| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056083 | A. Building<br>B. Wing | 04/04/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Woods Health Services | 2600 A Street<br>LA Verne, CA 91750 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that residents are fully informed and understand their health status, care and treatments.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49252<br><br>Based on interview and record review, the facility failed to promote the resident/responsible party's right to be informed of and participate in treatment for one of five (Resident 29) sampled residents by failing to obtain a consent and inform Resident 29's responsible party in advance of the risks and benefits of a psychoactive (medications that affect the mind or behavior) medication, Seroquel (a medication used to treat symptoms of psychosis [a collection of symptoms that affect the mind, where there has been some loss of contact with reality]).<br><br>This failure violated the responsible party's right to make an informed decision on behalf of Resident 29 regarding the use of a psychoactive medication.<br><br>Findings:<br><br>During a review of Resident 29's Admission Record (AR), the AR indicated Resident 29 was admitted to the facility on [DATE] with diagnoses that included Parkinson's disease (a progressive disease affecting the nervous system marked by tremor [involuntary shaking or movement], muscular rigidity, and slow, imprecise movements), dementia (a progressive state of decline in mental abilities), and a history of falling.<br><br>During a review of Resident 29's Care plan (CP), last revised on 4/29/2024, the CP indicated the resident used psychotropic medications (medications that affect a person's mental state), Seroquel for psychosis manifested by visual hallucinations evidenced by seeing children that are in distress. The CP's intervention indicated to monitor for side effects (unwanted, uncomfortable, or dangerous effects that a resident may have due to a medication) of antipsychotic medications.<br><br>During a review of Resident 29's History & Physical (H&P), dated 10/21/2024, the H&P indicated Resident 29 could make her needs known but could not make medical decisions.<br><br>During a review of Resident 29's Minimum Data Set (MDS, a resident assessment tool), dated 2/18/2025, the MDS indicated Resident 29 had severe impaired cognition (ability to understand).<br><br>During a review of Resident 29's Order Summary Report, dated active as of 4/1/2025, the Order Summary Report indicated an active physician's order, start date 3/19/2025, for Seroquel oral tablet 50 milligrams (mg, unit of measurement), 1 tablet given by mouth at bedtime for psychosis with visual hallucination manifested by seeing children running in the hallway and Resident 29 becoming aggressive.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of Resident 29's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 4/1/2025 to 4/30/2025, the MAR indicated administration of Seroquel 50 mg at bedtime on 4/1/2025 at 8 pm and 4/2/2025 at 8 pm to Resident 29.<br><br>During a concurrent interview and record review on 4/03/2025 at 2:49 PM with Licensed Vocational Nurse 1 (LVN 1), Resident 29's medical record was reviewed. There was no documented evidence that indicated an informed consent was completed for Seroquel 50 mg at bedtime for psychosis. LVN 1 stated, an informed consent was needed for this medication [Seroquel], which was a psychotropic medication. LVN 1 further stated, psychotropic medications had numerous side effects making it important to educate and inform the resident/responsible party.<br><br>During an interview on 4/4/2025 at 10:20 AM with the Director of Nursing (DON), the DON stated an informed consent needed to be completed by the resident or their family for the use of any psychotropic medication (a new order or an increased dosage) and it should have been completed by the nurse who received the medication order. The DON stated, if the informed consent was not completed, the medication should not be given. The DON further stated, without an informed consent the resident/responsible party would be uninformed, and it was their right to be informed about the [risks and benefits of the] medication.<br><br>During a review of the facility's policy and procedure (P&P) titled, Woods Health Services - Informed Consent, revised 1/9/2025, the P&P indicated, the physician informs the resident/resident representative of risks/benefits of psychotherapeutic drugs and obtains informed consent prior to use. |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Reasonably accommodate the needs and preferences of each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38108<br><br>Based on observation, interview and record review, the facility failed to ensure a call light was within reach for one of one sampled resident (Resident 31) and failed to ensure a call light was answered timely for one of one sampled resident (Resident 30).<br><br>This deficient practice had the potential to result in a delay in treatment and/or result in unmet needs for Resident 31 and Resident 30. Additional the deficient practice had the potential to result in harm to Resident 30.<br><br>Findings:<br><br>a. During a review of Resident 31's Admission Record (AR), the AR indicated that Resident 31 was admitted to the facility on [DATE] with diagnoses that included unspecified visual loss, muscle wasting and anxiety (a feeling of worry, nervousness, or unease).<br><br>During a review of Resident 31's care plan (CP) titled Sensory/perception Alterations: Visual with severely impaired vision, legally blind ., revised on 1/16/2023, the CP indicated the call light should be within reach and answered promptly as part of the facility's interventions.<br><br>During a review of Resident 31's History and Physical (H&P), dated 1/16/2024, the H & P indicated Resident 31 could make needs known but could not make medical decisions.<br><br>During a review of Resident 31's Minimum Data Set (MDS, a standardized assessment and care-screening tool), dated 1/20/2025, the MDS indicated Resident 31 was moderately impaired in cognitive skills (noticeable but not severe deficits). The same MDS indicated that Resident 31 was moderately (speaker had to increase volume and speaking distinctly) impaired in hearing and was severely impaired in vision (no vision or see only light, colors or shapes). The MDS indicated Resident 31 was dependent (helper does all the effort) on staff for toilet hygiene, shower and bathing.<br><br>During an observation ad concurrent interview with Resident 31 on 4/1/2025 at 10:54 am, while in the resident's room, Resident 31 was sitting in a wheelchair beside the bed. Resident 31's call light was observed laying in the middle of the resident's bed, and not within reach of the resident. Resident 31 stated, I am blind and could not find the call light as the resident moved her hands attempting to locate the call light. Resident 31 stated I don't know where my call light is. I want to be able to reach it (call light) so I can call them (staff)<br><br>During an observation and concurrent interview with Certified Nurse Assistant 1 (CNA 1), on 4/1/2025 at 10:58 am, CNA 1 stated Resident 31 was considered blind. The Call light should be in reach so the resident can push the button when assistance is needed.<br><br>During an interview with the Director of Nursing (DON), on 4/2/2025 at 3:29 pm, the DON stated Resident 31 was legally blind (no vision). The DON stated the call light should be within reach for residents, especially the blind. Call lights are important to use when asking for assistance and safety.<br><br>(continued on next page) |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of the facility's undated policy and procedure (P&P) titled Answering Call Lights, indicated to ensure that the call light is accessible to the resident<br><br>During a review of the facility 's policy and procedure titled Accommodation of Needs, dated 3/2021, 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.<br><br>49252<br><br>b. During a review of Resident 30's AR, the AR indicated Resident 30 was admitted to the facility on [DATE] with diagnoses that included but was not limited to pressure ulcer stage 3 (full-thickness loss of skin. Dead and black tissue may be visible), Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and dysphagia (difficulty swallowing).<br><br>During a review of Resident 30's H&P, dated 12/18/2024, the H&P indicated Resident 30 had the capacity to understand and make decisions.<br><br>During a review of Resident 30's MDS, dated [DATE], the MDS indicated Resident 30 had intact cognition (ability to understand).<br><br>During an observation on 4/1/2025 at 10:41 AM, Resident 30's call light outside Resident 30's room and the central call light located at the nursing station were lit. Resident 30's call light remained unanswered until 10:52 AM by LVN 2 (Resident 30's nurse).<br><br>During an interview on 4/1/2025 at 11 AM, Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated Resident 30 had called for a treatment. LVN 2 further stated, licensed and unlicensed nurses could answer the call lights, and should answer within three to five minutes to find out what the resident needed (in general) and assist them.<br><br>During an interview on 4/1/2025 at 11:07 AM, with Resident 30, Resident 30 stated he had to wait a while for assistance and did not like waiting when Resident 30 needed something.<br><br>During an interview on 4/4/2025 at 10:21 AM, with the DON, the DON stated call lights should be answered within three to five minutes and a maximum of ten minutes by nurses and nursing assistants. The DON further stated, the call light could be seen from the nursing station and the nurse in the station should call someone to assist the resident or answer the call light themselves. The DON stated, call lights needed to be answered timely to ensure the resident's needs were taken care of and for safety issues, such as fall prevention.<br><br>During a review of the facility's P&P titled, Call Light, undated, the P&P indicated, the objective was to respond to resident's requests and needs. The P&P indicated the call light should be answered promptly with a goal of three to five minutes and a maximum of 10 minutes. |

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| F 0640<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50016<br><br>Based on interview and record review, the facility failed to accurately code the Minimum Data Set (MDS - a standardized assessment and screening tool) related to anticoagulant (medicine that help prevent blood clots) use for one (1) of 1 sampled resident (Resident 26).<br><br>This deficient practice had the potential to negatively affect Resident 26's plan of care and delivery of necessary care and services.<br><br>Findings:<br><br>During a review of Resident 26's Admission Record (AR), the AR indicated the facility admitted Resident 26 to the facility on [DATE], and readmitted the resident on 3/1/2025, with diagnoses that included hemiplegia (paralysis that affects only one side of your body) and hemiparesis (weakness or the inability to move on one side of the body, making it hard to perform everyday activities like eating or dressing) following cerebral infarction (happens when blood flow to part of the brain is blocked, causing brain tissue to die due to lack of oxygen) affecting left non-dominant side, diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), and muscle weakness (generalized).<br><br>During a review of Resident 26's History and Physical (H&P), dated 3/3/2025, the H & P indicated Resident 26 had the capacity to understand and make decisions.<br><br>During a review of Resident 26's Order Summary Report, dated 4/2/2025, the Order Summary Report indicated an order on 3/1/2025 to give Resident 26 Plavix (is an antiplatelet drug to prevent blood clots) oral tablet 75 milligrams (mg) and Clopidogrel Bisulfate give 1 tablet by mouth one time a day for cerebrovascular accident (CVA-stroke, loss of blood flow to a part of the brain).<br><br>During a review of Resident 26's Minimum Data Set (MDS-a federally mandated resident assessment tool), dated 3/8/2025, indicated the resident received anticoagulant medication.<br><br>During a concurrent interview and record review on 4/2/2025 at 2:32 PM, Resident 26's MDS was reviewed with the MDS Nurse, the MDS stated that Plavix is classified as an antiplatelet medication, not an anticoagulant, and should have been coded as such. The MDS Nurse stated that antiplatelet medications should not be coded under the anticoagulant section (N0415E) of the MDS. The MDS Nurse stated that each medication class had its own designated items to ensure precise documentation and compliance with the Centers for Medicare & Medicaid Services (CMS) guidelines. The MDS Nurse stated that accurate documentation in the medication section (N0415E) of the MDS was crucial for reflecting the resident's medication regimen and ensuring appropriate care planning.<br><br>(continued on next page) |

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| F 0640<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 4/4/2025 at 9:35 AM, with the Director of Nursing (DON), the DON stated that accurate documentation of medications on the MDS ensured that the care plan reflected the resident's actual needs. The DON stated that it helped staff provide the right care and prevented errors. The DON stated that incorrect medication coding can lead to improper care which could have negatively impacted Resident 26's health and safety. The DON stated that anticoagulant and antiplatelet medications are categorized and coded separately due to their distant mechanisms and clinical uses.<br><br>During a review of the Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual Version 3.0, dated October 2024, indicated to check if an antiplatelet medication (e.g., aspirin/extended release, dipyridamole, clopidogrel) was taken by the resident at any time during the 7-day observation period (or since admission/entry or reentry if less than 7 days). |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49252<br><br>Based on interview and record review, the facility failed to ensure a Minimum Data Set (MDS, a resident assessment tool) accurately reflected one of one sampled resident's (Resident 47) hospice (interdisciplinary medical caregiving approach aimed at optimizing quality of life and mitigating or reducing suffering among people with serious and often terminal illnesses expected to live six months or less, end of life) status.<br><br>This deficient practice had the potential to result in unsuitable treatment and unmet needs to Resident 47.<br><br>Findings:<br><br>During a review of Resident 47's Admission Record (AR), the AR indicated Resident 47 was admitted to the facility on [DATE] with diagnoses that included heart failure (when the heart muscle can't pump enough blood to meet the body's needs for blood and oxygen), depression (a mood disorder that may cause persistent sadness or loss of interest in activities), and anxiety disorder (persistent feeling of dread or panic that can interfere with daily life).<br><br>During a review of Resident 47's Order Summary Report, dated active as of 4/1/2025, the Order Summary Report indicated Resident 47 had an active physician order, dated 3/6/2025, to admit Resident 47 to hospice.<br><br>During a review of Resident 47's History & Physical (H&P), dated 3/16/2025, the H&P indicated the resident had the capacity to understand and make decisions.<br><br>During a review of Resident 47's MDS, dated [DATE], the MDS indicated Resident 47 had intact cognition (ability to understand) and was not on hospice care while a resident [at the facility].<br><br>During a review of Resident 47's Care Plan (CP), last revised on 3/19/2025, the CP indicated Resident 47 had a terminal prognosis (medical term used for predicting the likelihood or expected development of a disease, including whether the signs and symptoms will improve, worsen, or remain stable over time) related to acute on chronic (long standing) heart failure (when the heart muscle can't pump enough blood to meet the body's needs for blood and oxygen). The CP's interventions indicated admit to hospice.<br><br>During an interview on 4/1/2025 at 10:32 AM with Resident 47, Resident 47 stated she was on hospice care.<br><br>During an interview on 4/3/2025 at 1:43 PM with Licensed Vocational Nurse (LVN 1), LVN 1 stated Resident 47 was on hospice care since admission on 3/6/2025.<br><br>During an interview on 4/4/2025 at 9:07 AM with the MDS Coordinator (MDS C), the MDS C stated Resident 47 was receiving hospice services since 3/6/2025. The MDS C stated Resident 47's MDS indicated Resident 47 was not receiving hospice services. The MDS C stated, the MDS was inaccurate and the MDS C would modify it.<br><br>(continued on next page) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 4/4/2025 at 10:11 AM with the Director of Nursing (DON), the DON stated Resident 47 had been on hospice since admission and the MDS was coded incorrectly. The DON stated, Resident 47's MDS would be modified to correct the error.<br><br>During a review of the facility's policy and procedure (P&P) titled, Woods Health Services - Charting and Documentation, last revised July 2017, the P&P indicated, documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.<br><br>During a review of the Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual Version 3.0, dated October 2024, the manual indicated the RAI process had multiple regulatory requirements. The manual indicated, federal regulations at 42 CFR 483.20 (b)(1)(xviii), (g), and (h) required that the assessment accurately reflected the resident's (in general) status. |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>50016<br><br>Based on observation, interview, and record review, the facility failed to ensure that medications, their purpose, and potential side effects were explained prior to administration for one (1) of two sampled residents (Resident 19).<br><br>This failure posed a risk of adverse drug reactions, decreased resident understanding and compliance, and a violation of resident rights to informed consent.<br><br>Findings:<br><br>During a review of Resident 19's Admission Record (AR), the AR indicated the facility admitted Resident 19 on 11/18/2022, with diagnoses that included pulmonary embolism (a blood clot, often originating in a leg vein, travels to the lungs and blocks a blood vessel, potentially causing serious health issues), diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), and dementia (a progressive state of decline in mental abilities).<br><br>During a review of Resident 19's History and Physical (H&P), dated 10/16/2024, the H & P indicated Resident 19 did not have the capacity to understand and make decisions.<br><br>During a review of Resident 19's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 2/24/2025, the MDS indicated Resident 19 required substantial/maximal assistance (helper does more than half the effort) with activities of daily living (ADL, term used in healthcare that refers to self-care activities) and dependent (helper does all the effort) with mobility.<br><br>During an observation on 4/3/2025 at 10:14 AM, Licensed Vocational Nurse (LVN) 3 did not ensure to explain Resident 19's morning medications, their purpose, and any potential side effects with the resident prior to medication administration. Medications administered:<br><br>-Amlodipine (a calcium channel blocker used to treat high blood pressure) tablet 2.5 milligrams (MG-metric unit of measurement, used for medication dosage and/or amount) give 1 tablet by mouth one time a day for hypertension (HTN-high blood pressure) hold if systolic blood pressure (the force of blood against your artery walls when your heart beats and pumps blood out to your body) less than 100.<br><br>-Cranberry Juice Powder Oral Capsule 425 MG give 1 capsule by mouth in the morning for prophylaxis (preventative treatment against disease).<br><br>-Docusate (stool softener) Sodium Oral Tablet 100 MG give 1 tablet by mouth two times a day for bowel management hold for loose stool.<br><br>-Eliquis (blood thinner) Oral Tablet 2.5 MG give 1 tablet by mouth two times a day for anticoagulation (the process of preventing or reducing blood clots).<br><br>-Lexapro (antidepressant) Oral Tablet 10 MG give 1 tablet by mouth one time a day for anxiety manifested by calling out without cause and verbalization of anxiousness.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Memantine (treatment for cognitive impairment) tablet 10 MG give 1 tablet by mouth two times a day for dementia (a progressive state of decline in mental abilities).<br><br>-Multivitamin Tablet give 1 tablet by mouth one time a day for supplement.<br><br>-Tylenol (treat minor aches and pains and reduces fever) Extra Strength Oral Tablet 500 MG give 1 tablet by mouth two times a day for Pain management.<br><br>-Vitamin B12 (a water-soluble vitamin essential for maintaining healthy blood and nerve cells) Oral Tablet 500 MCG (mg- metric unit of measurement, used for medication dosage and/or/ amount) give 1000 MCG by mouth one time a day for Supplement 2 tabs equals 1000 MCG<br><br>-Vitamin D3 (a fat-soluble vitamin for strong bones, muscles, and a healthy immune system) Oral Tablet 50 MCG give 1 tablet by mouth one time a day for Supplement.<br><br>During an interview on 4/3/2025 at 10:30 AM, with LVN 3, LVN 3 stated that it was important to explain medications to the residents before administering them, because residents have the right to know what they're being given and why. LVN 3 stated that explaining the medications also helped build trust and gave the resident a chance to be part of their own care, which could help reduce anxiety, especially if they were unfamiliar with the medication. LVN 3 stated that providing information about medications allows resident to exercise their right to refuse or ask questions.<br><br>During an interview on 4/3/2025 at 11:11 AM, with Resident 19, Resident 19 stated that when staff gave her medications, she wanted to know what was being given to her and what it was for. Resident 19 stated that it would have made her feel better, less confused, and gave her the choice to take them or not.<br><br>During an interview on 4/4/2025 at 9:35 AM, with the Director of Nursing (DON), the DON stated that explaining medications to the residents was a key part of informed consent. The DON stated that residents had the right to know what they're taking, why they're taking it, and what to expect. The DON stated that, by doing so, it helped build trust and helped ensure resident safety.<br><br>During a review of the facility's policy and procedure (P&P) titled, Resident's Rights, revision dated 2/2021, the P&P indicated that federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to:<br><br>-Exercise his or her rights as a resident of the facility and as a resident or citizen of the United States.<br><br>-Be informed of, participate in, his or her care planning and treatment.<br><br>During a review of the facility's policy and procedure (P&P) titled, Dignity, with a revision date of 2/2021, the P&P indicated that 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, and feelings of self-worth and self-esteem. The P&P indicated that the facility culture supports dignity and respect for residents by honoring resident goals, choices, preferences, values and beliefs. This begins with the initial admission and continues throughout the resident's facility stay. |

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|---|---|---|---|
| | 056083 | A. Building<br>B. Wing | 04/04/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Woods Health Services | 2600 A Street<br>LA Verne, CA 91750 |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49252<br><br>Based on observation, interview, and record review, the facility failed to provide care in accordance with professional standards of practice for one of one sampled residents (Resident 8) by failing to:<br><br>a. Ensure Resident 8 received the correct amount of oxygen [colorless, odorless gas] ordered via nasal cannula ([NC] a device-lightweight flexible plastic tubing used to deliver supplemental oxygen, tubing ending is placed in the nostrils and is fitted over the patient's ears).<br><br>This deficient practice resulted in incorrect oxygen administration to Resident 8 the the potential for a physical decline to Resident 8.<br><br>Findings:<br><br>a.During a review of Resident 8's Admission Record (AR), the AR indicated Resident 8 was admitted to the facility on [DATE] with diagnoses that included urinary tract infection (UTI- infection that happen when bacteria enter the urethra, and infect the urinary tract), heart failure (when the heart muscle can't pump enough blood to meet the body's needs for blood and oxygen), and dysphagia (difficulty swallowing).<br><br>During a review of Resident 8's Minimum Data Set (MDS, a resident assessment tool), dated 2/12/2025, the MDS indicated Resident 8 had moderate impaired cognition (ability to understand) and was dependent (helper does all the effort and resident does none of the effort to complete the activity or two or more helpers are required to complete the activity) for personal hygiene.<br><br>During a review of Resident 8's Care Plan (CP), last revised 11/9/2024, the CP indicated Resident 8 had asthma (narrow airways in the lungs that makes it difficult to breath) with shortness of breath and listed an intervention to check the oxygen liter flow every four hours to ensure proper flow for Resident 8.<br><br>During a review of Resident 8's Order Summary Report, dated active as of 4/2/2025, the Order Summary Report indicated an active physician order, dated 3/28/2025 for continuous oxygen at three liters (unit of volume) per minute via NC.<br><br>During a concurrent observation and interview on 4/1/2025 at 11:49 AM with Licensed Vocational Nurse 1 (LVN 1), Resident 8 was receiving four liters of oxygen via NC while in bed. LVN 1 stated, Resident 8's oxygen should be set at three liters and decreased the oxygen concentration.<br><br>During a review of Resident 8's Medication Administration Record (MAR), dated 4/1/2025 to 4/30/2025, the MAR indicated Resident 8 was receiving oxygen continuously at three liters per minute via NC each shift and the oxygen liter flow was checked every four hours to ensure proper flow.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a follow up interview on 4/3/2025 at 1:29 PM with LVN 1, LVN 1 stated oxygen was considered a treatment that needed a physician's order. LVN 1 further stated, oxygen should be administered by the licensed nurse at the ordered level because the doctor prescribed it that way and only licensed nurses were allowed to set oxygen levels.<br><br>During an interview on 4/4/2025 at 10:02 AM with the Director of Nursing (DON), the DON stated, Resident 8 had an oxygen order in place. The DON stated licensed nurses were responsible for checking the oxygen settings each shift and following the physician's order. The DON stated, when the oxygen setting was wrong, the resident did not receive the proper oxygen concentration.<br><br>During a review of the facility's policy and procedure (P&P) titled, Oxygen and Humidifier, undated, the P&P indicated, the purpose was to provide guidelines for safe oxygen administration and that staff should verify the physician's order for oxygen administration and review the physician's orders or facility protocol for oxygen administration. The P&P indicated for oxygen delivery to be set to the prescribed flow rate of oxygen to be used.<br><br>During a review of the facility's policy and procedure (P&P) titled, Oxygen Administration, revised 2/2024, the P&P indicated preparation included, verifying there was a physician's order for the procedure and review the physician's order or facility protocol for oxygen administration. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>50016<br><br>Based on observation, interview, and record review, the facility failed to implement a physician order for floor mats to be placed on both sides of the bed to prevent injury in the event of a fall for one (1) of three sampled residents (Resident 36).<br><br>This failure had the potential to result in a preventable injury, such as fractures or head trauma, due to an unprotected fall from bed, compromising resident safety and care standards.<br><br>Findings:<br><br>During a review of Resident 36's Admission Record (AR), the AR indicated the facility admitted Resident 36 on 6/20/2023, with diagnoses that included Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), dementia (a progressive state of decline in mental abilities), and repeated falls.<br><br>During a review of Resident 36's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 3/14/2025, the MDS indicated Resident 36's cognitive (the ability to think and process information) skills for daily decision making was severely impaired. The MDS indicated Resident 36 required substantial/maximal assistance (helper does more than half the effort) with activities of daily living (ADL, term used in healthcare that refers to self-care activities) and was dependent (helper does all of the effort) with mobility.<br><br>During an observation on 4/1/2025 at 11:05 AM, Resident 36 was lying in bed in semi-supine position with the bed in the lowest position. Resident 36 was noted with only one safety mat to the resident's left side of the bed.<br><br>During a concurrent interview and record review on 4/1/2025 at 2:57 PM, Resident 36's Order Summary Report was reviewed with Licensed Vocational Nurse (LVN) 2. LVN 2 stated that Resident 36 had a physician order indicating to place a floor mat on each side of the bed to prevent injury during a fall. LVN 2 stated that following physician orders for bilateral floor mats is crucial for patient safety and adherence to the care plan. LVN 2 stated that if Resident 36 had fallen on the unprotected side without a floor mat in place, the resident could have sustained serious injuries, including fractures, head trauma, or other complications.<br><br>During an interview on 4/4/2025 at 9:35 AM, with the Director of Nursing (DON), the DON stated that physician orders were part of the care plan and were based on the patient's medical needs. The DON stated that following physician orders is essential for safety and proper treatment. The DON stated that when a physician ordered floor mats, it was intended to help prevent serious injury, and failure to follow the order could have resulted in avoidable harm.<br><br>During a review of Resident 36's At Risk for Fall Care Plan, the care plan indicated and included an intervention for the floor mat to be placed on each side of the bed to prevent injury during a fall.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of the facility's Hourly Position Description of the Licensed Vocational Nurse, revised in 3/2024, the position description indicated that the LVN:<br><br>-Has knowledge of, and ensures compliance with, all physicians orders.<br><br>-Develops, updates, and implements the resident care plan.<br><br>During a review of the facility's Hourly Position Description of the Registered Nurse, revised in 1/2024, indicated that the RN:<br><br>-Has knowledge of, and ensures compliance with, all physicians orders for all residents of Woods Health Services.<br><br>-Develops, updates, and implements the resident care plan. |

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| F 0732<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Post nurse staffing information every day.<br><br>49252<br><br>Based on observation, interview, and record review, the facility failed to post the actual nursing hours for all shifts from 4/3/2025 to 4/4/2025 and failed to ensure the hours were posted in a prominent place to be readily accessible for residents and visitors.<br><br>This failure had the potential to result in the residents and visitors not knowing whether there was sufficient staff to provide quality care to the residents and resulted in nurse staffing information being inaccessible to visitors.<br><br>Findings:<br><br>During observations on 4/1/2025 at 4 PM, 4/2/2025 at 11:51 AM, and 4/3/2025 at 12:40 PM, the staffing sheet was only posted at the nursing station.<br><br>During an observation on 4/3/2025 at 2:58 PM, the staffing posting did not include total and actual hours worked per shift for licensed and unlicensed staff responsible for resident care.<br><br>During an interview on 4/4/2025 at 9:15 AM with the Staffing Assistant (SA), the SA stated the only nursing staffing postings in the facility were posted at the nursing station. The SA further stated, actual hours worked per shift for licensed and unlicensed staff responsible for resident care were not posted but were calculated by the end of the day or the end of the week depending on the workload. The SA stated, if actual hours were not posted, they wouldn't know if they were understaffed and [the facility] needed to ensure they had enough staffing hours for each resident by policy.<br><br>During an interview on 4/4/2025 at 10:23 AM with the Director of Nursing (DON), the DON stated the staffing posting was only at the nursing station and was unavailable to visitors. The DON stated, the nursing staffing postings of total and actual hours should be posted to ensure transparency and accountability within their nursing home staffing.<br><br>During a review of the facility's policy and procedure (P&P) titled, Woods Health Services - Posting Direct Care Daily Staffing Numbers, last revised 8/2022, the P&P indicated the facility posted on a daily basis for each shift nurse staffing data, which included the number of nursing personnel responsible for providing direct care to residents. The P&P indicated, within two hours of the beginning of each shift, the number of licensed nurses and the number of unlicensed nursing personnel directly responsible for resident care was posted in a prominent location (accessible to residents and visitors). The P&P further indicated, the information recorded on the form included the actual time worked during that shift for each category and type of nursing staff and total number of licensed and non-licensed nursing staff working for the posted shift. |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38108<br><br>Based on interview and record review, the facility failed to ensure irregularities identified from the Monthly Drug Regimen Review (MDRR), reported by the facility's pharmacist were acted upon for one of five sampled residents (Resident 13) by failing to:<br><br>a. Ensure action was taken for the use of GI meds Famotidine and pantoprazole for January 2025<br><br>b. Ensure Resident 13's physician was informed to reconsider the use of simvastatin (medication used to treat fat in the blood) for February 2025.<br><br>c. Ensure Resident 13's physician was informed to consider a gradual dose reduction for antipsychotic medication (medication to treat psychosis [loss of touch with reality] for March 25025,<br><br>These deficient practices had the potential to result in unnecessary medication administration.<br><br>Cross reference F758<br><br>Findings:<br><br>During a review of an Admission Record indicated Resident 13 was readmitted to the facility on [DATE] with diagnoses that included dementia (a decline in mental ability severe enough to interfere with daily life) with psychotic (a serious mental illness characterized by lost contact with reality) disturbances, anxiety (a feeling of worry, nervousness, or unease) and depression (causes feelings of sadness).<br><br>During a review of Resident 13's PO, the MDO indicated on 7/17/2023 to administer Simvastatin 20 mg at bedtime (HS).<br><br>During a review of Resident 13's physician orders (PO), the physician's order dated 2/5/2024 indicated to administer Famotidine (used to treat stomach ulcers) 20 milligrams (mg) twice a day (BID) by mouth (PO).<br><br>During a review of Resident 13's History and Physical, dated 7/7/2024, the History & Physical indicated Resident 13 did not have the capacity to understand and make decisions.<br><br>Further review of the physician's orders dated 8/22/2024 indicated to administer Pantoprazole (used to treat stomach ulcers) 40 mg PO every morning (QAM) and an order dated 11/14/2024, indicated to administer Seroquel 25 milligrams (mg. by mouth at bedtime.<br><br>(continued on next page) |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of the Note to Attending Physician/Prescriber ([NAME]), from the facilities pharmacist, dated 1/12/2025, the [NAME] indicated the resident took the following medications: Famotidine 20 mg PO BID (2/2024) and Pantoprazole 40 mg PO QAM (2/2024). Please reevaluate the continued use of both (medications). The [NAME] portion titled Physician/Prescribers Response, was left blank. The [NAME] did not indicate any documentation from Resident 13's physician whether the physician agreed or disagreed with the pharmacist recommendation.<br><br>During a review of Resident 13's Minimum Data Set (MDS, a standardized assessment and care-screening tool) dated 1/25/25, the MDS indicated Resident 13 was severely cognitively impaired and required supervision (helper provides verbal cues) with toilet hygiene, shower and bathing.<br><br>During a review of the facility's Consultant Pharmacist Medication Regimen Review (CPMRR), from the facility's pharmacist, dated 2/9/2025, the CPMRR indicated Resident 13 took Simvastatin 20 mg PO HS and to please consider discontinuation of use.<br><br>During an interview with the Hospice Registered Nurse (HRN), on 4/3/2025 at 10:31 am, the HRN stated the HRN was not aware of the pharmacist recommendation regarding Simvastatin. HRN stated any new development regarding Resident 13 was usually relayed by HRN to the resident's physician. HRN stated ultimately the physicians were the ones responsible for the care of the resident, so informing the physician was very important.<br><br>During a record review of a document titled Note to Attending Physician/Prescriber ([NAME]), from the facilities pharmacist, dated 3/9//2025 indicated Resident 13 had taken Seroquel 25 mg PO HS since November 2024. Please consider a dose reduction to 12.5 mg PO HS. If a gradual dose reduction (GDR) is contraindicated, please specify why. The [NAME] portion titled Physician/Prescriber Response, was left blank. The [NAME] did not indicate any documentation from the Resident 13's physician whether the physician agreed or disagreed with GDR.<br><br>During an interview with Registered Nurse Supervisor 1 (RN 1), on 4/2/2025 at 3:41 pm, RN 1 stated it was important to follow the pharmacist recommendations and to inform the resident's physician for the benefit of the resident and their overall health.<br><br>During an interview with the Director of Nursing (DON), on 4/4/2025 at 8:34 am, the DON stated the pharmacist recommendations should be followed because the pharmacist is specialized in medications regarding the use and drug interactions. Physicians should always be informed and they in turn need to respond in a timely manner because we want to ensure the resident will take the correct appropriate medication and dosages based on their medical conditions. The Physicians should be informed of the pharmacist recommendations within a one - two-day period.<br><br>(continued on next page) |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of the facility's policy titled Medication Regimen Review, revised on 5/2019, indicated the consultant pharmacist reviews the medication regimen of each resident at least monthly. The goal of the MRR is to promote positive outcomes while minimizing adverse consequences and potential risk associated with medications. An irregularity refers to the use of medication that is inconsistent with accepted pharmaceutical services standards of practice; is not supported by medial evidence; and/or impedes or interferes with achieving the intended outcomes of pharmaceutical services. If the identified irregularities represent a risk to a person's life, health, or safety, the consultant pharmacist contacts the physician immediately (within one hour) to report the information to the physician verbally and documents the notification. If the physician does not provide a timely or adequate response, or the consultant pharmacist identified that no action has been taken, he/she contacts the medial director or the administrator. The attending physician documents in the medical record that the irregularity has been reviewed and what action was taken to address it. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50016<br><br>Based on observation, interview, and record review, the facility failed to proper food storage and ensure sanitary conditions were followed by failing to:<br><br>A. Ensure food past it's use-by date was not stored in one of one walk-in refrigerator (Refrigerator 1) observed in the kitchen.<br><br>B. Ensure staff were completing the sanitation bucket log, ice machine log, and dish machine log daily.<br><br>These deficient practices placed the residents at risk for foodborne illnesses (refers to illness caused by the ingestion of contaminated food or beverages).<br><br>Findings:<br><br>A. During an observation on 4/1/2025 at 09:45 AM, in the kitchen, the Refrigerator 1 had 5 beef base containers stored and were labeled with a past best if used by date of 2/23/2025.<br><br>During an interview on 4/1/2025 at 10:14 AM, with the dietary supervisor (DS), the DS stated the facility should ensure food in Refrigerator 1 was not stored past its best if used by [date], because this ensured food safety, prevented contamination, and complied with health regulations. The DS stated food past the best if used by date should not be stored in Refrigerator 1, and should be discarded because the food could potentially cause a foodborne illness if served to the residents.<br><br>During a review of the facility's policy and procedure (P&P) titled Food and Supply Storage, dated revised 1/2023, the P&P indicated:<br><br>All food, non-food and supplies used in food preparation shall be stored in such a manner as to prevent contamination to maintain the safety and wholesomeness of the food for human consumption.<br><br>Most, but not all, products contain an expiration date. The words sell-by, best-by, enjoy-by, or use-by should precede the date. The sell-by date is the last date that food can be sold or consumed; do not sell products in retail areas or place on patient tray's/resident plates past the date on the product. Foods past the use by, sell-by, best-by, or enjoy by date should be discarded.<br><br>B. During a review of the kitchen's logs on 4/1/2025 at 10:01 AM, the logs for the month of March indicated the logs were incomplete:<br><br>The Red Bucket Log (sanitation) indicated that the concentration of the quaternary sanitizer solution (ammonium solution used for sanitizing surfaces) was not tested on [DATE] at 2:00 PM, 4:00 PM, and 06:00 PM as no test record was noted. The sanitation bucket log was missing the manager's initials in the weekly review section.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The Ice Machine Cleaning Log indicated the ice machine was not cleaned on 3/30/2025 during the morning shift. The log indicated to clean ice machine twice daily.<br><br>The Dishmachine Temperature Record (low temperature machine), the record indicated the dish machine temperature and chlorine rinse was not checked for dinner on 3/31/2025. The dish machine log was missing the manager's initials in the weekly review section.<br><br>During an interview and record review on 4/1/2025 at 10:01 AM, the sanitation bucket log, ice machine cleaning log, and dish machine temperature record were reviewed with the DS. The DS stated the sanitation bucket log, the ice machine cleaning log, and the dish machine temperature record were incomplete. The DS stated it was important to ensure staff were completing all kitchen logs accurately and daily for several reasons, such as: regulatory compliance, infection control & resident safety, accountability and consistency, equipment functionality and maintenance, and quality assurance. The DS stated record keeping provided clear paper trail that procedures were being followed and completed. The DS stated when managers consistently reviewed and initialed the logs, it reinforced the importance of sanitation and sets expectations for the rest of the team.<br><br>During a review of the facility's P&P, titled Sanitizing Food Contact Surfaces revision date 1/2023, the P&P indicated the Director/Designee:<br><br>-Verifies completion of logs; initials forms weekly.<br><br>-Retains the following logs for three (3) months:<br><br>-Pot-Sink Temperature & Sanitizer Concentration Log<br><br>-Sanitizer Solution from Dispenser<br><br>-Red Bucket Log<br><br>During a review of the facility's policy and procedure (P&P) titled Dish Machine Temperatures revision dated 1/2023, the P&P indicated the Director/Designee:<br><br>-Verifies completion of logs; initials forms weekly.<br><br>-Retains dish machine temperature records for one (1) year. |

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|---|---|---|---|
| | 056083 | A. Building<br>B. Wing | 04/04/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Woods Health Services | 2600 A Street<br>LA Verne, CA 91750 |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>50016<br><br>Based on interview and record review, the facility failed to ensure accurate discharge disposition medical record documentation for one of one sample resident (Resident 50).<br><br>This deficiency resulted in incomplete and potentially misleading information regarding the Resident 50's discharge status.<br><br>Findings:<br><br>During a review of Resident 50's Admission Record (AR), the AR indicated the facility admitted Resident 50 on 2/7/2025, with diagnoses including atrial fibrillation (an irregular heartbeat that occurs when the electrical signals in the atria [the two upper chambers of the heart] fire rapidly at the same time), shortness of breath, and muscle weakness (generalized).<br><br>During a review of Resident 50's Discharge Planning Review, undated, admitted d 2/7/2025, the review indicated Resident 50 requested a discharge to another long-term care center.<br><br>During a review of Resident 50's History and Physical (H&P), dated 2/10/2025, the H&P indicated Resident 50 had the capacity to understand and make decisions.<br><br>During a review of Resident 50's Minimum Data Set (Minimum Data Set (MDS - a resident assessment tool), dated 3/11/2025, the MDS indicated Resident 50 was discharged to a short-term general hospital.<br><br>During a review of Resident 50's Discharge Instruction Form, dated 3/11/2025, the form indicated Resident 50 was discharged to a long-term care center.<br><br>During a concurrent interview and record review on 4/3/2025 at 02:07 PM, Resident 50's Discharge Instruction Form dated 3/11/2025 was reviewed with the Minimum Data Set Coordinator (MDSC) Nurse. The MDSC stated the Discharge Instruction Form indicated Resident 50 was discharged to a long-term care facility. The MDS Nurse stated she had incorrectly documented Resident 50 as being discharged to an acute care hospital. The MDS Nurse stated accurate completion of resident information in the medical record directly impacted patient care and regulatory compliance.<br><br>During an interview on 4/4/2025 at 9:35 AM, with the Director of Nursing (DON), the DON stated accurate [documentation] in the medical record was the foundation of quality care. The DON stated [accuracy of medical records] guided the facility in developing the residents plan of care and helped ensure the residents needs were met. The DON stated accurate documentation of a resident's discharge status determined follow-up care, services, and support they received. The DON stated inaccurate discharge disposition could affect the resident and could potentially affect the help they needed after leaving the facility. The DON stated an inaccurate discharge disposition could negatively impact the resident and potentially hinder access to necessary post-discharge assistance.<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of the facility's Policy and Procedure (P&P) titled, Charting and Documentation revision date 7/2017, the P&P indicated documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38108<br><br>Based on observation, interview, and record review, the facility failed to maintain infection control practices by failing to:<br><br>a. Ensure enhanced barrier precautions (EBP, an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDROs, bacteria that have become resistant to certain antibiotics] in nursing homes) were followed and Personal Protective Equipment (PPE, gown, gloves, mask and face shield) were worn while providing care for Resident 47.<br><br>b. Ensure Resident 8's nasal cannula ([NC] a device-lightweight flexible plastic tubing used to deliver supplemental oxygen, tubing ending is placed in the nostrils and is fitted over the patient's ears) did not touch the floor.<br><br>c. Ensure Resident 47's NC did not touch the floor.<br><br>These deficient practices had the potential to result in the transmission of infectious microorganisms and increase the risk of infection for Residents 8 and 47.<br><br>Findings:<br><br>a. During a review of Resident 47s Admission Record (AR), the AR indicated Resident 47 was admitted to the facility on [DATE] with multiple diagnoses including pressure-induced deep tissue damage of the sacral region (bone at the bottom of the spine), congestive heart failure (the heart doesn't pump blood as well as it should), and depression (causes feelings of sadness and/or a loss).<br><br>During a review of Resident 47's Minimum Data Set (MDS - a standardized assessment and care planning tool) dated 3/17/2025, the MDS indicated Resident 47 had intact cognitive skills (ability to reason, make decisions) and was dependent (helper does all the effort) in oral/toileting hygiene, showering and upper body dressing.<br><br>During an observation on 4/4/2025 at 11:22 in Resident 47's room doorway, a signage was posted outside of the resident room titled Enhanced Barrier Precautions, from the US Department of Health and Human Services, Center for Disease Control and Prevention (DCD). The signage indicated staff must wear gloves and a gown for the following high-contact resident care activities .providing hygiene for wound care (residents): with any skin opening requiring a dressing. During the same observation, Certified Nurse Assistant 2 (CNA 2) was observed within one foot of Resident 47, wiping the resident's face with a face towel, without wearing personal protective equipment.<br><br>During an interview on 4/4/2025 at 11:25 am, with CNA 2, CNA 2 stated CNA 2 should have properly gowned up prior to entering Resident 47's room and that PPE's were important to be cautions to help protect the resident and CNA 2.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview with the Infection Preventionist Nurse (IPN), on 4/4/2025 at 11:41 am, the IPN stated staff needed to wear full PPE's when providing care to a resident on all types of isolation; contact and enhanced. The IPN stated any care (washing the face, combing hair, giving baths or providing peri-care) given to a resident on isolation is to protect the residents.<br><br>During an interview with the Director of Nursing (DON), on 4/4/2025 at 11:41 am, the DON stated PPE must be worn while providing care to any resident on isolation to avoid the spread of diseases.<br><br>During of a review of the facility's policy and procedure (P&P), titled, Standard Precautions dated 5/20/2013, the policy indicated, under Section 3. Masks, Eye Protection, Face Shields: A. Mask and eye protection or a face shield are worn to protect mucous membranes of the eyes, nose, and mouth during procedures and resident-care activities that are likely to generate splashes or sprays of blood, bodily fluids, secretions, and excretions.<br><br>During a review of the facility's in-service, titled, Infection Control Storage of Personal Belongings, dated 7/3/2023 to 7/5/2023, the in-service indicated participants would be able to understand the importance of proper storage of personal belongings. The in-service course content indicated, no personal belongings of food in resident rooms, hallways, breakrooms, medication rooms, or linen carts, e.g., sweaters, cell phones, coffee cups, water bottles.<br><br>49252<br><br>b. During a review of Resident 8's AR, the AR indicated Resident 8 was admitted to the facility on [DATE] with diagnoses that included urinary tract infection (UTI, an infection in any part of the urinary system: kidneys, bladder, or urethra [tube through which the urine leaves the body]) heart failure (when the heart muscle can't pump enough blood to meet the body's needs for blood and oxygen), and dysphagia (difficulty swallowing).<br><br>During a review of Resident 8's MDS, dated [DATE], the MDS indicated Resident 8 had moderate impaired cognition (ability to understand) and was dependent (helper does all the effort and resident does none of the effort to complete the activity or two or more helpers are required to complete the activity) for personal hygiene.<br><br>During a review of Resident 8's Order Summary Report, dated active as of 4/2/2025, the Order Summary Report indicated an active physician's order, dated 3/28/2025, for continuous oxygen at three liters (unit of volume) per minute via NC.<br><br>During a concurrent observation and interview on 4/1/2025 at 11:49 AM with Licensed Vocational Nurse 1 (LVN 1) in Resident 8's room, Resident 8's NC was touching the floor at the resident's right side while Resident 8 was lying in bed. LVN 1 stated, the NC should not be touching the ground for infection control [purposes] because the resident could get a respiratory infection.<br><br>During an interview on 4/4/2025 at 10:02 AM with the DON, the DON stated the NC tubing touching the floor was not appropriate for infection control [purposes].<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | c. During a review of Resident 47's AR, the AR indicated Resident 47 was admitted to the facility on [DATE] with diagnoses that included heart failure (when the heart muscle can't pump enough blood to meet the body's needs for blood and oxygen), depression (a mood disorder that may cause persistent sadness or loss of interest in activities), and anxiety disorder (persistent feeling of dread or panic that can interfere with daily life).<br><br>During a review of Resident 47's History & Physical (H&P), dated 3/16/2025, the H&P indicated the resident had the capacity to understand and make decisions.<br><br>During a review of Resident 47's MDS, dated [DATE], the MDS indicated Resident 47 had intact cognition (ability to understand) and was receiving oxygen therapy.<br><br>During a review of Resident 47's Order Summary Report, dated active as of 4/1/2025, the Order Summary Report indicated Resident 47 had an active physician order, dated 3/11/2025, for oxygen at two liters per minute via nasal cannula as needed for shortness of breath.<br><br>During a concurrent observation and interview on 4/4/2025 at 9:36 AM with LVN 1 in Resident 47's room, Resident 47's NC was touching the floor. LVN 1 stated, the NC should not be touching the ground because it created a risk for infection to the resident. LVN 1 further stated, she would replace Resident 47's NC tubing.<br><br>During an interview on 4/4/2025 at 10:09 AM with the DON, the DON stated the NC touching the ground was an infection control risk to Resident 47. The DON stated, they didn't know what type of viruses or bacteria were on the floor and what the resident could contract. The DON stated, the NC should be exchanged for a new one.<br><br>During a review of the facility's P&P, titled, Oxygen and Humidifier, undated, the P&P indicated that during oxygen delivery the oxygen delivery device must be kept clean at all times and changed as needed for cleanliness. |