust the water temperature. During an interview with the DM on 7/31/2024 at 11:48 am, the DM stated they check water temperature once a month in the handwashing sink. The DM stated they checked the water temperature thoroughly only when there was report that the water was not in the right temperature. During a concurrent review of the water temperature log and interview with Maintenance Worker (MW) on 7/31/2024 at 12:08 pm, MW stated MW did not check the water temperature every day, instead MW checked each building every other week however MW did not record in the log which building MW checked. During a review of the facility's log titled Sink and Surface Cleaner Sanitizer Solution Test for Kitchen 1 dated May 2024, June 2024 and July 2024 the log indicated the temperature for the testing solutions were not checked. During a review of the facility's log titled Sink and Surface Cleaner Sanitizer Solution test for Kitchen 2 dated May 2024, June 2024 and July 2024 the log indicated the temperature for the testing solutions were not checked. During an interview with the DAM on 7/31/2024 at 4:48 pm, the DAM stated they do not have a P&P for red and green buckets and testing the sanitizer, however, they just followed the manufacturer's guidelines.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. 47441 Based on observation, interview, and record review, the facility failed to dispose garbage and refuse properly when: 1. Four of four gray trash bins located outside of Kitchen 1 area and one of two black trash bin was not completely covered and closed located outside of Kitchen 3. 2. The facility did not maintain the trash area free from trash, soiled gloves, and other dirt debris in two of three kitchen (Kitchen 1 and Kitchen 3) dumpster areas. This deficient practice had a potential to attract birds, flies, insects, and pest and the potential to result in the spread of infections to residents residing at the facility. Findings: 1. During a concurrent observation of the dumpster (a large metal trash container designed to be emptied into a truck) area located outside of Kitchen 1 building and interview with the Dietary Area Manager (DAM) on 7/30/2024 at 10:30 am, four of four gray trash bins were overflowing with trash and were not completely closed. The DAM stated the trash bins should be completely covered and this was not good because the trashes were exposed. The DAM stated this was not healthy for the residents. The DAM stated it was the janitor's responsibility to clean the [dumpster] area. During a concurrent observation of the dumpster area located outside Kitchen 3 building and an interview with the DAM on 7/30/2024 at 10:31 am, 1 of 2 gray trash bins was not completely closed. The DAM stated the trash was overflowing and was not completely closed. 2. During a concurrent observation of Kitchen 3's dumpster area and an interview with the DAM on 7/30/2024 at 10:51 a.m., the DAM stated there was one trash bag on the ground, soiled gloves, and trash in the surrounding areas. The DAM stated this was not good due to infection control. The DAM stated it was important to maintain cleanliness of the trash areas to prevent rodents and other bacteria from spreading. During a concurrent observation of Kitchen 1's dumpster area and interview with the DAM on 7/30/2024 at 10:54 am, there were soiled gloves, food residue, and other trash on the floor. The DAM stated the truck must have picked up the trash and the trash might have fallen onto the ground. (continued on next page)

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Environmental Services Manager (EVSM) on 7/31/2024 at 3:13 pm, the EVSM stated they have more trash that includes gowns from the red zone (cohorting [grouping patients infected or colonized with the same infectious agent] for residents who tested positive for COVID-19 [(Coronavirus, an infectious disease that can cause mild to severe respiratory illness and is a virus that spreads from person to person]) rooms. The EVSM stated the trashes were picked up every day except on Sunday with no schedule for time. The EVSM stated the trash bins should not be overflowing due to the smell and for sanitation purposes because overflowing trash could attract a lot of insects and rodents. The EVSM stated it was important for the area to [remain] clean to prevent insects, rodents, and diseases. The EVSM stated it was not acceptable for the bins to be open, overflowing, and for the surrounding areas to have trash and soiled gloves because residents could get sick and trash in the surrounding areas would cause an upset stomach, headaches, and nauseousness. During a record review of the facility's policies and procedures (P&P) titled Dispose of Garbage and Refuse dated 7/9/2024, indicated All garbage and refuse will be collected and disposed of in a safe and efficient manner. Procedures. (1) The Dinning Services Director coordinates with the Director of Maintenance to ensure that the area surrounding the exterior dumpster area is maintained in a manner free of rubbish or other debris. (2) The Dinning Service Director will ensure that: Appropriately lined containers are available within the food service area for disposal of garbage or other refuse. Appropriate lids are provided for all containers. During a review of Food Code 2017, indicated, 5-501.15 Outside receptacles. (A) Receptacles and waste handling units for REFUSE, recyclables, and returnable used with materials containing FOOD residue and used outside the FOOD ESTABLISHMENT shall be designed and constructed to have tight-fitting lids, doors, or covers. 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.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45382 Based on observation, interview, and record review, the facility failed to provide Speech Therapy (ST, profession aimed in the prevention, assessment, and treatment of speech, language, communicative, and swallowing disorders) evaluations in accordance with physician's orders for three of nine sampled residents (Residents 147, 198, and 280) who had swallowing, communication, and cognitive (ability to think, understand, learn, and remember) concerns. This deficient practice prevented Residents 147, 198, and 280 from receiving ST services to potentially improve swallowing, cognitive, and communication abilities and maintain or achieve the highest practicable level of function. Findings: a. During a review of Resident 147's Face Sheet, the Face Sheet indicated the facility initially admitted Resident 147 on 1/9/2018 and readmitted the resident on 6/21/2024 with diagnoses including encephalopathy (any damage or disease that affects the brain), cirrhosis (condition in which the liver is scarred and permanently damaged), and chronic obstructive pulmonary disease (COPD, lung disease that causes obstruction of airflow and can limit normal breathing). During a review of Resident 147's physician's orders, dated 6/21/2024, the physician's orders indicated Resident 147 was to receive no food or water by mouth (NPO) and used a gastronomy tube (G-tube, a tube placed directly into the stomach for long-term feeding) for nutrition. During a review of Resident 147's physician's orders, dated 6/21/2024, the physician's orders indicated for ST to evaluate Resident 147. During a review of Resident 147's Re-admission Therapy Screen, dated 6/24/2024, the Therapy Screen indicated ST received the physician's orders for a ST evaluation and skilled ST services (services that require specialized training and experience of a licensed therapist or therapy assistant) did not appear warranted. During a review of Resident 147's Minimum Data Set (MDS, an assessment and care-screening tool), dated 6/27/2024, the MDS indicated Resident 147 was severely cognitively impaired. The MDS indicated Resident 147 was usually able to express wants and ideas and had difficulty communicating some words or finishing thoughts. The MDS indicated Resident 147 was receiving nutrition through a G-tube. During an observation on 7/30/2024 at 10:44 a.m., in Resident 147's room, Resident 147 was lying in bed, sleeping, and receiving nutrition through a G-tube. (continued on next page)

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	056079	A. Building B. Wing	08/02/2024

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 8/1/2024 at 3:52 p.m. with the Director of Rehabilitation (DOR), the DOR confirmed Resident 147 had a physician's order for an ST evaluation on 6/21/2024. The DOR reviewed Resident 147's clinical record and stated Resident 147 received a Therapy Screen on 6/24/2024 and did not receive an ST evaluation as ordered by the physician. The DOR stated ST was supposed to follow physician's orders but did not. The DOR stated it was important physician's orders were followed and the residents received therapy evaluations as ordered to ensure the residents received the care and services they needed to reach their highest functional level. During a concurrent interview and record review on 8/2/2024 at 9:43 a.m. with the Speech Therapist 1 (ST 1), ST 1 stated ST services evaluated and treated residents per physician's orders with swallowing, communication, and cognitive disorders. ST 1 confirmed Resident 147 had a physician's order for an ST evaluation on 6/21/2024. ST 1 stated Resident 147 received a Therapy Screen on 6/24/2024 and did not receive an ST evaluation as ordered by the physician. ST 1 stated a Therapy Screen, and an ST evaluation were different. ST 1 stated a Therapy Screen consisted primarily of observation of the resident eating to determine if a comprehensive (complete, including all or nearly all elements or aspects of something) ST evaluation was needed. ST 1 stated the ST evaluation was a comprehensive assessment of the resident's ST needs which included eating and trialing different food textures with the goal of advancing the resident to the safest and most appropriate diet. ST 1 stated if the physician ordered an ST evaluation, an ST evaluation should have been done but was not. ST 1 stated if residents who had physician's orders for an ST evaluation did not receive it, it could potentially result in aspiration, delay in diet advancement, delay in care, and an indefinite NPO status. b. During a review of Resident 198's Face Sheet, the Face Sheet indicated the facility initially admitted Resident 198 on 6/8/2021 and readmitted the resident on 6/27/2024 with diagnoses including dysphagia (difficulty swallowing) and G-tube malfunction. During a review of Resident 198's physician's orders, dated 6/27/2024, the physician's orders indicated Resident 198 was NPO. During a review of Resident 198's physician's orders, dated 6/27/2024, the physician's orders indicated for ST to evaluate Resident 198. During a review of Resident 198's Re-admission Therapy Screen, dated 6/28/2024, the Therapy Screen indicated skilled ST services did not appear warranted. During a review of Resident 198's MDS dated [DATE], the MDS indicated Resident 198 was severely cognitively impaired. The MDS indicated Resident 198 had unclear speech and was receiving nutrition through a G-tube. During an observation on 7/30/2024 at 10:51 a.m., in Resident 198's room, Resident 198 was lying in bed and receiving nutrition through a G-tube. Resident 198 was awake, alert with both eyes open, and did not speak when spoken to. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 8/1/2024 at 3:52 p.m. with the Director of Rehabilitation (DOR), the DOR confirmed Resident 198 had a physician's order for an ST evaluation on 6/27/2024. The DOR reviewed Resident 198's clinical record and stated Resident 198 did not receive an ST evaluation as ordered by the physician. The DOR stated ST was supposed to follow physician's orders but did not. The DOR stated it was important physician's orders were followed and the residents received therapy evaluations as ordered to ensure the residents received the care and services they needed to reach their highest functional level. During a concurrent interview and record review on 8/2/2024 at 9:43 a.m. with ST 1, ST 1 stated ST evaluated and treated residents per physician's orders with swallowing, communication, and cognitive disorders. ST 1 confirmed Resident 198 had a physician's order for an ST evaluation on 6/27/2024. ST 1 reviewed Resident 198's clinical record and confirmed Resident 198 did not receive an ST evaluation as ordered by the physician. ST 1 stated if the physician ordered an ST evaluation, an ST evaluation should have been done but was not. ST 1 stated if residents who had physician's orders for an ST evaluation did not receive it, it could potentially result in aspiration, delay in diet advancement, delay in care, and an indefinite NPO status. c. During a review of Resident 280's Face Sheet, the Face Sheet indicated the facility admitted Resident 280 on 5/30/2024 with diagnoses including dysphagia, metabolic encephalopathy, and COPD. During a review of Resident 280's physician's orders, dated 5/30/2024, the physician's orders indicated Resident 280 was on a pureed diet (texture modified diet that involves eating soft foods that can be swallowed and digested without chewing). During a review of Resident 280's physician's orders, dated 5/30/2024, the physician's orders indicated for ST to evaluate Resident 280. During a review of Resident 280's Re-admission Therapy Screen, dated 5/31/2024, the Therapy Screen indicated skilled ST services did not appear warranted. During a review of Resident 280's physician's orders, dated 6/3/2024 and signed by a Registered Nurse (unidentified), the physician's orders indicated for ST to discontinue ST evaluation orders. During a review of Resident 280's MDS dated [DATE], the MDS indicated Resident 198 was severely cognitively impaired. The MDS indicated Resident 280 was dependent for eating and was on a mechanically altered diet (requires a change in texture or liquids). During an observation and interview on 7/30/2024 at 10:32 a.m., in Resident 280's room, Resident 280 was lying in bed. Resident 280 stated she required assistance with feeding and ate soft foods at the facility. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 8/1/2024 at 3:52 p.m. with the Director of Rehabilitation (DOR), the DOR confirmed Resident 280 had a physician's order for an ST evaluation on 5/30/2024. The DOR confirmed Resident 280 had an order to discontinue the ST evaluation on 6/3/2024 which was signed by a Registered Nurse, not the physician. The DOR reviewed Resident 280's clinical record and stated Resident 280 received a ST Therapy Screen and did not receive an ST evaluation per physician's order. The DOR stated ST was supposed to follow physician's orders but did not. The DOR stated it was important physician's orders were followed and the residents received therapy evaluations as ordered to ensure the residents received the care and services they needed to reach their highest functional level. During a concurrent interview and record review on 8/2/2024 at 9:43 a.m. with ST 1, ST 1 stated ST evaluated and treated residents per physician's orders with swallowing, communication, and cognitive disorders. ST 1 confirmed Resident 280 had a physician's order for an ST evaluation on 5/30/2024. ST 1 stated ST 1 performed a Therapy Screen for Resident 280 but did not perform an ST evaluation. ST 1 stated a Therapy Screen, and an ST evaluation were different. ST 1 stated a Therapy Screen consisted primarily of observation of the resident eating to determine if a comprehensive ST evaluation was needed. ST 1 stated the ST evaluation was a comprehensive assessment of the resident's ST needs which included eating and trialing different food textures with the goal of advancing the resident to the safest and most appropriate diet. ST 1 stated ST 1 wrote the physician's order to discontinue the ST evaluation on 6/3/2024, notified a Registered Nurse, and did not notify the physician. ST 1 stated if the physician ordered an ST evaluation, an ST evaluation should have been done but was not. ST 1 stated she should have notified the physician that the ST evaluation was not done, and the ST evaluation order was discontinued but did not. ST 1 stated if residents who had physician's orders for an ST evaluation did not receive it, it could potentially result in aspiration, delay in diet advancement, delay in care, and an indefinite NPO status. During a review of the facility's Policy and Procedure (P/P) titled, Speech-Language Pathologist, dated 2/19/2021, the P/P indicated the ST duties and responsibilities included to Follow relevant physician's orders for evaluation and treatment. During a review of the facility's undated P/P titled, Specialized Rehabilitative Services, the P/P indicated the facility provided or obtained services from an outside resource for specialized rehabilitative services, which included Speech-Language Pathology, if required by the resident's comprehensive assessment and care plan. The P/P indicated specialized rehabilitative services would be provided under the written order of a physician by qualified personnel.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40037 Based on interview and record review, the facility failed to ensure for one of three sampled residents (Resident 250) who signed the Resident-Facility Arbitration Agreement (AA, a Binding Arbitration Agreement requires the person who signed it resolve any dispute by binding arbitration, rather than in court) on 1/1/2024 had the capacity to understand and make decisions. This failure had the potential risk to result in Resident 250 to not be able to make an informed decision and/or his rights to be denied. Findings: During a review of Resident 250's Face Sheet (FS), the FS indicated Resident 250 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including bipolar disorder (a mental health condition that causes extreme mood swings that include emotional highs and lows), psychosis (a mental disorder characterized by a disconnection from reality), and dysphagia (difficulty swallowing foods or liquids). During a review of Resident 250's History and Physical (H&P) dated 5/20/2024, the H&P indicated Resident 250 had fluctuating capacity (a person's ability to make a specific decision change frequently) to understand and make decisions. During a review of Resident 250's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 5/23/2024, the MDS indicated Resident 250 had moderately impaired cognitive skills (the ability to make daily decisions). The MDS indicated Resident 250 required setup or clean-up assistance (helper sets up or cleans up; resident completes activity) on staff for chair/bed-to-chair transfer. During a concurrent interview and record review on 8/13/2024 at 9:13 am with Resident 250, Resident 250's AA signed on 1/1/2024 was reviewed. Resident 250 stated, it was Resident 250's signature on the AA but Resident 250 did not know what the AA form was. Resident 250 did not remember if anyone explained the AA to Resident 250. During an interview on 8/2/2024 at 9:48 am, the Administrator (ADM) stated, Resident 250 was sometimes confused and did not have full capacity to make decisions. The ADM stated, the facility should not have Resident 250 signed the AA and Resident 250's responsible party should sign if he/she wanted to. The ADM stated, the AA should be fully explained and understood by resident or responsible party before they sign it. The ADM stated, Resident 250's AA was an invalid document, and it was a violation of resident's right. During a review of the facility's Policy and Procedure (P&P) titled Binding Arbitration Agreements, revised 2023, the P&P indicated When explaining the arbitration agreement, the facility shall ensure the resident or his or her representative acknowledges that he or she understands the agreement.

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F 0848 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide a neutral and fair arbitration process and agree to arbitrator and venue. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40037 Based on interview and record review, the facility failed to ensure its Resident-Facility Arbitration Agreement (AA, a Binding Arbitration Agreement requires the person who signed it resolve any dispute by binding arbitration, rather than in court) included selection of a venue convenient to both facility and residents and resident's responsible party for three of three sampled residents (Residents 250, 294 and 402). These deficient practices placed Residents 250, 294 and 402 at risk for unjust arbitration and delayed arbitration hearing in an event of an arbitration dispute. Findings: a. During a review of Resident 250's Face Sheet (FS), the FS indicated Resident 250 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including bipolar disorder (a mental health condition that causes extreme mood swings that include emotional highs and lows), psychosis (a mental disorder characterized by a disconnection from reality), and dysphagia (difficulty swallowing foods or liquids). During a review of Resident 250's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 5/23/2024, the MDS indicated Resident 250 had moderately impaired cognitive skills (the ability to make daily decisions). The MDS indicated Resident 250 required setup or clean-up assistance (helper sets up or cleans up; resident completes activity) on staff for chair/bed-to-chair transfer. b. During a review of Resident 294's FS, the FS indicated Resident 294 was admitted to the facility on [DATE] with diagnoses including dementia (loss of memory, language, problem-solving and thinking abilities) and dehydration (loss of body fluid). During a review of Resident 294's MDS dated [DATE], the MDS indicated Resident 294 had moderately impaired cognitive skills. The MDS indicated Resident 294 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) for eating and chair/bed-to-chair transfer. c. During a review of Resident 402's FS, the FS indicated Resident 402 was admitted to the facility on [DATE] with diagnoses including traumatic brain injury (brain dysfunction caused by outside force) and history of mental and behavioral disorders. During a review of Resident 402's MDS dated [DATE], the MDS indicated Resident 402 had moderately impaired cognitive skills. The MDS indicated Resident 402 required setup or clean-up assistance (helper sets up or cleans up; resident completes activity) for eating and chair/bed-to-chair transfer. (continued on next page)

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F 0848 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and concurrent record review on 8/2/2024 at 9:48 am with the Administrator (ADM), the ADM stated, the AA for Residents 250, 294 and 402 did not have a written language that the AA had provided for selection of a venue that is convenient to both parties. The ADM stated the facility's policy for AA did not indicate the facility was required to provide selection of a venue that was convenient to both parties that entered AA. The ADM stated, the facility should update its AA form and the policy for binding arbitration agreement. During a review of the facility's Policy and Procedure (P&P) titled Binding Arbitration Agreement, revised 2023, the P&P did not indicate the facility needed to provide selection of a venue that was convenient to both parties per regulatory requirement.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. 40913 Based on interview and record review for one of three sampled residents (Resident 80) on hospice care (medical service designed to give supportive care to people in the final phase of a terminal illness and focus on comfort and quality of life), the facility failed to ensure: a. Documentation of services provided by the Hospice Health Aide (HHA) to Resident 80 during HHA visits. b. Accurate documentation of hospice Licensed Vocational Nurse visits. c. Hospice Licensed Nurse visits were implemented in accordance with the hospice physician's order. Findings: During a review of Resident 80's Face Sheet, the face sheet indicated the facility initially admitted the resident on 4/4/15 and readmitted the resident on 6/6/24, with diagnoses that included dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning) and dysphagia (difficulty swallowing.) During a review of Resident 80's Minimum Data Set (MDS - a standardized assessment and care planning tool) dated 6/21/24, the MDS indicated the resident had severe cognitive (ability to understand) impairment. The MDS indicated Resident 80 was dependent with all activities of daily living. a. During a review of the Hospice and Nursing Facility Services Agreement dated 6/14/24, the agreement indicated on the Delineation of Nursing and Aid Services, the Hospice Health Aide responsibilities included the completion of assignment as indicated by Hospice RN and the provision of a copy of the completed assignment form to the facility and communication of care provided. During a review of the Hospice and Nursing Facility Services Agreement dated 6/14/24, the agreement indicated HHA services included provision of personal care to patients including bathing, dressing, grooming and provision of diversional activities. During a concurrent record review and interview on 8/1/24 at 3:25 pm, Resident 80's Certified Hospice Health Aide (CHHA) Flow Sheet indicated the dates of the visit were from 6/20/24 to 7/31/24 with a written note indicating regular visit written on 6/20/24. The Flow Sheet did not indicate the care provided to Resident 80. Registered Nurse 3 (RN 3) stated the Hospice Book designated for Resident 80 contained all the documents related to Resident 80. RN 3 stated the HHA needed to document the care and services provided since the Hospice Book would be the communication between the Hospice and the facility. b. During a review of the Hospice and Nursing Facility Services Agreement dated 6/14/24, the agreement indicated nursing care is provided by or under the supervision of a registered nurse. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent record review and interview on 8/1/24 at 3:28 pm, Resident 80's Hospice Licensed Vocational Nurse (LVN) Flowsheet indicated LVN visit was completed on 6/17/24 and there were four documented vital signs after the 6/17/24 visit. The four documented vital signs did not have a date written. RN 3 stated the only visit completed was on 6/17/24 and the facility could not use the documented vital signs as proof of LVN visits because there was no documented date. RN 3 stated the Hospice Agency (HA) staff needed to document accurately the care provided and the Hospice LVN needed to document Resident 80's response to care provided. RN 3 stated documentation of hospice visits needed to be on Resident 80's chart or on Resident 80's designated Hospice Book. c. During a concurrent record review and interview on 8/1/24 at 3:30 pm, Resident 80's Hospice Licensed Vocational Nurse (LVN) Flowsheet indicated LVN visit was completed on 6/17/24 and there were four documented vital signs after the 6/17/24 visit. Registered Nurse 3 stated LVN visits was not completed according to the hospice visit calendar provided by Hospice Agency 1 (HA 1) and according to the physician's orders. RN 3 stated the only documented visit was on 6/17/24. During a review of Resident 80's hospice Physician Order dated 6/14/24, the physician's order indicated for skilled nurse visits two times a week to promote comfort and symptom management. During a review of the facility's undated Policy and Procedure (P&P) titled Coordination of Hospice Services, the P&P indicated the facility will communicate with Hospice and identify, communicate, follow, and document all interventions put into place by Hospice and the facility. The facility will maintain communication with Hospice as it relates to the resident's plan of care and services to ensure each entity is aware of their responsibilities.

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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** 45064 Based on observation, interview and record review, the facility failed to: a. Dispose soiled gauze in a safe and sanitary method in one of one resident's room (Resident 191's room). b. Ensure one of one Restorative Nursing Aide (RNA 1) removed an isolation gown (protective apparel used to protect the wearer from the transfer of microorganisms and body fluids) and gloves and performed hand hygiene after exiting Resident 147's room and entering the hallway during an Restorative Nursing Aide (RNA, nursing aide program that help residents maintain any progress made after therapy intervention to maintain their function) session with Resident 147 who was on Contact Isolation Precautions (procedures to reduce risk of spread of infections through direct or indirect contact). c. Follow the facility's policy on COVID-19 (highly contagious respiratory disease caused by the SARS-CoV-2 virus that is spread through droplets when an infected person coughs, sneezes, or talks) and Public Health Nurse (PHN) COVID-19 guidance for residents in Station 2 and Station 3 yellow zones (isolation zones for new admissions, exposed, or symptomatic residents awaiting confirmation of COVID-19 test results) when staff were observed to not don (put on) on full PPE when entering a Novel Precaution Room (newly identified respiratory organism that causes acute respiratory infections which require the use of a N95 [PPE that is used to provide a tight seal on the person's face to prevent particles or liquid contamination of the face], face shield, gown and gloves prior to entering the room) on 7/30/2024. These violations had the potential to spread diseases and infection to all residents, staff and vistors. Findings: a. During a review of Resident 191's Face Sheet (FS), the FS indicated, Resident 191 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses included anemia (low red blood cells), Alzheimer's disease (a brain disorder that destroys memory and other important mental functions), and muscle weakness. During a review of Resident 191's Minimum Data Set (MDS-a standardized assessment and care planning tool) dated 6/26/2024, the MDS indicated, Resident 191 had severely impaired cognitive (ability to think and process information) skills. During a concurrent observation and interview on 7/30/2024 at 12:24 PM with Licensed Vocational Nurse (LVN 1), a soiled gauze dressing placed next to Resident 191's head on the right side of the bed. LVN 1 stated, the soiled gauze dressing should be dispose and that might be left by the wound doctor (unidentified) this morning. LVN 1 stated, the dirty gauze dressing placing next to the resident which may cause the spread of infection because the gauze was soiled and contaminated. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/1/2024 at 7:46 am with Infection Prevention Nurse 1 (IPN 1), the IPN 1 stated the soiled gauze was left on the bed next to Resident 191 indicated that whoever changing the resident wound did not clean up afterward which can potentially spread infection to the resident. IPN 1 stated, the expectation that staff follow proper infection control protocol, leave the area clean after a wound treatment and discard soiled gauze dressing appropriately. 45382 b. During a review of Resident 147's Face Sheet, the Face Sheet indicated the facility initially admitted Resident 147 on 1/9/2018 and readmitted the resident on 6/21/2024 with diagnoses including encephalopathy (any damage or disease that affects the brain), cirrhosis (condition in which the liver is scarred and permanently damaged), and chronic obstructive pulmonary disease (lung disease that causes obstruction of airflow and can limit normal breathing). During a review of Resident 147's physician's orders, dated 7/26/2024, the physician's orders indicated Resident 147 was placed on Contact Isolation precautions. During an observation on 08/1/2024 at 8:57 a.m., in the hallway in front of Resident 147's room, a sign on the wall indicated all persons who entered the Contact isolation room were to clean their hands before entering the room and when leaving the room, put on gloves and an isolation gown before entering the room, and discard gloves and isolation gown before exiting the room. During a concurrent observation and interview on 08/1/2024 at 8:59 a.m., in Resident 147's room, RNA 1 and Restorative Nursing Aide 2 (RNA 2) were observed wearing contact isolation gowns, gloves, and N-95 mask respirators (a respiratory protective device designed to achieve a very close facial fit and very efficient filtration of airborne particles) while assisting Resident 147 move from the bed to a wheelchair. Once Resident 147 was seated in the wheelchair, RNA 1 transported Resident 147 out of the room and into the hallway while wearing the same isolation gown and gloves and did not perform hand hygiene. RNA 1 confirmed he exited Resident 147's room and entered the hallway without performing hand hygiene and removing his isolation gown and gloves. RNA 1 stated he was supposed to perform hand hygiene and remove both the isolation gown and gloves before exiting the room to prevent the spread of infection since Resident 147 was on Contact Isolation Precautions but did not. During an interview on 8/2/2024 at 11:19 a.m., the Infection Preventionist Nurse (IPN) stated the proper 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 must be worn before entering a resident's room and discarded before exiting a resident's room who was on Contact Isolation Precautions. The IPN stated hand hygiene must be performed before entering a resident's room and before exiting a resident's room for residents on Contact Isolation Precautions. The IPN stated it was important all staff followed the appropriate infection control procedures when working with residents on Contact Isolation Precautions to prevent cross contamination and the spread of infection. During an interview on 8/2/2024 at 12:24 p.m., the Director of Nursing (DON) stated it was important staff followed the appropriate infection control procedures when working with residents in the facility to prevent the spread of infection. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056079	A. Building B. Wing	08/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glendora Grand, Inc	805 W. Arrow Hwy. Glendora, CA 91740

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's undated Policy and Procedure (P/P) titled, Transmission-Based Precautions, the P/P indicated the facility would take appropriate precautions to prevent the transmission of infectious agents. The P/P indicated Contact Precautions were intended to prevent transmission of infectious agents which were spread by direct or indirect contact with the resident or the resident's environment. The P/P indicated donning PPE upon room entry and discarding before exiting the room was done to contain pathogens, especially those that have been implicated in transmission through environmental contamination. During a review of the facility's P/P, titled Infection Prevention and Control Program, revised 2023, the P/P indicated the facility established and maintained an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The P/P indicated all staff were responsible for following all policies and procedures related to the program. 48905 c. During a record review of the guidance from the Public Health Nurse (PHN) dated 7/23/2024 at 1:13 PM, the PHN guidance indicated yellow zone rooms require the purple sign, a sign indicating the room is an exposure, place carts with PPE inside, and staff to wear full PPE for each yellow zone patient. During an observation on 7/30/2024 at 9:54 AM in Station 2 hallway, PPE carts were observed outside in the hallway with no face shields inside. During an interview on 7/30/2024 at 9:54 AM with IPN 2, IPN 2 stated staff members in the yellow zone did not require the use of a face shield when entering a COVID-19 precaution room. During an observation on 10:03 AM in the hallway on Station 2 in front of room [ROOM NUMBER], a purple sign that indicated Stop, Novel Respiratory Precautions was observed outside room [ROOM NUMBER] and indicated on room entry to clean hands, wear a gown, an N-95 and face shield or goggles, gloves, and clean hands when exiting. Certified Nursing Assistant (CNA) 10 was observed to enter room [ROOM NUMBER] with an N95, gown, and gloves. During an interview on 7/30/2024 at 10:06 AM with CNA 10, CNA 10 stated face shields are not stocked in the PPE carts for Station 2 and stated staff enter yellow zone rooms with a gown, gloves, and N95 mask. During a record review of the PHN guidance dated 7/30/2024 at 1:07 PM, the PHN indicated staff need to wear full PPE and face shields for yellow zones. During an observation on 7/30/2024 at 3:00 PM in Station 3 yellow zone, PPE carts were observed to not have face shields inside. During an interview on 7/30/2024 at 4 PM with IPN 1 and IPN 2, IPN 1 stated based on guidelines from the PHN and facility policy staff should be wearing a face shield when entering residents' rooms in the yellow zone. IPN 1 stated yellow zones consisted of Station 1, 2, and half of 3. IPN 1 stated the risk of not donning on the proper PPE is that it could spread to other residents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled, COVID-19 Prevention, Response, and Reporting, the P&P indicated a health care professional (HCP) who enters the room of a resident with suspected or confirmed SARS-CoV-2 infection should adhere to standard precautions and use a National institute for Occupational Safety and Health (NIOSH, agency that provides recommendations for the prevention of work related injuries and illnesses) approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 40037 Based on observation, interview, and record review, the facility failed to keep three of three laundry dryers in a safe, operating, and sanitary condition for residents. This failure had the potential to result in spread of infection and pose as potential fire hazard. Findings: During a concurrent observation and interview on 8/1/2024 at 10:13 am with the Environmental Service Manager (EVSM), in the facility's laundry room, there were total of three dryers in the laundry room. All three dryer's drum (the actual container to put wet laundry for drying) had multiple random thick patches of brown/black material on the dryers' drum inner wall. The EVSM stated the dryers' drums were dirty with these patches, and the EVSM did not know how these patches formed. The EVSM stated the facility needed to keep the dryers' drum clean to prevent cross contamination and infection when drying residents' clothes. The EVSM stated the patches could pose as potential fire hazard when the patches covered the drum holes decreasing heat and moisture ventilation. The EVSM stated the EVSM needed to report the patches to the maintenance department for cleaning and sanitizing of the dryers' drums to ensure a safe and sanitary condition for all residents. The EVSM stated washers and dryers needed to be checked and kept clean every day and after each use. During a review of the facility's policy and procedure (P&P) titled, Washer and Dryer Maintenance Policy, undated, the P&P indicated, To ensure that washers and dryers are properly maintained, operating efficiently, and complying with health and safety regulations to provide clean, safe linens and personal clothing for residents. The P&P indicated, inspect washers and dryers daily for signs of wear, damage, or malfunction. The P&P indicated, inspect and clean dryer vents and ducts to prevent fire hazards. During a review of the facility's P&P titled, Laundry Maintenance Policy, undated, the P&P indicated, To ensure that laundry facilities and equipment are properly maintained, promoting cleanliness, preventing infections, and complying with health and safety regulations. The P&P indicated, clean and sanitize all laundry equipment daily, including washers, dryers, folding tables, and carts. The P&P indicated, report any issues immediately to the maintenance department.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 40037 Based on interview and record review, the facility failed to have a documented tracking process in place to ensure one of three sampled Certified Nursing Assistants (CNA 4) attended the required in-service trainings for nurse aides. This failure had the potential to result in CNA 4 to not receive the necessary training that could affect resident care and safety. Findings: During a review of the facility's Inservice Education Record (IER), dated 7/10/2024, the IER indicated, the subject for training was abuse prevention, types of abuse, and mandated abuse reporting. The IER indicated, CNA 4 did not attend the training. The IER indicated, the Director of Staff Development (DSD) provided the training. During an interview on 7/30/2024 at 4:04 pm with the DSD, the DSD stated the DSD provided the abuse in-service training on 7/10/2024. The DSD stated all staff needed to attend the regularly scheduled in-service trainings including abuse. The DSD stated the DSD did not know that CNA 4 had not attended the abuse training. The DSD stated the DSD did not have a system in place to check, track, and ensure all staff attended the required trainings. The DSD stated it was important for all staff to receive the required trainings to promote resident's quality of care and safety. During a review of the facility's policy and procedure (P&P) titled, In-Service Training Program, Nurse Aide, undated, indicated, all nurse aide personnel needed to participate and attend regularly scheduled in-service training classes. The P&P indicated, all training classes attended by the employee were entered on the respective employee's Employee Training Attendance Record by the department supervisor or other person(s) as designated by the supervisor. During a review of the facility's (P&P) titled, Education and Training Program Policy, undated, the P&P indicated, the facility ensured that all staff members received comprehensive, ongoing education and training to maintain high standards of care, comply with regulations, and promote professional development.