

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056080	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/05/2025
NAME OF PROVIDER OR SUPPLIER The Bellefontaine Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 150 Bellefontaine St Pasadena, CA 91105	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42223</p> <p>Based on observation, interview and record review, the facility failed to ensure one (1) of two (2) sampled residents (Resident 39) was treated with respect and dignity in accordance with the facility policy by failing to keep the resident's bed linen clean and free of food particles/ crumbs.</p> <p>This deficient practice had the potential to affect the resident's self-worth and self-esteem.</p> <p>Findings:</p> <p>During a review of Resident 39's Admission Record, the Admission Record indicated the resident was originally admitted to the facility on [DATE] and was readmitted on [DATE] with the following diagnoses of major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and dementia (a progressive state of decline in mental abilities).</p> <p>During a review of Resident 39's Minimum Data Set (MDS - a resident assessment tool), dated 3/8/2025, the MDS indicated resident was severely impaired (never/ rarely make decisions) with cognitive (the ability to understand and make decisions) skills for daily decision making. The MDS also indicated the resident required substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with oral hygiene, upper body dressing, lower body dressing and putting on/taking off footwear but is dependent (helper does all of the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity.) The MDS indicated Resident 39 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contract guard assistance was resident completes activity. Assistance may be provided throughout the activity or intermittently.)</p> <p>During a concurrent observation in Resident 39's room and interview on 4/28/2025 at 11:01 AM with Certified Nursing Assistant 2 (CNA 2), Resident 39's bed linen was observed with yellow particles. CNA 2 observed picking up the yellow particles and stated it was eggs. CNA 2 also stated, it is not okay to have food crumbs/ particles on the resident's bed because the resident should be treated with dignity.</p> <p>During an interview on 5/2/2025 at 11:23 AM, Registered Nurse 1 (RN 1) stated there should not be any food crumbs/ particles on Resident 39's bed linen because the resident should be treated with dignity. RN 1 also stated the blankets/sheets would need to be changed if food particles were observed.</p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/5/2025 at 2:05 PM, CNA 2 stated Resident 39 feed herself. CNA 2 also stated when the resident is finished eating, CNA 2 did not clean up the resident but should clean up after the resident to maintain resident's clean and provide resident's dignity.</p> <p>During a review of the facility's Policy and Procedure (P&P) titled, Quality of Life - Dignity, revised 2/2020, the P&P indicated each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, feeling of self-worth and self-esteem. The P&P also stated residents are treated with dignity and respect at all times.</p>

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45099</p> <p>Based on observation, interview, and record review, the facility failed to ensure two (2) of 22 sampled residents (Resident 223 and 53) were provided with the following in accordance with the facility's policy:</p> <ol style="list-style-type: none"> 1. Resident 223's call light (device used by residents to call staff) was not within arm's reach. <p>This deficient practice had the potential for Resident 223 not to be able to call the facility staff for help or assistance, especially during an emergency.</p> <ol style="list-style-type: none"> 2. Facility failed to ensure Resident 53's bed had a footboard (a flat board placed at the foot of a resident's bed to help maintain proper positioning and alignment, thereby preventing the feet from slipping off the bed). <p>This deficient practice had the potential to negatively impact Resident 53's comfort and physical well-being due to improper positioning of the foot.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a review of Resident 223's Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE] with a diagnosis of post laminectomy (surgical operation to remove the back of one or more vertebrae, usually to give access to the spinal cord or to relieve pressure on nerves) syndrome (a chronic pain that continues or starts after back surgery) and abnormalities of gait (the manner or pattern of how someone walks, runs, or moves on foot) and mobility. <p>During a review of resident 223's Care Plan initiated on 4/23/2025, the Care Plan indicated Resident 223 was at risk for Activities of Daily Living (ADLs- activities such as bathing, dressing and toileting a person performs daily) decline. The Care Plan also indicated an approach to encourage Resident 223 to use the call light for assistance.</p> <p>During a review of Resident 223's Minimum Data Set (MDS- a resident assessment tool), dated 4/29/2025, the MDS indicated Resident 223 had an intact cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 223 was dependent (helper does all the effort) with toileting hygiene, shower, upper and lower body dressing and putting on/taking off footwear. The MDS further indicated Resident 223 required partial/moderate assistance (helper does less than half the effort) with oral hygiene and required supervision (helper provides cues) with eating.</p> <p>During an observation on 4/28/2025 at 9:58 AM, Resident 223 was found sleeping in bed with the Resident 223 call light cord hanging on the right side of the bed and on the call light on the floor.</p> <p>During an interview on 5/2/2025 at 4:40 PM, Licensed Vocational Nurse 2 (LVN 2) stated call light should be placed within the reach (arm's length) of the resident in case the resident needs anything they can use it to call facility staff, and residents would be able to call the staff during emergencies.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/2/2025 at 5:11 PM, the Director of Nursing (DON) stated Resident 223's call light should be within the resident's reach so the resident would be able call the staff if the resident needed something.</p> <p>During a review of the facility's policy and procedure titled, Call Light, revised in March 2018, the policy indicated that the facility must ensure that the call light is within the resident's reach when in his/her room or when on the toilet to assure residents receive prompt assistance. The policy also indicated that all staff should know how to place the call light for a resident.</p> <p>46919</p> <p>2. During a review of Resident 53's Admission Record, the Admission Record indicated Resident 53 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included cerebral infarction (when the blood supply to part of the brain is blocked or reduced), protein-calorie malnutrition (inadequate intake of food that leads to changes in the body), and pneumonia (an infection/inflammation in the lungs).</p> <p>During a review of Resident 53's MDS, dated [DATE], the MDS indicated Resident 53 was assessed having severely impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. Resident 53 required substantial/maximal assistance (helper does more than half the effort) with oral/toileting hygiene, upper/lower body dressing, shower/bathe self, roll left and right, sit to lying, sit to stand, and walking 10 feet (ft- unit of measurement).</p> <p>During an observation on 4/28/2025, at 10 AM, in Resident 53's room, Resident 53 was asleep in bed. Resident 53's foot of the bed was elevated, forming a curve shape on the bed and resident's posture. Resident 53's bed did not have a footboard.</p> <p>During a concurrent observation and interview on 5/5/2025, at 1:43 PM, with Certified Nursing Assistant 4 (CNA 4), in Resident 53's room, CNA 4 stated Resident 53's bed did not have a footboard. CNA 4 stated Resident 53's bed has not had a footboard for as long as she could remember. CNA 4 stated she did not inform maintenance because the bed was always without a footboard. CNA 4 stated she always elevated the foot of the bed after providing care to prevent Resident 53 from sliding down the bed.</p> <p>During an interview on 5/5/2025, at 4:48 PM, with the Director of Nursing (DON), the DON stated the Resident 53's bed should have been checked to make sure the resident's bed had a footboard. The DON stated facility staff should have notified the maintenance department about the missing footboard instead of just elevating the foot of the bed. The DON stated the footboard was important for Resident 53's comfort and positioning in bed.</p> <p>During a review of the facility's policy and procedure (P&P), titled, Maintenance Service revised on 12/2009, the P&P indicated the following:</p> <p>Maintenance service shall be provided to all areas of the building, grounds, and equipment.</p> <p>The Maintenance Department is responsible for maintaining buildings, grounds, and equipment in a safe and operable manner at all times.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's P&P, titled, Accommodation of Needs revised on 3/2021, the P&P indicated the facility's environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving safe independent functioning, dignity and well-being.</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42223</p> <p>Based on interview and record review, the facility failed to follow its Advance Directive (a legal document indicating resident preference on end-of-life treatment decisions) policy to ensure the advance directive was in the chart for two (2) of four (4) sampled residents (Resident 30 and Resident 222).</p> <p>This deficient practice had the potential for Resident 30 and Resident 222 to not have their wishes met regarding life-sustaining treatment (any treatment that serves to prolong life without reversing the underlying medical condition) or health care.</p> <p>Findings:</p> <p>1. During a review of Resident 30's Admission Record, the Admission Record indicated resident was originally admitted on [DATE] and was readmitted on [DATE] with the following diagnoses of End Stage Renal Disease (ESRD- irreversible kidney failure) and atherosclerotic heart disease (the buildup of fats, cholesterol and other substances in and on the artery walls).</p> <p>During a review of Resident 30's Minimum Data Set (MDS - a resident assessment tool), dated 2/18/2025, the MDS indicated the resident was moderately impaired with cognitive (the ability to understand and make decisions) skills for daily decision making. The MDS also indicated Resident 30 required substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with shower/bathe self, lower body dressing, putting /taking off footwear, and personal hygiene but required partial/moderate assistance (helper does less than half the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort) with toileting hygiene and upper body dressing.</p> <p>During a record review in Resident 30's medical chart on 5/1/2025 at 12:57 PM, Physician Orders for Life Sustaining Treatment (POLST - a written medical order from a physician that helps give people with serious illnesses more control over their own care by specifying the types of medical treatment they want to receive during serious illness), dated 6/17/2024, the POLST indicated there is an advance directive dated 6/17/2025 but there was no advance directive included in Resident 30 medical chart.</p> <p>During an interview on 5/5/2025 at 8:45 AM, Social Services 1 (SS 1) stated Resident 30's advance directive was not in the resident's medical chart. SSD stated it should have been in the resident's medical chart and /or the facility should have a copy available for licensed staff to see/ access. SS1 also stated the facility got Resident 30's advance directive on 5/2/2025 and prior to that the facility did not have a copy. SS 1 stated it is important to have the resident's advance directive in the resident's medical chart in case of an emergency, the facility will know what type of care to provide for the resident.</p> <p>45099</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. During a review of Resident 222's Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and asthma (a condition in which a person's airways become inflamed, narrows, swells, and produces extra mucus, which makes it difficult to breathe).</p> <p>During a review of Resident 222's MDS, dated [DATE], the MDS indicated Resident 222 had an intact cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 222 required substantial assistance (helper does more than half the effort) with toileting hygiene, shower, upper and lower body dressing and putting on/taking off footwear. The MDS further indicated Resident 222 required partial/moderate assistance (helper does less than half the effort) with oral hygiene and required supervision (helper provides cues) with eating.</p> <p>During a record review of Resident 222's Advance Directives Acknowledgement form, dated 4/14/2025, the Advance Directive Acknowledgement form indicated that Resident 222 had executed an advanced directive.</p> <p>During a concurrent interview and record review on 5/5/2025 at 11:08 AM, Resident 222's medical records dated from 4/14/2025 to 5/5/2025 were reviewed. The medical records did not include Resident 222's advance directives. The Director of Nursing (DON) confirmed Resident 222 did not have a copy of the Advanced Directive in the resident's chart. The DON also stated the advanced directive should also be in the resident's chart so the facility would know the residents' wishes and be able to honor them. The DON further stated the Advanced Directive should be in the chart for the facility to know who to call with decision making in case of an emergency.</p> <p>During a review of the facility's policy and procedure titled, Advance Directives, revised December 2016, the policy indicated that, information about whether the resident has executed an advance directive shall be displayed prominently in the medical record.</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46919</p> <p>Based on observation, interview, and record review, the facility staff failed to provide privacy and confidentiality (safeguarding the content of information including video, audio, or other computer stored information from unauthorized disclosure without the consent of the resident and/or the individual's surrogate or representative) for one of 22 sampled residents (Resident 223) when Resident 223's medical records were left exposed by leaving the computer unattended and not turning off the computer screen on 5/1/2025.</p> <p>This deficient practice violated Resident 223's right to privacy and confidentiality.</p> <p>Findings:</p> <p>During a review of Resident 223's Admission Record, the Admission Record indicated Resident 223 was admitted to the facility on [DATE] with diagnoses that included post laminectomy syndrome (chronic pain that persist after a laminectomy [surgical removal of the roof of the spinal canal] or other back surgery), arthrodesis status (when a joint has been surgically fused or fixed to prevent movement, often to treat conditions like arthritis or instability), and postural kyphosis (excessive rounding of the upper back caused by poor posture and muscle imbalances).</p> <p>During a review of Resident 223's Minimum Data Set (MDS- a resident assessment tool), dated 4/29/2025, the MDS indicated Resident 223 was assessed having intact memory and cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. Resident 223 was dependent (helper does all of the effort) with toileting hygiene, shower/bathe self, upper/lower body dressing, sit to stand, and toilet transfer. Resident 223 required substantial/maximal assistance (helper does more than half the effort) with roll left and right and walking 10 feet (ft- unit of measurement).</p> <p>During a concurrent observation in the Nurse's Station 1 (NS 1), and interview on 5/1/2025, at 11:21 AM, with Registered Nurse Supervisor 2 (RNS 2), Computer 1 (COM 1) was observed unattended with Resident 223's information on the computer screen. RNS 2 stated the computer should not have been left unattended with Resident 223's medical record showing on the computer screen.</p> <p>During an interview on 5/2/2025, at 9:49 AM with MDS Nurse (MDSN), MDSN stated facility staff should not leave the computer on and unattended. MDSN stated facility staff should log out of the computer before leaving. MDSN stated it was important to log out of the computer to prevent unauthorized people from tampering with the documentation or accessing the residents' documents. MDSN stated it is a Health Insurance Portability and Accountability Act (HIPAA) violation (failure to comply with rules established by the HIPAA which includes unauthorized access, use or disclosure of Protected Health Information (PHI), inadequate security measures) to leave the computer unattended with Resident 223's medical record showing.</p> <p>During an interview on 5/5/2025, at 4:52 PM, with the Director of Nursing (DON), the DON stated facility staff should turn log off (to terminate the current user session) the computer once they finish their charting or if they need to stop charting. The DON stated it was important for facility staff to protect the residents' information from visitors and family members.</p> <p>(continued on next page)</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's policy and procedure (P&P), titled, Management and Protection of Protected Health Information (PHI), revised on 4/2014, the P&P indicated, It is the responsibility of all personnel who have access to resident and facility information to ensure that such information is managed and protected to prevent unauthorized release or disclosure.</p> <p>During a review of the facility's P&P, titled, Charting and Documentation, revised on 7/2017, the P&P indicated that information documented in the resident's clinical record is confidential and may only be released in accordance with state law, HIPAA, and facility policy.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46919</p> <p>Based on interview and record review, the facility failed to ensure accurate assessment of resident's medication on the Minimum Data Set (MDS, a resident assessment tool) for one (1) of 22 sampled residents (Resident 50) as indicated on the facility policy.</p> <p>This deficient practice had the potential for the facility to not develop and implement a resident centered care plan for Resident 50 to receive necessary care and services.</p> <p>Findings:</p> <p>During a review of Resident 50's Admission Record, the Admission Record indicated Resident 50 was admitted to the facility on [DATE] with diagnoses that included unspecified dislocation of left hip (when the ball at the end of the thighbone is pushed out of its socket in the pelvis), abnormalities of gait (walking) and mobility, and hyperlipidemia (a condition in which there are high levels of fat particles in the blood).</p> <p>During a review of Resident 50's MDS, dated [DATE], the MDS indicated Resident 50 was assessed having intact memory and cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. Resident 50 required partial/moderate assistance (helper does less than half the effort) with toileting hygiene, upper/lower body dressing, putting on/taking off footwear, toilet transfer, and walk 10 feet (ft- unit of measurement). MDS indicated Resident 50 received insulin for 7 days during the last 7 days of the look-back period.</p> <p>During a review of Resident 50's Order Summary Report, dated 3/31/2025, the Order Summary Report indicated a physician order, with a start date of 6/22/2024 for Ozempic (semaglutide-weekly injection that helps with weight loss by lowering the blood sugar by helping the pancreas make more insulin) inject 2 mg subcutaneously (under the skin) one time a day every Tuesday.</p> <p>During a review of Resident 50's Medication Administration Record (MAR), from 4/1/2025 to 4/30/2025, the MAR indicated Resident 50 received Ozempic on 4/1,2025, 4/8/2025, 4/15/2025, and 4/22/2025.</p> <p>During an interview on 4/28/2025, at 10:43 AM with Resident 50, Resident 50 stated she did not have diabetes and was not on insulin (a hormone produced by the pancreas that regulates blood sugar levels). Resident 50 stated she was getting Ozempic injections for weight loss.</p> <p>During an interview on 5/2/2025, at 8:55 AM, with MDS Nurse (MDSN), MDSN stated Resident 50 was ordered Ozempic for weight loss. MDSN stated Ozempic was not classified (the systemic organization and grouping of drugs based on their shared characteristics) as insulin.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 5/2/2025, at 1:12 PM, with the MDSN, Resident 50's MDS dated [DATE] was reviewed. MDSN stated Resident 50's MDS assessment indicated Resident 50 received an injection for 7 days during the last 7 days of the look-back period (the timeframe used to gather information about a resident's condition or status). MDSN stated Resident 50's MDS should have indicated Resident 50 received an injection for 1 day during the last 7 days of the look-back period since her Ozempic was ordered weekly. MDSN stated the MDS indicated Resident 50 received insulin for 7 days during the last 7 days of the look-back period. MDSN stated Resident 50's MDS should have indicated Resident 50 received insulin for 0 days during the last 7 days of the look-back period since Resident 50 was not receiving insulin. MDSN stated it was important for the resident's MDS assessments to be accurate.</p> <p>During an interview on 5/5/2025, at 4:50 PM, with the Director of Nursing (DON), the DON stated it was important for the MDS assessment to be accurate to ensure that the right treatment and care is provided to the residents. The DON stated MDSN should have checked the frequency (how often a medication is prescribed to be taken by a resident) and drug classification of Ozempic before completing Resident 50's MDS assessment.</p> <p>During a record review of the facility's policy and procedure (P&P) titled, Resident Assessments, revised on 11/2019, the P&P indicated All persons who have completed any portion of the MDS Resident Assessment Form must sign the document attesting to the accuracy of such information.</p> <p>During a record review of the facility's P&P, titled, Charting and Documentation, revised on 7/2017, the P&P indicated documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49537</p> <p>Based on interview and record review, the facility failed to follow through with the Preadmission Screening and Resident Review (PASARR-a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care) recommendation to obtain a PASARR level II (a detailed assessment performed on individuals identified during a Level I PASSR screening as potentially having a serious mental illness [SMI], intellectual disability [ID], developmental disability [DD], or related condition [RC]) evaluation for one (Resident 84) of three sampled residents after receiving a Level II Notice of Attempted Evaluation Letter, dated 11/7/2024.</p> <p>This deficient practice had the potential to result in inappropriate placement and unidentified specialized services for Resident 84.</p> <p>Findings:</p> <p>During a review of Resident 84's Admission Record, the Admission Record indicated the facility initially admitted Resident 84 on 9/3/2022 and readmitted on [DATE] with diagnoses including but not limited to schizoaffective disorder (a mental health condition that is marked by a mix of schizophrenia [serious mental illness that affects how a person thinks, feels, and behaves, often disrupting their perception of reality] and a mood disorder (mental health condition characterized by persistent and significant changes in mood that interfere with daily functioning and well-being), and dementia (a decline in thinking, memory, and reasoning skills severe enough to interfere with daily life).</p> <p>During a review of Resident 84's Minimum Data Set (MDS-a resident assessment tool) dated 2/15/2025, the MDS indicated Resident 84 had moderate impairment of cognitive (mental processes used for thinking, learning, and problem-solving) skills for daily decision making. The MDS indicated Resident 84 was independent (resident completes the activity by himself with no assistance from a helper) with eating. The MDS also indicated Resident 84 required supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) with oral hygiene and upper body dressing. The MDS further indicated Resident 84 required partial/moderate assistance (Helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with toileting and personal hygiene, shower/bathing self, lower body dressing and putting on/off footwear.</p> <p>During a concurrent interview and record review on 5/5/2025 at 8:36 AM with the MDS Nurse (MDSN), the PASARR Level I screening results and Level II Notice of Attempted Evaluation Letter dated 11/7/2024, were reviewed. PASARR Level I Screening Results indicated a Serious Mental Illness (SMI) Level II Mental Health Evaluation was required. The Notice of Attempted Evaluation Letter indicated that the California Department of Health Care Services (DHCS) was unable to complete Level II Evaluation for SMI. The letter indicated that the SMI Level II mental health evaluation was not scheduled because facility staff were unresponsive to two or more separate attempts of communication within 48 hours of the Level I screening. The MDSN stated he was assigned by the facility to be responsible for the PASARR screenings.</p> <p>(continued on next page)</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/5/2025 at 8:40 AM with the MDSN, the MDSN stated that he was not made aware that the Level II evaluation was not completed. The MDSN stated he cannot recall if he followed up on the failed attempt for Level II evaluation. The MDSN stated there was no documented evidence that he did follow up. The MDSN stated it was important to complete the Level II evaluation, especially if residents were positive for SMI. The MDSN stated that Level II PASARR screening was important to determine if residents were inappropriately placed and if residents needed specialized services.</p> <p>During an interview on 5/5/2025 at 8:55 AM with the MDSN, the MDSN stated that once the notification letter was received, follow-up should be done. The MDSN stated that the PASARR evaluation for each resident admitted to the facility should be checked and followed up.</p> <p>During an interview on 5/5/2025 at 10:27 AM with the SSD, the SSD stated the Admissions Coordinator and MDSN receives the papers and documents from the hospital and had no access to the PASARR screening portal, so she was unable to see if the PASARR was completed or not or needed to be followed up.</p> <p>During an interview on 5/5/2025 at 12:30 PM with the Director of Nursing (DON), the DON stated she was not aware that the PASARR Level II evaluation for Resident 84 was not completed. The DON stated that it was important for PASARR Level II evaluation to be completed, if required, to determine appropriate placement and if specialized services were needed for the residents.</p> <p>During a review of the facility's Policy and Procedures (P&P) titled Admission Criteria, revised 3/2019, the P&P indicated that if a Level I screen indicates that the individual may meet the criteria for mental disorders (MD), intellectual disabilities (ID), or related disorders (RD), the resident is referred to the state PASARR representative for the Level II (evaluation and determination) screening process. The P&P indicated that the admitting nurse notified the social services department when a resident is identified as having a possible (or evident) MD, ID, or RD. The P&P also indicated that the social worker is responsible for making referrals to the appropriate state-designated authority.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45099</p> <p>Based on interview and record review, the facility failed to follow the fluid restriction for one (1) of three (3) sampled residents (Resident 102) as indicated on the physician's order.</p> <p>This deficient practice has the potential for Resident 102 to have fluid overload (a condition where the body has too much fluid which could lead to various symptoms, including swelling, shortness of breath, and weight gain).</p> <p>Findings:</p> <p>During a review of Resident 102's Admission Record, the Admission Record indicated the resident was admitted on [DATE] with diagnoses that included congestive heart failure (CHF- a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling) and chronic kidney disease (a condition in which the kidneys are damaged and cannot filter as well as they should).</p> <p>During a review of Resident 102's Care Plan initiated on 2/12/2025, the Care Plan indicated Resident 102 was at risk for heart failure with an approach plan to encourage 1200 cc fluid restriction as ordered which included the breakdown as follows:</p> <ol style="list-style-type: none"> 1. Dietary - 720 cc/24 hours <ol style="list-style-type: none"> a) Breakfast - 240 cc b) Lunch - 240 cc c) Dinner - 240 cc 2. Nursing - 480 cc/24 hours <ol style="list-style-type: none"> a) 7-3 pm (AM shift) - 160 cc b) 3-11pm (PM shift) - 160 cc c) 11-7 am (night shift) - 160 cc <p>During a review of Resident 102's Minimum Data Set (MDS - a resident assessment tool), dated 2/16/2025, the MDS indicated Resident 102 had intact cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 102 was dependent (helper does all the effort) with oral and toileting hygiene, shower, upper and lower body dressing and putting on/taking off footwear. The MDS further indicated Resident 102 required supervision (helper provides cues) with eating.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 102's physician's order, dated 4/8/2025, the physicians order indicated an order for 1200 cubic centimeters (cc, a unit of volume) per 24 hours fluid restriction broken down to kitchen = 720 cc/24 hours and Nursing = 480 cc/24 hours.</p> <p>During a review of Resident 102's Certified Nurse Assistant (CNA) task and Nursing's Medication Administration Record (MAR) documentation of oral fluid intake consumed on 4/19/2025, 4/20/2025, 4/24/2025, and 4/26/2025, the document indicated the following:</p> <ol style="list-style-type: none"> 1. On 4/19/2025 - Resident 102 received a total of 2800 cc of fluids in 24 hours. <ul style="list-style-type: none"> a) CNA - 2000 cc b) Nursing - 800 cc 2. On 4/20/2025 - Resident 102 received a total of 1320 cc of fluid in 24 hours. <ul style="list-style-type: none"> a) CNA - 520 cc b) Nursing - 800 cc 3. On 4/24/2025 - Resident 102 received a total of 1420 cc of fluids in 24 hours <ul style="list-style-type: none"> a) CNA - 860 cc b) Nursing - 560 cc 4. On 4/26/2025 - Resident 102 received a total of 1880 cc of fluids in 24 hours. <ul style="list-style-type: none"> a) CNA - 1400 cc b) Nursing - 480 cc <p>During a concurrent observation and interview on 4/28/2025 at 9:50 AM, Resident 102 was observed lying in bed with water pitched half filled with water (approximately 500 cc) and a cup of tea (approximately 240 cc) at his overbed bedside table. A fluid restriction sign was posted on top of Resident 102's bed but did not indicate how much fluids were restricted. Resident 102 stated the facility staff fills his water pitcher everyday and he just takes them.</p> <p>During an observation on 5/2/2025 at 9:20 AM, Resident 102 did not have a fluid restriction sign posted on the top of Resident 102's bed.</p> <p>During an interview on 5/2/2025 at 9:26 AM, Licensed Vocational Nurse 1 (LVN 1) stated Resident 102 was provided with fluids during meals and medication pass only and documented separately. LVN 1 stated Resident 102 should not have a pitcher of water at the bedside because he could develop edema and triggers heart failure. LVN 1 further stated there should be a fluid restriction sign posted inside Resident 102's room specific to how much fluids are restricted so everyone knows how much fluids the resident was allowed to have.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/2/2025 at 9:39 AM, Registered Nurse 1 (RN 1) confirmed Resident 102 was on 1200 cc/24 hours fluid restriction. RN 1 stated Resident 102 was on fluid restriction because of his CHF and giving the resident too much fluids could adversely affect his organs which could lead to electrolyte imbalance (when the body has too much or too little of certain minerals that are vital for the body's functions) and fluid overload (when the body has too much water or salt). RN 1 also stated Resident 102 could also develop an edema on his legs and arms which could cause pain and discomfort affecting his mobility and his ability to participate in activities like walking.</p> <p>During a review of the facility's Policy and Procedure (P&P) titled, Encouraging and Restricting Fluids, revised 10/2010, the P&P indicated in preparation is to ensure there is a physician's order. The P&P also indicated the guidelines is to:</p> <ol style="list-style-type: none"> 1. Follow specific instructions concerning fluid intake or restrictions 2. Encourage the resident's family and visitors to stay within the limits of his or her intake. 3. When a resident has been placed on restricted fluids, remove the water pitcher and cup from the room. 		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45099</p> <p>Based on observation, interview, and record review, the facility failed to ensure proper application of resting hand splint (provide support and rest to the hand and wrist, particularly during periods of rest or sleep to help reduce pain, swelling, stiffness, and contractures [shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints]) and elbow splint (a support or brace that helps stabilize and protect the elbow joint) for one (1) of four (4) sampled residents (Resident 56) with limited range of motion (ROM - movement of the joints) as indicate on the physician's order.</p> <p>This deficient practice had the potential to cause complications such as pain, swelling, and contractures) to Resident 56's right arm, fingers and wrist.</p> <p>Findings:</p> <p>During a review of Resident 56's Admission Record, the Admission Record indicated the resident was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses of contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion) of upper arm muscle and right hand.</p> <p>During a review of Resident 56's Minimum Data Set (MDS- a resident assessment tool), dated 4/6/2025, the MDS indicated Resident 56 had severe impairment in cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 56 was dependent (helper does all the effort) with shower, lower body dressing, and putting on and taking off footwear and required substantial assistance (helper does more than half the effort) with toileting and personal hygiene and upper body dressing. The MDS further indicated Resident 56 required supervision (helper provides cues) with oral hygiene and setup assistance (helper sets up; resident completes activity) with eating.</p> <p>During a review of Resident 56's Physician's Order dated 6/27/2024, the Physicians Order indicated Restorative Nursing Aide (RNA- responsible for providing restorative and rehabilitation care for residents/patients to maintain or regain physical, mental, and emotional well-being) to apply resting hand splint and elbow splint on the right arm for 4 hours as tolerated daily five (5) times a week. The physician's order also indicated to do skin checks before and after application of the splints for signs of redness or swelling.</p> <p>During a review of Resident 1's Care Plan initiated on 6/27/2024, the Care Plan indicated Resident 56 was at risk for decline in functional mobility with an approach plan for RNA to apply resting hand splint and elbow splint on right arm for 4 hours as tolerated daily 5 times a week. The Care Plan also indicated to do skin checks before and after application of the splints for signs of redness or swelling.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 5/1/2025 at 11:19 AM, Certified Nursing Assistant 3 (CNA 3) was seen attempting to re-apply Resident 56 resting hand splint and readjust the right elbow splint that was off the resident. CNA 3 was seen struggling to re-adjust both splints to fit Resident 56 right arm. CNA 3 confirmed it is the RNAs responsibility to apply and take off Residents 56 splints not the CNAs.</p> <p>During an interview on 5/2/2025 at 9:17 AM, Licensed Vocational Nurse 1 (LVN 1) stated the RNAs apply the splints to the residents and not the CNAs. LVN 1 also stated CNAs are not trained to apply splints and could cause injury to the residents if not correctly placed.</p> <p>During another interview with CNA 3 on 5/5/2025 at 8:40 AM, CNA 3 stated she was not trained to apply splints to the residents in the facility and should have called the RNA to reapply Resident 56's right arm splints instead of trying to apply them herself. CNA 3 also stated the RNAs had the experience that she does not have on how to correctly apply arm splints.</p> <p>During an interview on 5/5/2025 at 9:57 AM, RNA 1 stated CNAs are not supposed to apply splints because they are not trained and certified to apply them like the RNAs. RNA 1 also stated if splints are applied by a CNA the resident could sustain skin tears and skin irritation if not applied properly. RNA 1 further stated range of motion (ROM- how far one can move or stretch a part of the body, such as a joint or a muscle) exercises needed to be done prior to applying splints and CNAs are not trained to do ROM.</p> <p>During a review of the facility's Policy and Procedure titled, Splints and Positioning Device, revised July 2017, the Policy and Procedure indicated that if a device is ordered other than a simple hand roll, an in-service will be given to the RNA and any other appropriate staff on the use of the device, to ensure proper application (usually RNA).</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45099</p> <p>Based on observation, interview, and record review, the facility failed to follow its policy to post a No Smoking sign outside the room of one of two sampled residents (Resident 222) while the oxygen was in use.</p> <p>This deficient practice had the potential to cause fire which could harm the residents, staff, and visitors at the facility.</p> <p>Findings:</p> <p>During a review of Resident 222's Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE] with a diagnosis of asthma (a condition in which a person's airways become inflamed, narrows, swells, and produces extra mucus, which makes it difficult to breathe).</p> <p>During a review of Resident 222's Minimum Data Set (MDS- a resident assessment tool), dated 4/15/2025, the MDS indicated Resident 222 had an intact cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 222 required substantial assistance (helper does more than half the effort) with toileting hygiene, shower, upper and lower body dressing and putting on/taking off footwear. The MDS further indicated Resident 222 required partial/moderate assistance (helper does less than half the effort) with oral hygiene and required supervision (helper provides cues) with eating.</p> <p>During an observation on 4/28/2025 at 9:29 AM, Resident 222 was observed using oxygen at 2 liters (L, unit of flow rate) per minute via nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen). There was no No Smoking sign posted outside Resident 222's room.</p> <p>During an interview on 5/2/2025 at 9:17 AM, Licensed Vocational Nurse 1 (LVN 1) stated a No Smoking sign should be placed at Resident 222's front door visible for everyone to see when oxygen is in use to prevent fire since oxygen is flammable and is a fire hazard.</p> <p>During an interview on 5/2/2025 at 9:49 AM, Registered Nurse 1 (RN 1) stated a No Smoking sign should be placed outside Resident 222's door to let everyone know the resident's room has oxygen. RN 1 also stated smoking could ignite the oxygen increasing the risk of fire that could cause injury and harm to the residents.</p> <p>During a review of the facility's Policy and Procedure (P&P) titled, Fire Safety and Prevention, revised May 2011, the P&P indicated to use visible No Smoking signs where oxygen is stored and being administered for oxygen safety.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46919</p> <p>Based on observation, interview, and record review, the facility failed to provide pharmaceutical services to meet the needs of one of three sampled residents (Resident 62) in accordance with the facility policy by failing to administer cholecalciferol (a dietary supplement used to treat Vitamin D deficiency) and Miralax (a medication used to treat occasional constipation [difficult bowel movement]) as indicated on the physician's order.</p> <p>This deficient practice had the potential for Resident 62 to experience constipation, muscle weakness, and bone and joint pain.</p> <p>Findings:</p> <p>During a review of Resident 62's Admission Record, the Admission Record indicated Resident 62 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included encounter for attention to gastrostomy (the care and maintenance of an artificial opening into the stomach, typically a gastrostomy tube [G-tube]), respiratory failure (a condition where the lungs are unable to adequately deliver oxygen to the blood or remove carbon dioxide), and peritoneal abscess (a localized collection of pus within the space between the abdominal organs and the abdominal wall).</p> <p>During a review of Resident 62's Minimum Data Set (MDS- a resident assessment tool), dated 3/9/2025, the MDS indicated Resident 62 was assessed having moderately impaired (decisions poor, cues/supervision required) cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. Resident 62 was dependent (helper does all of the effort) with eating, toileting/oral/personal hygiene, upper/lower body dressing, sit to lying, sit to stand, and toile transfer.</p> <p>During a review of Resident 62's Oder Summary Report, dated 4/29/2025, the Order Summary Report indicated a physician order, with a start date of 3/1/2024, for cholecalciferol oral tablet give 125 micrograms (mcg- unit of measurement) via G-tube one time a day for supplement.</p> <p>During a review of Resident 62's Oder Summary Report, dated 3/13/2024, the Order Summary Report indicated Miralax Oral Powder 17 grams (gm- unit of measurement)/scoop, give 17 gm via G-tube one time a day for bowel management, hold for loose stools, mix with 4-8 ounce (oz- unit of measurement) of fluids.</p> <p>During an observation of the medication administration, on 5/5/2025, at 9:36 AM, with Licensed Vocational Nurse 8 (LVN 8), LVN 8 administered the following medications via Resident 62's G-tube:</p> <ol style="list-style-type: none"> 1. Lacosamide (medication used to treat partial onset seizures [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness] that involve only one part of the brain)10 milligrams (mg, unit of mass)/milliliter (ml, unit of measurement for volume) solution <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ol style="list-style-type: none"> 2. Propranolol (medication that slows down the heart rate and makes it easier for the heart to pump blood) 10 mg 3. Nuedexta (medication used to treat uncontrollable crying or laughing) 20-10 mg 4. Docusate Sodium (medication used to treat and prevent constipation by softening the stool) Liquid 50mg/5ml, 10 ml 5. Lactulose (medication used to treat constipation and to reduce ammonia levels in the blood) 10gm/15ml solution, 30 ml 6. Levetiracetam (medication used to treat seizures) 100mg/ml solution, 7.5 ml 7. Memantine (medication used to treat memory loss) Hydrochloride (HCl) 10 mg tablet 8. Senna Oral (medication used to relieve occasional constipation) Tablet 8.6 mg 9. Vitamin C (an essential nutrient that the body needs in small amounts to function properly) tablet 500 mg 10. Valproic Acid (medication used to treat seizures) 250 mg/5ml <p>LVN 8 did not administer Cholecalciferol Oral Tablet 125 mcg and Miralax Oral Powder 17 gm to Resident 62.</p> <p>During the same observation, on 5/5/2025, at 9:53 AM, LVN 8 restarted Resident 62's G-tube feeding.</p> <p>During a review of Resident 62's Medication Administration Record (MAR), from 5/1/2025 to 5/31/2025, the MAR indicated Resident 62 was scheduled to receive twelve medications at 9AM:</p> <ol style="list-style-type: none"> 1. Lacosamide 10 mg/ml solution via G-tube 2. Propranolol 10 mg via G-tube 3. Cholecalciferol Oral Tablet 125 mcg via G-tube 4. Miralax Oral Powder 17 gm via G-tube 5. Nuedexta 20-10 mg via G-tube 6. Docusate Sodium Liquid 50mg/5ml, 10 ml via G-tube 7. Lactulose 10gm/15ml solution, 30 ml via G-tube 8. Levetiracetam 100mg/ml solution, 7.5 ml via G-tube 9. Memantine HCl 10 mg tablet via G-tube <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>10. Senna Oral Tablet 8.6 mg via G-tube</p> <p>11. Vitamin C tablet 500 mg via G-tube</p> <p>12. Valproic Acid 250 mg/5ml via G-tube</p> <p>During a concurrent interview and interview, on 5/5/2025, at 11:06 AM, with LVN 8, Resident 62's list of administered medications was reviewed. LVN 8 stated she did not realize she did not administer Resident 62's cholecalciferol and Miralax as scheduled at 9AM. LVN 8 stated residents' medications can be given one hour before and one hour after the scheduled time. LVN 8 stated it was important to administer Resident 62's medications as scheduled to prevent drug interactions.</p> <p>During an interview, on 5/5/2025, at 4:31 PM, with the Director of Nursing (DON), the DON stated LVN 8 should have followed the physician's order to administer cholecalciferol and Miralax as scheduled at 9 AM. The DON stated it was important that residents receive their medication as ordered to prevent side effects.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Administering Medications, revised on 4/2019, the P&P indicated the following:</p> <p>Medications are administered in a safe and timely manner, and as prescribed</p> <p>Medications are administered in accordance with prescriber orders, including any required time frame</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46919</p> <p>Based on observation, interview, and record review, the facility failed to ensure its medication error rate was less than five (5) percent (%). Two (2) medication errors (the observed or identified preparation or administration of medications or biologicals which are not in accordance with the prescriber's order; manufacturers specifications / accepted professional standards and principles) out of 33 opportunities (observed administered medications) for error which yielded a facility medication error rate of 6.06 percent for one of three sampled residents (Resident 62) observed during medication administration (med pass).</p> <p>Licensed Vocational Nurse 8 (LVN 8) failed to administer cholecalciferol (a dietary supplement used to treat Vitamin D deficiency) and Miralax (a medication used to treat occasional constipation [difficult bowel movement]) once daily as indicated in the Physician's order.</p> <p>This deficient practice had the potential to result in adverse reactions (an undesired harmful effect resulting from a medication or other intervention) to Resident 62.</p> <p>Findings:</p> <p>During a review of Resident 62's Admission Record, the Admission Record indicated Resident 62 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included encounter for attention to gastrostomy (the care and maintenance of an artificial opening into the stomach, typically a gastrostomy tube [G-tube]), respiratory failure (a condition where the lungs are unable to adequately deliver oxygen to the blood or remove carbon dioxide), and peritoneal abscess (a localized collection of pus within the space between the abdominal organs and the abdominal wall).</p> <p>During a review of Resident 62's Minimum Data Set (MDS- a resident assessment tool), dated 3/9/2025, the MDS indicated Resident 62 was assessed having moderately impaired (decisions poor, cues/supervision required) cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. Resident 62 was dependent (helper does all of the effort) with eating, toileting/oral/personal hygiene, upper/lower body dressing, sit to lying, sit to stand, and toile transfer.</p> <p>During a review of Resident 62's Oder Summary Report, dated 4/29/2025, the Order Summary Report indicated a physician order, with a start date of 3/1/2024, for cholecalciferol oral tablet give 125 micrograms (mcg- unit of measurement) via G-tube one time a day for supplement.</p> <p>During a review of Resident 62's Oder Summary Report, dated 3/13/2024, the Order Summary Report indicated Miralax Oral Powder 17 grams (gm- unit of measurement)/scoop, give 17 gm via G-tube one time a day for bowel management, hold for loose stools, mix with 4-8 ounce (oz- unit of measurement) of fluids.</p> <p>During an observation of the medication administration, on 5/5/2025, at 9:36 AM, with Licensed Vocational Nurse 8 (LVN 8), LVN 8 administered the following medications via Resident 62's G-tube:</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ol style="list-style-type: none"> 1. Lacosamide (medication used to treat partial onset seizures [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness] that involve only one part of the brain)10 milligrams (mg, unit of mass)/milliliter (ml, unit of measurement for volume) solution 2. Propranolol (medication that slows down the heart rate and makes it easier for the heart to pump blood) 10 mg 3. Nuedexta (medication used to treat uncontrollable crying or laughing) 20-10 mg 4. Docusate Sodium (medication used to treat and prevent constipation by softening the stool) Liquid 50mg/5ml, 10 ml 5. Lactulose (medication used to treat constipation and to reduce ammonia levels in the blood) 10gm/15ml solution, 30 ml 6. Levetiracetam (medication used to treat seizures) 100mg/ml solution, 7.5 ml 7. Memantine (medication used to treat memory loss) Hydrochloride (HCl) 10 mg tablet 8. Senna Oral (medication used to relieve occasional constipation) Tablet 8.6 mg 9. Vitamin C (an essential nutrient that the body needs in small amounts to function properly) tablet 500 mg 10. Valproic Acid (medication used to treat seizures) 250 mg/5ml <p>LVN 8 did not administer Cholecalciferol Oral Tablet 125 mcg and Miralax Oral Powder 17 gm to Resident 62.</p> <p>During the same observation, on 5/5/2025, at 9:53 AM, LVN 8 restarted Resident 62's G-tube feeding.</p> <p>During a review of Resident 62's Medication Administration Record (MAR), from 5/1/2025 to 5/31/2025, the MAR indicated Resident 62 was scheduled to receive twelve medications at 9AM:</p> <ol style="list-style-type: none"> 1. Lacosamide 10 mg/ml solution via G-tube 2. Propranolol 10 mg via G-tube 3. Cholecalciferol Oral Tablet 125 mcg via G-tube 4. Miralax Oral Powder 17 gm via G-tube 5. Nuedexta 20-10 mg via G-tube 6. Docusate Sodium Liquid 50mg/5ml, 10 ml via G-tube <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>7. Lactulose 10gm/15ml solution, 30 ml via G-tube</p> <p>8. Levetiracetam 100mg/ml solution, 7.5 ml via G-tube</p> <p>9. Memantine HCl 10 mg tablet via G-tube</p> <p>10. Senna Oral Tablet 8.6 mg via G-tube</p> <p>11. Vitamin C tablet 500 mg via G-tube</p> <p>12. Valproic Acid 250 mg/5ml via G-tube</p> <p>During a concurrent interview and interview, on 5/5/2025, at 11:06 AM, with LVN 8, Resident 62's list of administered medications was reviewed. LVN 8 stated she did not realize she did not administer Resident 62's cholecalciferol and Miralax as scheduled at 9AM. LVN 8 stated residents' medications can be given one hour before and one hour after the scheduled time. LVN 8 stated it was important to administer Resident 62's medications as scheduled to prevent drug interactions.</p> <p>During an interview, on 5/5/2025, at 4:31 PM, with the Director of Nursing (DON), the DON stated LVN 8 should have followed the physician's order to administer cholecalciferol and Miralax as scheduled at 9 AM. The DON stated it was important that residents receive their medication as ordered to prevent side effects.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Administering Medications, revised on 4/2019, the P&P indicated the following:</p> <p>Medications are administered in a safe and timely manner, and as prescribed</p> <p>Medications are administered in accordance with prescriber orders, including any required time frame</p>

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain dental services for each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49537</p> <p>Based on observation, interview, and record review, the facility failed to promptly provide dental services for one of two sampled residents (Resident 46) as in accordance with the facility's Dental Services policy.</p> <p>This deficient practice resulted in Resident 46 having pain when wearing dentures, poor food intake from inability to effectively chew food and had the potential to result in weight loss, lack of energy, and loss of muscle mass.</p> <p>Findings:</p> <p>During a review of Resident 46's Admission Record, the Admission Record indicated the facility initially admitted Resident 46 on 6/17/2020 and readmitted on [DATE] with diagnoses including, but not limited to, hypertension (high blood pressure), dysphagia (difficulty swallowing), protein-calorie malnutrition (state of inadequate intake of food as a source of protein[builds, maintains, and replaces the tissues in the body], calories [unit of measurement for the energy contained n food], and other essential nutrients [chemical compounds in food that are used by the body to function properly and maintain health]), and bipolar disorder (a mental health condition characterized by extreme shifts in mood, energy, and activity levels).</p> <p>During a review of Resident 46's History and Physical (H&P-a comprehensive assessment by a healthcare provider that includes a thorough medical history and a physical exam), dated 10/4/2024, the H&P indicated Resident 46 had the capacity to understand and make decisions.</p> <p>During a review of the Minimum Data Set (MDS-a resident assessment tool), dated 4/5/2025, the MDS indicated Resident 46 required set up or clean up assistance (Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following activity) with eating and oral hygiene. The MDS indicated Resident 46 required substantial/maximal assistance (Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with toileting and personal hygiene, upper and lower body dressing, and putting on/taking off footwear. The MDS also indicated that Resident 46 was dependent (Helper does all the effort. Resident does none of the effort to complete the activity or the assistance of two or more helpers is required for the resident to complete the activity. The MDS did not indicate Resident 46's oral/dental status as having broken or loosely fitting full or partial denture, mouth or facial pain, discomfort or difficulty with chewing.</p> <p>During an observation and interview on 5/1/2025 at 11:04 AM with Resident 46 inside the resident's room, Resident 46 was observed laying in her bed. Resident 46's denture cup was observed on top of the dresser. Resident 46 stated that her dentures do not fit for months now and need to be refitted. Resident 46 stated after using her dentures (could not remember the date), it had started to hurt when she puts it on to eat. Resident 46 stated not all her teeth were removed and she does not know why. Resident 46 stated she had notified staff that she couldn't eat food anymore because she couldn't chew the food due to pain. Resident 46 stated there were no staff who came to set up dental referral.</p> <p>(continued on next page)</p>		

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/5/2025 at 12:02 PM with Certified Nurse Assistant 1 (CNA 1), CNA 1 stated that 2 months ago (unable to recall exact date), Resident 46 told her that it hurts when she puts on her dentures. CNA 1 stated she informed the Licensed Vocational Nurse 3 (LVN 3) at that time. CNA 1 stated Resident 46 again told her the next day and last week (do not recall exact dates) that it hurts when she puts on her dentures. CNA1 stated she notified LVN 4. CNA 1 does not know what has been done to address Resident 46's denture problem.</p> <p>During an interview on 5/5/2025 at 2:06 PM with LVN 3, LVN 3 stated she recalled CNA 1 notifying her of Resident 46's complaint of pain when putting on her dentures. LVN 3 stated she informed the Speech Therapist (ST, healthcare professional who specializes in diagnosing and treating communication and swallowing disorders) and recalled that the ST then went to see Resident 46. LVN 3 stated she failed to notify Resident 46's Attending Physician (MD-Doctor of Medicine) and the Social Services Director (SSD). LVN 3 stated it was important to notify the MD and SSD so orders for referral to the Dentist can be obtained and SSD can work on the referral in a timely manner. LVN 3 stated that if the denture problem was not addressed timely, Resident 46 could have poor oral intake, weight loss, and malnutrition (lack of proper nutrition, caused by not having enough to eat, not eating enough of the right things, or being unable to use the food that one does eat.)</p> <p>During an interview on 5/5/2025 at 4 PM with SSD, SSD stated she was not made aware of Resident 46's denture issue. SSD stated it was important to communicate any issues of the residents to social services so the issues can be resolved in a timely manner.</p> <p>During a concurrent interview and record review on 5/5/2025 at 4:40 PM with the Director of Nursing (DON) and Director of Rehabilitation (DOR), the Speech Therapy Treatment Encounter Notes dated 3/24/2025 and 4/2/2025 were reviewed. The ST treatment encounter notes indicated that Resident 46's upper and lower dentures were loose, and Resident 46 did not want to wear them for that reason. The DON and DOR cannot confirm if ST endorsed this to Nursing staff or SSD. The DON and DOR both confirmed that it was important to notify the MD of residents' complaints so something can be done in a timely manner. The DON and DOR stated that there was a delay in dental care and services for Resident 46 when the MD and SSD were not informed of Resident 46's loose fitting dentures and pain when wearing them.</p> <p>During a review of Resident 46's Care Plan with focus on potential for dental problems- edentulous (condition where a person has lost all natural teeth in either the upper, lower, or both jaws), initiated 10/3/2022, the Care Plan indicated interventions indicated to monitor dental condition and refer for dental evaluation if indicated.</p> <p>During a review of the facility's Policy and Procedures (P&P) titled, Dental Services, revised 12/2016, the P&P indicated routine, and emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care. The P&P also indicated if dentures are damaged or lost, residents will be referred for dental services within three days. If the referral is not made within three days, documentation will be provided regarding what is being done to ensure that the resident is able to eat and drink adequately while awaiting the dental services and the reason for the delay.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>45099</p> <p>Based on observation, interview, and record review, the facility failed to ensure:</p> <ol style="list-style-type: none"> 1. Foods are stored in a manner that prevents foodborne illness (illness that comes from eating contaminated food) for residents. 2. All personnels in the kitchen, which includes outside maintenance, working on kitchen equipment, wore hair nets. <p>These deficient practices have the potential to result in foodborne illness in a population of 103 residents who consume the food prepared by the facility every day.</p> <p>Findings:</p> <p>During an observation on 4/28/2025 at 8:05 a.m. in the walk-in refrigerator, the following items were found:</p> <ol style="list-style-type: none"> 1. Sesame dressing received on 2/11/25 and opened at 2/25/25. 2. Multiple small cups of cranberry and orange juice on a large tray without a prepared date found on the cups or on the tray. <p>During an interview on 4/28/2025 at 8:10 AM, [NAME] 1 (CK 1) stated the sesame dressing should only be good for one (1) month once opened and should be thrown after to prevent the residents from getting sick.</p> <p>During a concurrent interview and review of the facilities Dry Goods Storage from Healthcare Menus Direct (company that specializes in providing menu services in facilities) on 4/28/2025 at 8:14 AM, the Dietary Aid 1 (DA 1) confirmed that the bottled salad dressing once opened should be refrigerated then discarded after 1 month. DA 1 stated sesame dressing was stored for 2 months from the opened date and should only be stored for 1 month from the date it was opened. DA 1 also stated the sesame dressing could turn rancid and residents could develop stomach upset when consumed.</p> <p>During a concurrent observation and interviews on 5/2/2025 at 11:00 AM, an outside Maintenance (OM) from a juice company was seen fixing the large juicer in the kitchen without wearing a hair net. OM stated he was aware of wearing hair nets while inside the kitchen, but other facilities do not enforce it. The Dietary Service Supervisor (DSS) stated everyone who enters the kitchen should be wearing hair nets to prevent hair from falling on food preparation areas.</p> <p>During an interview on 5/2/2025 at 11:09AM, the DSS stated the cups of juices should have a prepared date to prevent residents from consuming spoiled juices and cause foodborne illnesses. The DSS also stated the sesame dressing should have been discarded since it could potentially cause foodborne illness if it gets consumed by the residents.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility's Policy and Procedure titled, Food Receiving and Storage, revised July 2014, the Policy and Procedure indicated that Foods shall be received and stored in a manner that complies with safe food handling practices. The policy also stated that all foods stored in the refrigerator or freezer with be covered, labeled, and dated with a use by date.</p> <p>During a review of the facility's Policy and Procedure titled, Labeling and Dating of Food, dated 2023, the Policy and Procedure indicated that all prepared foods need to be covered, labeled, and dated. The policy also stated that items can be dated individually or in bulk stored on a tray with masking tape if going to be used for meal service (i.e. drinks).</p> <p>During a review of the facility's Policy and Procedure titled, Preventing Foodborne Illness - Employee Hygiene and Sanitary Practices, revised October 2017, the Policy and Procedure indicated that hair nets or caps and/or beard restraints must be worn to keep hair from contacting exposed food, clean equipment, utensils and linens.</p>		

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<p>F 0813</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Have a policy regarding use and storage of foods brought to residents by family and other visitors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49537</p> <p>Based on observation, interview, and record review the facility failed to ensure food brought in by family met the prescribed diet and ensure food safety requirements for one (Resident 66) of three sampled residents.</p> <p>This deficient practice had the potential to result in electrolyte (crucial for various bodily functions, including maintaining fluid balance, regulating muscle and nerve function, and supporting heart health) imbalances, fluid overload (medical condition where there is too much fluid in the body), and food borne illnesses (food poisoning) to Resident 66 that can lead to other serious complications and hospitalization .</p> <p>Findings:</p> <p>During a review of Resident 66's Admission Record, the Admission Record indicated the facility initially admitted the resident on 1/29/2024 and readmitted on [DATE] with diagnoses including, but not limited to, chronic kidney disease stage five (final stage of kidney failure, also known as end stage renal disease [ESRD]), dependence on hemodialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidneys have failed), heart failure (condition where the heart muscle is unable to pump blood effectively enough to meet the body's needs), protein-calorie malnutrition (refers to a nutritional status in which reduced availability of nutrients leads to changes in body composition and function), and hypertension (high blood pressure).</p> <p>During a review of Resident 66's Minimum Data Set (MDS-a resident assessment tool) dated 2/4/2025, the MDS indicated Resident 66 had intact cognitive (mental processes that take place in the brain, including thinking, attention, language learning, memory, and perception skills for daily decision making) skills for daily decision making. The MDS indicated Resident 66 required partial/moderate assistance (Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with eating and oral hygiene. The MDS indicated Resident 66 required substantial/maximal assistance (Helper lifts or holds trunk or limbs and provides more than half the effort) with toileting and personal hygiene, shower/bathing self, upper and lower body dressing, and putting on/taking off footwear. The MDS also indicated Resident 66 was on a mechanically altered diet (foods that are easy to swallow because they are blended, chopped, grinded, or mashed so that they are easy to chew and swallow) and therapeutic diet (a specialized meal plan designed to treat or manage specific health conditions).</p> <p>During a review of Resident 66's Order Summary, the Order Summary indicated Renal diet(foods that have lower amounts of sodium, protein, potassium, or phosphorus), regular texture, thin liquids consistency, double protein cut up meat and vegetable, dated 3/21/2024. The Order Summary also indicated Dietary Fluid Restriction of one liter (a unit for measuring the volume of a liquid or gas, equal to 1,000 cubic centimeters (unit of volume in the metric system, commonly used to measure small amounts of fluids) in 24 hours, dated 4/8/2025.</p> <p>(continued on next page)</p>		

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<p>F 0813</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 4/28/2025 at 12:11 PM at Resident 66's room, Resident 66 was observed lying comfortably in bed, awake, with family present in the room. Resident 66 stated that family brings home cooked foods. Resident 66 stated he preferred his family to bring him food from home. Resident 66 stated he does not recall if the facility discussed the policy about bringing food from home or outside the facility.</p> <p>During a concurrent interview and record review on 5/5/2025 at 8:50 AM with the MDS Nurse (MDSN), the Care Plan for nutritional risk, initiated on 2/20/2024, was reviewed. The Care Plan interventions included to encourage adherence with diet, educate on risk of non-adherence, and provide, serve diet as ordered. The MDSN stated care plan did not address food being brought in by family and if family was educated on what Resident 66's diet composition was and food safety requirements. The MDSN stated that, for nutrition care plans, it was the Registered Dietician (RD) and/or the Dietary Service Supervisor (DSS) that initiates and revises the care plan. The MDSN stated that the family of Resident 66 had been bringing food since resident's admission. The MDSN stated there was no care plan in Resident 66's medical record addressing food brought in by family, education on prescribed diet and fluid restriction in relation to food brought in and food safety. The MDSN stated it was important to have a care plan for each actual and potential problem to guide the staff in the provision of care to the residents. The MDSN also confirmed that there were no Interdisciplinary Team (a group of healthcare professionals with various areas of expertise who work together toward the goals of the patients) meeting notes discussing food being brought in for Resident 66 from outside the facility.</p> <p>During a concurrent interview and record review on 5/5/2025 at 10:03 AM with the DSS, the nutritional risk care plan initiated on 2/20/2024 was reviewed. The care plan indicated to encourage adherence with diet, educate on risk of non-adherence, to provide and serve diet as ordered. The DSS stated she was aware of family bringing food from home or outside since Resident 66's admission but she failed to include it in the care plan. The DSS stated she could not remember if she educated the resident and family about following the prescribed diet and safety and sanitation of food brought in from outside the facility and if the facility policy was discussed and provided to the resident and family when family started to bring food. The DSS stated she knew that family was bringing food for the resident since admission. The DSS stated it was important to have included this in the care plan as it could affect the resident's weight, if the food was within resident's specified/ordered diet, and if food was prepared safely and without pathogens (microorganisms or other biological agents that cause diseases). DSS stated that both her and the RD missed including food brought from outside the facility in the care plan and that could affect Resident 66's care and health because he had end stage renal disease (ESRD). The DSS stated that she was aware that care plans should be patient centered, she just failed to include food brought from outside the facility in the problem list. The DSS further stated that not updating and revising care plans could affect the care being given to the residents as interventions would be different or no longer applicable.</p> <p>During an interview on 5/5/2025 at 12:40 PM with the Registered Dietician (RD), the RD stated Resident 66 had been gaining weight and she had spoken with the Hemodialysis Center's Dietician about it. RD stated she had documented in her monthly review, that resident's family was bringing him food affecting fluids but there was no documentation that resident and family were given education about food from outside the facility meeting prescribed diet. The RD stated she did not meet with the resident and family to discuss and educate them about Resident 66's diet and fluid restriction adherence.</p> <p>(continued on next page)</p>		

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<p>F 0813</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's Policy and Procedures (P&P) titled, Food Brought by Family/Visitors, revised 10/2017, the P&P indicated food brought to the facility by visitors and family is permitted. Facility staff will strive to balance resident choice and a homelike environment with the nutritional and safety needs of residents. The P&P further indicated:</p> <p>1 Nursing staff will provide family/visitors who wish to bring food to the facility with a copy of this policy.</p> <p>2 Family/Visitors are asked to prepare and transport food using safe food handling practices including: safe cooling a reheating process; holding temperatures; preventing cross contamination with raw or undercooked foods; and hand hygiene.</p> <p>3 Safe food handling practices will be explained to family/visitors in a language and format they understand.</p> <p>4 When meals or snacks are provided by family/visitors frequently (more than three times a week), the dietician or nurse may request a meeting with the resident or representative to discuss the nutrition goals and wishes of the resident.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42223</p> <p>Based on observation, interview, and record review, the facility failed to observe infection control measures for three of 22 sampled residents (Residents 175, 173 and 271) as indicated on the facility policy by failing to ensure:</p> <ol style="list-style-type: none"> 1. Treatment Nurse 1 (TN 1) doff (take off) Personal Protective Equipment (PPE, protective clothing, goggles, or other garments to prevent or minimize exposure to and spread of infection or illness) and perform hand hygiene (cleaning hands to prevent germs) after repositioning Resident 175 and before continuing wound care treatment. 2. Licensed Vocational Nurse 5 (LVN 5) doff PPE after administering medications to Resident 173 and before touching the medication cart. <p>This deficient practice has the potential to spread infection to staff and residents.</p> <ol style="list-style-type: none"> 3. Resident 271's indwelling catheter drainage bag (Foley catheter- a tube that allows urine to drain from the bladder into a drainage bag) was not touching the floor. <p>This deficient practice had the potential to expose Resident 271 to harmful bacteria and viruses, leading to infection, delayed recovery, prolonged illness, and/or hospitalization .</p> <ol style="list-style-type: none"> 4. The water used to wash one load of soiled linens in one of three washing machines (WM) had the correct temperature in accordance with the facility's policy. <p>This deficient practice had the potential to compromise infection control measures to eliminate disease causing bacteria, germs, and viruses on linens which could get residents sick and potential spread infection in the facility</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a review of Resident 175's Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE] with the following diagnoses of dementia (a progressive state of decline in mental abilities) and sepsis (a life-threatening blood infection). <p>During a review of Resident 175's History and Physical (H&P), dated 5/5/2025, the H&P indicated the resident does not have the capacity to understand and make decisions.</p> <p>During a review of Resident 175's Physician Order, dated 4/30/2025, the Physician Order indicated cleanse pressure injury (localized damage to the skin and/or underlying tissue usually over a bony prominence) with normal saline, pat dry, apply zinc oxide (medicated cream that treats or prevents skin irritation) and cover with dry dressing every day or as needed.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a wound care observation on 5/5/2025 at 10:34 AM, TN1 was observed not changing gloves and not performing hand hygiene after repositioning the resident and before continuing wound care treatment. TN 1 was observed repositioning the resident using the same gloves to continue the wound care treatment.</p> <p>During an interview on 5/5/2025 at 10:55 AM, TN 1 stated she should have changed her gloves and performed hand hygiene after she repositioned the resident to prevent the spread of infection.</p> <p>During an interview on 5/5/2025 at 12 PM, the Director of Nursing (DON) stated TN 1 should change gloves and perform hand hygiene before continuing the wound care treatment to prevent the spread of infection.</p> <p>During an interview on 5/5/2025 at 3:04 PM, the Infection Preventionist Nurse (IPN) stated TN 1 should have removed her gloves, perform hand hygiene and put on a new set of gloves prior to continuing wound care treatment. IPN also stated repositioning the resident, and then touching the wound with the same gloves can spread infection to the resident.</p> <p>2. During a review of Resident 173's Admission Record, the Admission Record indicated the resident was originally admitted to the facility on [DATE] and was readmitted on [DATE] with the following diagnoses of sepsis and pneumonia (an infection/inflammation in the lungs).</p> <p>During a review of Resident 173's Minimum Data Set (MDS, resident assessment tool), dated 4/24/2025, the MDS indicated the resident was assessed being independent with cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 173 required substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with eating, oral hygiene, upper body dressing and personal hygiene but was dependent (helper does all of the effort. Resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity) with toileting hygiene, lower body dressing and putting on/taking off footwear.</p> <p>During a medication administration observation and interview on 5/2/2025 at 10:15 AM, LVN 5 finished administering medications to Resident 173 and with PPEs on, LVN 5 walked out of Resident 173's room and proceeded to open the medication cart. LVN 5 neither doffed her PPE nor performed hand hygiene. LVN 5 stated she should have doffed her PPE and performed hand hygiene prior to exiting the residents room and before opening the medication cart. LVN 5 also stated that not doffing PPE could spread infection.</p> <p>During an interview on 5/2/2025 at 10:54 AM, the DON stated LVN 5 should doff PPE and perform hand hygiene when exiting the resident room and before going to the medication cart. DON also stated it is infection control and can spread infection.</p> <p>During an interview on 5/5/2025 at 3:04 PM, IPN stated LVN 5 should have doffed her PPE and performed hand hygiene before exiting the room and going to the medication cart. IPN also stated LVN 5 have contaminated the medication cart and can spread infection.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility's Policy and Procedure (P&P) titled, Infection Prevention and Control Program, revised 10/2018, the P&P indicated an infection prevention and control program is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.</p> <p>During a review of the facility's P&P titled, Handwashing/Hand Hygiene, revised 8/2019, the P&P indicated to use alcohol-based hand rub or soap and water:</p> <ol style="list-style-type: none"> 1. Before moving from a contaminated body site to a clean body site during resident care. 2. After contact with objects in the immediate vicinity of the resident 3. Before and after direct contact with residents 4. After removing gloves <p>The P&P also indicated the use of gloves does not replace hand washing/hand hygiene.</p> <p>46919</p> <p>3. During a review of Resident 271's Admission Record, the Admission Record indicated Resident 271 was admitted to the facility on [DATE] with diagnoses that included pulmonary fibrosis (a condition where the lungs become scarred and thickened, making it difficult to breathe), acute (severe and sudden onset) and chronic (an illness persisting for a long time or constantly recurring) respiratory failure (a condition where the lungs cannot adequately exchange gases, resulting in insufficient oxygen uptake and/or excessive carbon dioxide buildup in the blood) with hypoxia (a condition where the body's tissues do not receive enough oxygen), and malignant neoplasm of colon (a cancerous growth that develops in the tissues of the largest part of the large intestine).</p> <p>During a review of Resident 271's Minimum Data Set (MDS- a resident assessment tool), dated 4/10/2025, the MDS indicated Resident 271 was assessed having moderately impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. Resident 271 required substantial/maximal assistance (helper does more than half the effort) with eating, oral/personal hygiene, sit to lying, sit to stand, and walking 10 feet (ft- unit of measurement). Resident 271 was dependent helper does all of the effort) with toileting hygiene, upper/lower body dressing, chair/bed-to-chair transfer, and tub/shower transfer. Resident 271 had an indwelling catheter.</p> <p>During a review of Resident 271's Order Summary Report, dated 4/29/2025, the Order Summary Report indicated a physician order, with a start date of 4/8/2025, for indwelling foley catheter to gravity drainage bag/leg bag due to neurogenic bladder (when a person lacks bladder control due to brain, spinal cord or nerve problems), check placement and patency (condition of not being blocked or obstructed) every day shift.</p> <p>During a review of Resident 271's Order Summary Report, dated 4/29/2025, the Order Summary Report indicated a physician order, with a start date of 4/7/2025, to secure indwelling catheter tubing using anchoring device/leg strap to prevent movement and urethral traction (when a catheter is inserted into the urethra [a tube in the male body that carries urine from the bladder out of the body] to create pressure against the bladder neck or prostate).</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 271's Care Plan, dated 4/4/2025, the Care Plan indicated Resident 271 had altered elimination due to use of indwelling foley catheter to gravity drainage bag/leg bag for clinical indication of neurogenic bladder. Resident 271's Care Plan interventions indicated to change the foley catheter and drainage bag per facility protocol.</p> <p>During a concurrent observation and interview, on 5/2/2025, at 9:59 AM, Certified Occupational Therapy Assistant 1 (COTA 1) was observed pushing Resident 271 in front of Nurse's Station (NS 1) to the oxygen supply room. Resident 271's indwelling catheter collection bag was observed touching the floor while Resident 271 was being pushed on his wheelchair by COTA 1. COTA 1 stated Resident 271 was going to the rehabilitation room (rehab- a room that provides services to residents for the purpose of improving strength, fitness, and mobility).</p> <p>During an interview, on 5/2/2025, at 12:36 PM, with the Director of Rehabilitation (DOR), the DOR stated COTA 1 should have ensured Resident 271's collection bag did not touch the floor while pushing his wheelchair to rehab. The DOR stated the collection bag needed to be kept off the floor for infection control purposes.</p> <p>During an interview, on 5/2/2025, at 1:48 PM, with COTA 1, COTA 1 stated he hooked Resident 271's collection bag to the wheelchair before pushing Resident 271 out of his room. COTA 1 stated the hook must have gotten loose causing the collection bag to touch the floor. COTA 1 stated bacteria can enter the collection bag when it touches the floor and can cause a resident to get sick from an infection.</p> <p>During an interview, on 5/5/2025, at 4:44 PM, with the Director of Nursing (DON), the DON stated foley catheters should be off the floor to prevent infections. The DON stated an infection can cause a change in condition for the residents.</p> <p>During a review of the facility's policy and procedure (P&P), titled, Catheter Care, Urinary revised on 9/2014, the P&P indicated, under infection control, to be sure the catheter tubing and drainage bag are kept off the floor.</p> <p>4. During a concurrent observation and interview, on 5/2/2025, at 11:17 AM, in the laundry room with Laundry Staff 1 (LS1) and LS 2, LS 1 stated there was 1 load of linens being washed in Washing Machine 1 (WM 1). LS 2 stated WM 1 containing residents' linens. LS 2 stated the washing machine thermometer on the wall behind WM 1 and WM 2 read 130 degrees Fahrenheit (?).</p> <p>During a concurrent observation and interview, on 5/2/2025, at 11:28 AM, with Maintenance Director (MD) and Maintenance Assistant (MA) in the boiler room (a room with equipment for heating a building), MA checked Water [NAME] 1 (WH 1) and stated the screen that indicated the water temperature was off. MA stated if WH 1's screen was off then WH 1 was turned off. MD checked the electrical outlet and stated WH 1's electrical cord was loose and not properly plugged in the electrical outlet. MD stated he did not know how long WH 1 had been turned off. MA stated WH 1 was used to heat the water in the laundry room.</p> <p>During the same concurrent observation and interview, on 5/2/2025, at 11:31 AM, MD checked the water machine thermometer in the laundry room and stated the temperature was still at 130 ?. MD manually checked the water temperature in the laundry room sink from 11:33 AM to 11:37 AM and stated the water temperature was only 138 ?.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a follow up interview, on 5/5/2025, at 1:22 PM, with MD, MD stated the water temperature for washing linen should be 160 ?. MD stated it was important for the water to be at 160? to make sure linens are cleaned during the wash. MD stated germs and bacteria can survive on the linens if washed at a lower temperature.</p> <p>During an interview, on 5/5/2025, at 2:51 PM, with Infection Preventionist Nurse (IPN), IPN stated the temperature of WM 1 should be at 160 ? for the duration of thirty minutes to disinfect (clean, especially with a chemical, to destroy bacteria) the linens and kill the germs. IPN stated organisms can stay on the linens and get transferred to the residents if the linens are not washed properly. IPN stated contaminated (make something dirty by introducing unwanted or harmful substances into it) linens can spread infection to residents if used.</p> <p>During a review of the facility's policy titled, Laundry and Bedding, soiled revised on 09/2022, the policy indicated the following:</p> <ul style="list-style-type: none"> > Soiled laundry/bedding shall be handled, transported and processed according to best practices for infection prevention and control. > Laundry processed in hot water temperatures is 160 F (71 C) for 25 minutes. 		