STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056114	A. Building B. Wing	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
East Terrace Rehabilitation & Wellness Centre, LP	2415 South Western Avenue Los Angeles, CA 90018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46832 Based on observation, interview and record review, the facility failed to: 1. Provide a privacy bag on a foley catheter for one of five sampled residents (Resident 2). 2. Ensure one out of six sampled residents (Resident 72) dignity was maintained after placing bilateral bedrails (metal rails that are attached to the side of a bed to help to prevent patients from falling out). This deficient practice had the potential to affect resident's sense of self-worth and self-esteem. Findings: a. During a review of Resident 2's face sheet (front page of the chart that contains a summary of basic information about the resident), the face sheet indicated Resident 2 was readmitted to the facility on [DATE] and had an initial admitted [DATE]. The face sheet indicated Resident 2 had diagnoses which included benign prostatic hyperplasia (a noncancerous condition that causes the prostate gland to grow larger than normal), parkinsonism (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), and dementia (a progressive state of decline in mental abilities). During a review of the Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 10/2/2024, the MDS indicated Resident 2 cognitive skills was intact. The MDS also indicated Resident 2 required supervision for toileting needs, showering, and upper/lower body dressing. During an observation, on 12/3/2024, at 1:26 p.m., in Resident 2's room, Resident 2 was observed lying in his bed, with a foley catheter bag, uncovered, sitting in a pink basin. Resident 2 stated he had not had a privacy bag for his foley catheter since it was inserted on 11/30/2024. Resident 2 stated he was not informed on whether a bag should had been provided. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review, on 12/5/2024, at 8:22 a.m., with the Director of Nursing (DON), the DON stated all residents with foley catheters was to be provided a dignity bag. The DON stated Resident 2 should had been provided a dignity bag and was not. The DON stated the risk of not providing a dignity/privacy bag could result in an infection control issue such as cross-contamination and a self-esteem issue with a resident. During a review of the facility's policy and procedures, titled Indwelling Catheter, dated 9/2014, indicated, The resident's privacy and dignity will be protected by placing cover over drainage bag. 46144 b. During a review of Resident 72's Admission Record (Face Sheet- front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 72 was initially admitted to the facility on [DATE] and readmitted on [DATE]. The face sheet indicated, Resident 72's diagnoses included metabolic encephalopathy (a brain dysfunction caused by a chemical imbalance in the blood that affects the brain), major depressive disorder (a mental health condition that causes a persistently low mood and a loss of interest in activities), and spinal stenosis (a narrowing of the spinal canal that compresses the spinal cord, nerves, and resulting in pain in the back and legs). During a review of Resident 72's History and Physical (H&P), dated 9/18/2024, the H&P indicated Resident 72 can make needs known but cannot make medical decisions. During a review of Resident 72's Minimum Data Set ([MDS] a federally mandated assessment tool), dated 11/15/2024 the MDS indicated, Resident 72's cognition (ability to learn, reason, remember, understand, and make decisions) was able to understand and be understood. The MDS indicated Resident 72 was dependent on staff for personal hygiene, showering, and dressing. During an observation on 12/3/2024 at 10:52 a.m. Resident 72 had bilateral bedrails. Resident 72 was not able to easily release the bedrails from the bed. During an interview on 12/4/2024 at 8:54 a.m. with Resident 72, Resident 72 stated I do not want these bed rails on the bed. Resident 72 stated the staff did not discuss with him the reasons for the bed rails. Resident 72 stated he cannot remove the bed rails the staff had to take them off to get him out of the bed. Resident 72 stated the bed rails make him feel trapped and closed in (surrounded or confined, often with a sense of restriction). During an interview on 12/4/2024 at 1:17 p.m. with Registered Nurse (RN) 1, RN 1 stated the bed rails could make the Resident 72 feel isolated and start to feel lonely in the room. RN 1 stated it could have psychosocial impact (the social aspects of a person's life, and how they affect a patient's life, health, and well-being) on the resident. RN 1 stated it could make him feel a lack of social interaction which would become a dignity issue. During concurrent observation and interview on 12/5/2024 at 11:29 a.m. with Director of Nursing (DON), the DON stated if Resident 72 cannot easily and voluntarily release the bed rails the use of the bed rails is considered a restraint (a device, method, or process that limits a patient's movement). The DON stated if Resident 72 cannot easily remove the bed rails it could make him feel frustrated. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled, Resident Rights-Quality of Life, dated 3/2017, the P&P indicated, each resident shall be cared for in a manner that promotes and enhances the quality of life, dignity, respect, individuality, and receives services in a person-centered manner. The P&P indicated staff will keep the resident informed and oriented to his/her environment. The P&P indicated the facility staff will avoid demeaning practices and standards of care that compromise dignity was prohibited.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46144 Based on observation, interview, and record review the facility failed to ensure one out of six sampled residents (Resident 72) had the call light within reach. This deficient practice on not having the call light within reach placed the resident at risk for not receiving goods and services. Findings: During a review of Resident 72's Admission Record (Face Sheet- front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 72 was initially admitted to the facility on [DATE] and readmitted on [DATE]. The face sheet indicated, Resident 72's diagnoses included metabolic encephalopathy (a brain dysfunction caused by a chemical imbalance in the blood that affects the brain), major depressive disorder (a mental health condition that causes a persistently low mood and a loss of interest in activities), and spinal stenosis (a narrowing of the spinal canal that compresses the spinal cord, nerves, and resulting in pain in the back and legs). During a review of Resident 72's History and Physical (H&P), dated 9/18/2024, the H&P indicated Resident 72 can make needs known but cannot make medical decisions. During a review of Resident 72's Minimum Data Set ([MDS] a resident mandated assessment tool), dated 11/15/2024 the MDS indicated, Resident 72's cognition (ability to learn, reason, remember, understand, and make decisions) was able to understand and be understood. The MDS indicated Resident 72 was dependent on staff for personal hygiene, showering, and dressing. During an observation on 12/4/2024 at 9:02 a.m. in Resident 72's room. Resident 72's call light was not within reach. Resident 72 attempted to reach for the call light and could not reach the call light. During an interview on 12/4/2024 at 3:00 p.m. with Restorative Nurse Assistant (RNA) 1, RNA 1 stated after giving care to the residents the staff is to place the call light within reach. RNA 1 stated it was important to keep the call light within reach for Resident 72 just incase he had an emergency. RNA 1 stated if the call light is not within reach will not get the services and help he needs. During an interview on 12/5/2024 at 2:34 p.m. with Certified Nursing Assistant (CNA) 2, CNA 2 stated the call light needed be within reach. CNA 2 stated if the resident needed assistance the staff would not know what is going on with Resident 72. CNA 2 stated if Resident 72 wanted water he wound not be able to call for assistance. During an interview on 12/5/2024 at 2:38 p.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated Resident 72 's call light needed to be within reach. LVN 2 stated when the call light was not in reach; Resident 72 could feel isolated and not felt heard. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Communication-Call System, dated 10/2024, the P&P indicated the facility will maintain a communication system to allow residents to call for staff assistance from their rooms. The P&P indicated the call alert device will be placed within the resident's reach.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46832 Based on observation, interview and record review, the facility failed to: 1. Ensure an updated Physician's Order for Life Sustaining Treatment (POLST-(POLST- a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end-of life) form was transferred to the hospital for one out of three sampled residents (Resident 38). 2. Ensure an Advance Directive (a legal document indicating resident preference on end-of-life treatment decisions) acknowledgement form was obtained for one of three sampled residents (Resident 90). 3. Ensure one out of six sampled residents (Resident 17) had an updated code status (a patient's documented wishes regarding what life-saving measures should be taken if their heart stops beating or breathing ceases). This deficient practice had the potential to result in a conflict with residents' wishes regarding health care services. Findings: a. During a review of Resident 38's face sheet (front page of the chart that contains a summary of basic information about the resident), the fact sheet indicated Resident 38 was readmitted to the facility on [DATE] and originally admitted to the facility on [DATE]. The face sheet indicated Resident 38 diagnoses included acute respiratory failure (a life-threatening condition that occurs when the lungs are unable to provide enough oxygen to the body's tissues or remove enough carbon dioxide), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), dementia (a progressive state of decline in mental abilities), and dysphagia (difficulty swallowing). During a review of Resident 38's Minimum Data Set (MDS- a federally mandated resident assessment tool), the MDS indicated Resident 38's cognitive skills was severely impaired. The MDS also indicated Resident 38 was dependent on staff for toileting needs, showering, eating and upper/lower body dressing. b. During a review of Resident 90's face sheet, the fact sheet indicated Resident 90 was readmitted to the facility on [DATE] and originally admitted to the facility on [DATE]. The face sheet indicated Resident 90 diagnoses included sepsis (a life-threatening blood infection), hypotension (low blood pressure), Huntington's disease (a genetic disorder that causes nerve cells in the brain to break down over time) and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 90's Minimum Data Set (MDS- a federally mandated resident assessment tool), the MDS indicated Resident 90's cognitive skills was intact. The MDS also indicated Resident 90 was dependent on staff for toileting needs, showering, eating and upper/lower body dressing. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review, on 12/5/2024, at 11:42 a.m., with the Registered Nurse Supervisor (RNS), the RNS stated Resident 38 was transferred to the hospital on 11/30/24. The RNS stated the protocol when being transferred to the hospital was to ensure a correct and updated Advance Directive was sent with a resident. The RNS stated Resident 38's daughter had called the facility on 12/4/2024, informing her (RNS) that Resident 38 was transferred to the hospital with an outdated Advance Directive. The RNS confirmed Resident 38 was transferred with an outdated Advance Directive. The RNS stated she faxed the updated Advance Directive to the hospital. The RNS stated the risk of transferring a resident with an outdated Advance Directive could have resulted in a delay of care in a medical emergency. During a concurrent interview and record review, on 12/5/2024, at 11:58 a.m., with the Registered Nurse Supervisor, the Registered Nurse Supervisor stated Resident 90 did not have an advance directive acknowledge form in their chart. The RNS stated the risk could had result in a delay of care and not knowing the code status of a resident in case of an emergency. During a review of the facility's policy and procedures, titled Physician Orders for Life Sustaining Treatment, dated 6/3/2020, indicated If the POLST form conflicts with the president's health care instructions or Advance Health Care Directive, the most recent expression of the resident's wishes govern. During a review of the facility's policy and procedures, titled Advance Directives, dated 7/2024, indicated, Upon admission, the Admissions Staff or Designee will provide written information to the resident concerning his or her right to make decisions concerning medical care; including the right to accept or refuse medical or surgical treatment, and the right to formulate advance directives. 46144 c. During a review of Resident 17's Admission Record (Face Sheet- front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 17 was initially admitted to the facility on [DATE] and readmitted on [DATE]. The face sheet indicated, Resident 17's diagnoses included dementia (a progressive state of decline in mental abilities), major depressive disorder (a mental health condition that causes a persistently low mood and a loss of interest in activities), and muscle weakness (a patient has a reduced ability to move their muscles). During a review of Resident 17's History and Physical (H&P), dated 12/4/2024, the H&P indicated Resident 17's can make needs known but cannot make medical decisions. During a review of Resident 17's Minimum Data Set ([MDS]- a federally mandated assessment tool), dated 10/23/2024 the MDS indicated, Resident 17's cognition (ability to learn, reason, remember, understand, and make decisions) was usually understands and understood. The MDS indicated Resident 17 was substantial assistance on staff for personal hygiene, showering, and dressing. The MDS indicated resident prefers family involved in care discussions. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/3/2024 at 1:55 p.m. with responsible party (RP), the RP stated Resident 17 is no longer able to make medical decisions. The RP stated due to his decline in his health they had discussed Resident 17 would not want to be on a breathing machine. The RP stated Social Services had not called her to discuss code status since there had been a decline with Resident 17 to make medical decisions. The RP stated Resident 17 is no longer able to make medical decisions and his wish was not to be on a breathing machine (a device that helps people breathe when they are unable to do so on their own). During an interview on 12/5/2024 at 12:05 p.m. with DSS, the DSS stated the RP is involved with making medical decisions since 4/2024. The DSS stated since the Resident has had a decline and cannot make medical decisions the RP should had been contacted about the code status. The DSS stated she failed to follow up with the family about Resident 17's code status. The DSS stated it was a lack of communication on her part and should have asked the RP. The DSS stated it was important to update the code status to set emotional boundaries for the resident's wishes to not resuscitate ([DNR] - instructs healthcare provides to not perform cardiopulmonary resuscitation if a patient's heart stops beating or breathing). During a review of the facility's policy and procedure (P&P) titled, Social Service Coordinator Job Description, date unknown, the P&P indicated clinically/administratively to ensure the residents' psychosocial and concrete needs are identified. The P&P indicated implement and update resident care plan, communicate needs with the responsible parties. The P&P indicated assist with the facilitation of Advance Directives. During a review of the facility's policy and procedure (P&P) titled, Advance Directive, dated 7/2024, the P&P indicated the facility will respect a resident's right to request, refuse, and/or discontinue treatment and to formulate an advance directive (a resident's written preferences regarding treatment options). The P&P indicated to include provisions to inform and provide written information to all adult residents concerning their right to accept or refuse medical treatment.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46144 Based on interview and record review the facility failed to: 1. Ensure one out of six sampled residents (Resident 28) misssing glasses and dentures both were replaced. 2. Provide a homelike environment for two of five sampled residents (Residents 10 and 6). This failure resulted in Resident 28 not having a pair of eyeglasses to see and dentures to chew and Resident 10 and 6 not being in a homelike environment. Findings: a. During a review of Resident 28's Admission Record (Face Sheet- front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 28 was initially admitted to the facility on [DATE] and readmitted on [DATE]. The face sheet indicated, Resident 28's diagnoses included end stage renal disease (a chronic condition where the kidneys permanently stop working), diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor round healing), and heart failure (a serious condition that occurs when the heart is unable to pump enough blood and oxygen to the body's organ). During a review of Resident 28's Minimum Data Set ([MDS] a resident assessment tool), dated 11/13/2024 the MDS indicated, Resident 28's cognition (ability to learn, reason, remember, understand, and make decisions) was able to understand and be understood. The MDS indicated Resident 28 was dependent on staff for personal toilet, chair, and shower transfer. During an interview on 12/3/2024 at 10:30 a.m. with Resident 28, Resident 28 stated her reading glasses and dentures were missing. Resident 28 stated the staff had not helped to look for the reading glasses and dentures since the last room change. During a review of Resident 28's optometry services, titled Optometric Consultation, dated 11/2/2022, the Optometric Consultation indicated, Resident 28's recommendation was to have new glasses for reading. During a concurrent observation and interview on 12/5/2024 at 12:12 p.m. with Director of Social Services (DSS), the DSS stated the reading glasses are not in her room and she was not able to locate the reading glasses. The DSS stated the process is to keep track of the resident inventory items when on admission, discharges, and when the residents change rooms. The DSS stated Resident 28 did not have her reading glasses and therefore would not be able to see what she is reading. During a concurrent observation and interview on 12/5/2024 at 12:08 p.m. with DSS, the DSS stated the dentures were not in Resident 28's room and were missing. The DSS stated she did have dentures and last time she had saw them were in September 2024. The DSS stated the missing dentures would not accommodate her needs to help the resident to chew her food. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled, Theft and Loss, dated 7/2017, the P&P indicated to assist residents in safeguarding their personal property. The P&P indicated all inquiries regarding lost or stolen items are reported to the Administrator and/or designee. The P&P indicated Social Services staff documents reports of lost resident property. During a review of the facility's policy and procedure (P&P), titled Social Service Coordinator, date unknown, the P&P indicated social service coordinator principal responsibilities included communicate needs and plan of care for resident, maintain a theft/loss binder, and assist with coordination of resident room moves. 46832 b. During a review of Resident 10's face sheet (front page of the chart that contains a summary of basic information about the resident), the face sheet indicated Resident 10 was readmitted on [DATE] and initially admitted on [DATE]. The face sheet indicated Resident 10 diagnoses included bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), schizophrenia (a mental illness that is characterized by disturbances in thought), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and pneumonia (an infection/inflammation in the lungs). During a review of Resident 10's Minimum Data Set (MDS- a federally mandated resident assessment tool), the MDS indicated Resident 10's cognitive skill was intact. The MDS also indicated Resident 10 was dependent on staff with toileting needs, showering, and upper/lower body dressing. During an observation, on 12/3/2024, at 8:13 a.m., in Resident 10's room, Resident 10 stated the room window and blinds had been broken for weeks. Resident 10 stated he informed staff of the broken window latch and blinds, but it hadn't been fixed. Resident 10 stated the broken blinds and windows caused him to feel closed in. Resident 10 stated I would like to open the window for fresh air and have working blinds. During a concurrent observation and interview, on 12/5/24 at 1:00 p.m., with the Maintenance Supervisor (MS), the MS stated the Maintenance department kept a logbook for repairs at the nurse's station. The MS stated he did not have any pending repairs logged in the book. The MS stated Resident 10's blinds and broken window latch were in poor condition. The MS stated the resident should had been able to open windows and blinds in their rooms. The MS stated the risk of a broken window and blinds being in a resident's room could have influenced their self-esteem due to non-working equipment. The MS stated, It isn't homelike. A review of the facility's policy and procedures, titled Accommodation of Needs, dated 1/2012, indicated, In order to accommodate residents' needs and preferences, the Facility may make adaptations to the physical environment, including the resident's bedroom and bathroom, as well as the common areas in the facility. 49906 c. During an initial tour on 12/3/4024, at 8 a.m., three blind's slats covering a glass patio door were missing. Paper towels were observed taped to the glass door. There were two rooms with repairs to the walls that were not painted. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with on December 3, 2024, at 11:23 am with Resident 6, Resident 6 stated the slats have been missing and replaced a few times. The slats continue to fall off. Resident 6 stated she decided to put paper towels up with tape so no one can look into the room. During an interview on December 5, 2024 at 1:00 pm with the Maintenance Supervisor (MS), the MS stated he was not aware Resident 6 had missing blinds. The MS stated he has a logbook located at the nurse's station for needed repairs to be entered by staff. During a review of an undated policy and procedure titled Resident Rooms and Environment indicated that the facility would provide residents with a safe, clean, comfortable, and homelike environment.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46832 Based on interview and record review, the facility failed to: 1. Ensure a Pre-Admission Screening Resident Review (PASRR- a federal assessment requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are placed in facilities that can provide the appropriate care) was submitted for one of five sampled residents (Resident 84). This deficient practice had the potential to result in residents not receiving mental health care and services needed. Findings: During a review of Resident 84's face sheet (front page of the chart that contains a summary of basic information about the resident), the face sheet indicated Resident 84 was admitted on [DATE]. The face sheet indicated Resident 84's diagnoses included psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), altered mental status (a noticeable change in a person's mental function), violent behavior (any action that intentionally harms, injures, or threatens to harm someone or something) and encephalopathy (a disease in which the functioning of the brain is affected by an infection or toxins). During a review of Resident 84's Minimum Data Set (MDS- a federally mandated resident assessment tool), the MDS indicated Resident 84's cognitive skill was moderately intact. The MDS also indicated Resident 84 was dependent on staff with toileting needs, showering, and required moderate assistance with upper/lower body dressing. During a concurrent interview and record review, on 12/4/2024, at 1:11 p.m., with the Quality Assurance Nurse (QA 1), QA 1 stated all residents with mental illnesses were required to have a PASRR submitted. QA 1 stated Resident 84 was admitted with a diagnosis of psychosis and received scheduled psychotropic medications. QA 1 stated Resident 84's PASRR, dated 10/02/2024, indicated Resident 84 did not have a mental illness due to inaccurate information on Resident 84's Level 1 screening. QA 1 stated a new PASRR should had been submitted with accurate information for Resident 84. QA 1 stated the risk of not submitting a PASRR for a resident who had a mental illness could result in resident not receiving mental health services needed. During a review of the facility's policy and procedures, titled Pre-Admission Screening and Resident Review, dated 4/2024, indicated The facility staff will complete a new PASRR upon readmission from the acute hospital if there has been a significant change in the resident's condition.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46832 Based on interview and record review, the facility failed to: 1. Ensure a Pre-Admission Screening Resident Review (PASRR- a federal assessment requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are placed in facilities that can provide the appropriate care) was resubmitted for one of five sampled residents (Resident 10). This deficient practice had the potential to result in resident not receiving mental health care and services needed. Findings: During a review of Resident 10's face sheet (front page of the chart that contains a summary of basic information about the resident), the face sheet indicated Resident 10 was readmitted on [DATE] and initially admitted on [DATE]. The face sheet indicated Resident 10's diagnoses included bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), schizophrenia (a mental illness that is characterized by disturbances in thought), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and pneumonia (an infection/inflammation in the lungs). During a review of Resident 10's Minimum Data Set (MDS- a federally mandated resident assessment tool), the MDS indicated Resident 10's cognitive skill was intact. The MDS also indicated Resident 10 was dependent on staff with toileting needs, showering, and upper/lower body dressing. During a concurrent interview and record review, on 12/4/2024, at 1:11 p.m., with the Quality Assurance Nurse (QA 1), QA 1 stated all residents with mental illnesses were required to have a PASRR submitted. QA 1 stated Resident 10 was admitted with diagnoses of bipolar disorder, schizophrenia, major depressive disorder. QA 1 stated Resident 10's Level 1 PASRR, dated 11/18/2024, stated the facility staff were unresponsive to two or more separate attempts of communication within 48 hours of the Level 1 screening. QA 1 stated she did not know what happened and Resident 10's PASRR should had been resubmitted. QA 1 stated the risk of not submitting a PASRR for a resident who had a mental illness could result in a resident not receiving mental health services needed. During a review of the facility's policy and procedures, titled Pre-Admission Screening and Resident Review, dated 4/2024, indicated, The Facility MDS Coordinator will be responsible for accessing and ensure updates to the PASRR are completed per MDS guidelines.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43419 Based on interview and record review, the facility failed to create an individualized comprehensive nursing care plan (a document that summarizes the care and treatment) for two of two sampled resident (Resident 90 & 28). This failure resulted in Resident 90's gastrostomy tube (G-tube-a plastic tube inserted into the stomach to provide nutrition) being dislodged three times and Resident 28 not able to chew without dentures. Findings: During a review of Resident 90's admission record dated 8/2023, it indicated Resident 90 had the following diagnosis but not limited to a having a G-tube. During a review of Resident 90's MDS (a standardized assessment tool) record dated 8/16/2023, it indicated the resident has a G-tube. During a record review of Resident 90's nursing progress notes dated 7/25/2024 through 8/18/2024, the nursing progress notes indicated Resident 90's G-tube was dislodged on 7/25/2024, 7/30/2024, and 8/17/2024. The nursing notes also did not indicate Resident 90 used an abdominal binder (a device placed around the abdomen to keep the G-tube in place). During a concurrent interview and record review on 12/5/2024 at 11:00 a.m. with Charge Nurse (CN) 1, Resident s 90 care plans dated from 8/2023 to 7/2024 were reviewed. The care plans did not indicate interventions to prevent G-tube dislodgement. CN 1 stated Resident 90's care plan did not include interventions for the management of Resident 90's G-tube. CN 1 stated on admission, Resident 90's G-tube care plan should have had an intervention such as an abdominal binder to prevent the G-tube from being dislodged. During an interview on 12/5/2024 at 2:45 p.m. with the Licensed Vocational Nurse (LVN) 2, LVN 2 stated it is the registered nurse ' s responsibility to initiate a care plan for the residents upon admission and to update the resident ' s care plan every shift. LVN 2 stated the care plan is important as it guides the resident's care and treatments. During a review of the facility policy and procedure (P&P) titled, Comprehensive Person-Centered Care Planning, dated 8/2023, it indicated, The baseline care plan must include the minimum healthcare information necessary to properly care for each resident immediately upon their admission. The baseline care plan summary will be developed and implemented, using the necessary combination of problem specific care plans, within 48 hours of the resident admission. The baseline care plan must reflect the resident ' s stated goals and objectives and include interventions that address his or her needs. 46144 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. During a review of Resident 28's Admission Record (Face Sheet- front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 28 was initially admitted to the facility on [DATE] and readmitted on [DATE]. The face sheet indicated, Resident 28's diagnoses included end stage renal disease (a chronic condition where the kidneys permanently stop working), diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor round healing), and heart failure (a serious condition that occurs when the heart is unable to pump enough blood and oxygen to the body's organ). During a review of Resident 28's Minimum Data Set ([MDS] a resident assessment tool), dated 11/13/2024 the MDS indicated, Resident 28's cognition (ability to learn, reason, remember, understand, and make decisions) was able to understand and be understood. The MDS indicated Resident 28 was dependent on staff for personal toilet, chair, and shower transfer. During a review of Resident 28's dental services, titled Elite Mobile Dental, dated 5/2/2024, the Elite Mobil Dental indicated, Resident 28 had dentures delivered to the facility on [DATE]. During an interview on 12/3/2024 at 10:30 a.m. with Resident 28, Resident 28 stated her dentures were missing. Resident 28 stated sometimes I can eat the food and sometimes I can't eat the food, but it would be easier to eat the food with my dentures. During an interview on 12/5/2024 at 12:08 p.m. with Director Social Service (DSS), the DSS stated Resident 28 refused to wear her dentures. The DSS stated a care plan should have been developed about the refusal to wear dentures. The DSS stated it was important to have a care plan to educate the resident about how it would help her to chew her food better. The DSS stated the staff would be aware of the interventions to encourage Resident 28 to wear her dentures while eating. During an interview on 12/5/2024 at 12:39 p.m. with Registered Nurse (RN) 1, RN 1 stated Resident 28 had the right to refuse to wear her dentures. RN 1 stated a care plan would be started and interventions would be implemented. RN 1 stated it was important to have a care plan so there is proper documentation of the refusal. RN 1 stated the staff would need to keep track of her weight and chewing issues due to not wearing the dentures. During a review of the facility's policy and procedure (P&P), titled Comprehensive Person-Centered Care Planning, dated 9/2023, the P&P indicated the facility will ensure that a comprehensive person-centered care plan is developed for each resident. The P&P indicated the resident's comprehensive care plan will be made based on the assessed needs of the resident. During a review of the facility's policy and procedure (P&P), titled Social Service Coordinator, date unknown, the P&P indicated social service coordinator principal responsibilities included communicate needs and plan of care for resident, maintain a theft/loss binder, and assist with coordination of resident room moves.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46144 Based on observation, interview, and record review the facility failed to ensure one out of six sampled residents (Resident 42) toenails were trimmed. This deficient practice of not trimming Resident 42's toenails had the potential to cause discomfort. Findings: During a review of Resident 42's Admission Record (Face Sheet- front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 42 was initially admitted to the facility on [DATE]. The face sheet indicated, Resident 42's diagnoses included metabolic encephalopathy (a brain dysfunction caused by a chemical imbalance in the blood that affects the brain), major depressive disorder (a mental health condition that causes a persistently low mood and a loss of interest in activities), and left/right knee contracture (the muscles, tendons, and tissue around the knees have become tightened and shortened limiting range of motion). During a review of Resident 42's History and Physical (H&P), dated 3/6/2024, the H&P indicated Resident 42 does not have the capacity to understand and make decisions. During a review of Resident 42's Minimum Data Set ([MDS] a federally mandated assessment tool), dated 9/8/2024 the MDS indicated, Resident 42's cognition (ability to learn, reason, remember, understand, and make decisions) was able to understand and be understood. The MDS indicated Resident 42 was dependent on staff for personal hygiene, showering, and dressing. During an observation on 12/3/2024 at 10:17 a.m. in Resident 42's room, Resident 42 had long untrimmed toenails. During a concurrent observation and interview on 12/4/2024 at 1:21 p.m. with Registered Nurse (RN) 1 in Resident 42's room, RN 1 stated Resident 42's toenails are too long and needed to be cut. RN 1 stated the CNAs are the one who is assigned to the resident and are the ones to cut the residents nails. During a concurrent interview and record review on 12/4/2024 at 1:30 p.m. with RN 1, Resident 42's care plan, titled The resident has an Activity of Daily Living ([ADL] -) self-performance deficit related to limited mobility and disease process, dated 12/21/2022 was reviewed. The care plan indicated the resident will improve current level of function. The care plan interventions included check nail length, trim, and clean on bath day. RN 1 stated the long toenails not being trimmed can harm the skin and cause discomfort. During an interview on 12/4/2024 at 2:08 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated when the nails are too long the staff is to clip their feet and hand nails. CNA 1 stated it was important to keep the nails cut to prevent the residents from scratching their skin to prevention infection. CNA 1 stated keeping the Resident 42's nails trimmed would help him to look good and feel good. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of facility's policy and procedure (P&P), titled Grooming, dated 1/2012, the P&P indicated the facility will work with and assist residents to improve their hygiene, comfort, self-esteem, and dignity. The P&P indicated for nail care a nailbrush can be used to gently remove any dirty particles under the nails. The P&P indicated nails are to be kept short and manageable. During a review of facility's policy and procedure (P&P), titled Certified Nursing Assistant, date unknown, the P&P indicated a nursing assistant responsible for providing routine nursing care in accordance with established policies and procedures and as may be directed by the Charge Nurse, RN supervisor, Director of Nursing or Administrator, to assure that the highest degree of quality resident care can be maintained at all times. The P&P indicated clinically the CNAs are to clip and trim fingernails.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 43419 Based on interview and record review, the facility failed to prevent the hospitalization for one of one sampled resident (Resident 90). This failure resulted in Resident 90's going to the hospital for treatment due to a dislodged gastrostomy tube (G-tube-a plastic tube inserted into the stomach to provide nutrition). Findings: During a review of Resident 90 ' s admission record dated 8/2023, it indicated Resident 90 had the following diagnosis but not limited to a having a G-tube. During a review of Resident 90 ' s MDS (a standardized assessment tool) record dated 8/16/2023, it indicated the resident has a G-tube. During a record review of Resident 90's nursing progress notes dated 7/25/2024 through 8/18/2024, the nursing progress notes indicated Resident 90 was sent to the hospital due to a dislodged G-tube on 7/25/2024 and 7/30/2024. The nursing notes also did not indicate Resident 90 used an abdominal binder (a device placed around the abdomen to keep the G-tube in place). During an interview on 12/5/2024 at 8:17 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 90 should have had an abdominal binder to prevent G-tube dislodgement. During an interview on 12/5/2024 at 11:00 a.m. with the Charge Nurse (CN) 1, CN 1 stated on admission, Resident 90 should have had an abdominal binder to prevent the G-tube from being dislodged. During a review of the facility ' s policy and procedure (P&P) titled, Enteral Tube Management: Nasogastric Tube, Gastrostomy Tube and Jejunostomy Tube, dated 9/2023, the P&P indicated, it is the responsibility of the facility to maintain safety of enteral tubes (a flexible tube into the stomach for nutrition) before initiating enteral feeding.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46144 Based on observation, interview, and record review the facility failed to ensure one out of six sampled residents (Resident 9) had the correct settings for low air loss mattress ([LAL]-a type of mattress used to help prevent and treat pressure wounds). This deficient practice of not having the correct LAL mattress setting placed Resident 9 at risk for pressure injuries (a localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence). Findings: During a review of Resident 9's Admission Record (Face Sheet- front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 9 was initially admitted to the facility on [DATE] and readmitted on [DATE]. The face sheet indicated, Resident 9's diagnoses included osteomyelitis (a serious bone infection), adult failure to thrive (a decline in physical and mental), and methicillin resistant staphylococcus aureus ([MRSA] a type of bacterial infection that is resistant to many antibiotics). During a review of Resident 9's History and Physical (H&P), dated 10/1/2024, the H&P indicated Resident 9 had the capacity to understand and make decisions. During a review of Resident 9's Minimum Data Set ([MDS] a mandated assessment tool), dated 11/3/2024 the MDS indicated, Resident 9's cognition (ability to learn, reason, remember, understand, and make decisions) was able to understand and be understood. The MDS indicated Resident 9 was dependent on staff for personal hygiene, showering, and dressing. The MDS indicated Resident 9 was at risk of developing pressure ulcers. During an observation on 12/3/2024 at 10:38 a.m. in Resident 9's room, Resident 9's LAL mattress was set at 350 pounds (a unit of measurement for weight). During a record review on 12/4/2024 at 8:52 a.m. Resident 9 weighed 142 pounds. During a concurrent observation and interview on 12/5/2024 at 11:21 a.m. with Director of Nursing (DON) in Resident 9's room, Resident 9's LAL mattress settings were set at 350 pounds. The DON stated the LAL mattress is for to relieve the pressure on the skin. The DON stated the LAL mattress is used to avoid a pressure ulcer. The DON stated the LAL mattress settings are incorrect and the resident could get a pressure ulcer. During an interview on 12/5/2024 at 11:40 a.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 stated LAL mattress is for skin maintenance due to Resident 9 bony prominence (an area of bone that is close to the skin's surface) in the sacral (the base of the spine that forms the lower back of the pelvis) area. LVN 3 stated when the LAL mattress settings are incorrect the bed is no longer serving its purpose to help to prevent pressure ulcers. LVN 3 stated the wrong settings would increase Resident 9's risk for skin breakdown. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P), titled Mattresses, dated 1/2012, the P&P indicated the facility will provide mattresses capable of meeting the following needs of residents. The P&P indicated to provide pressure reduction to residents at risk for skin breakdown. The P&P indicated be sure that the mattress is inflated properly and check air mattress routinely to ensure that it is working properly.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46144 Based on observation, interview, and record review the facility failed to ensure one out of six sampled residents (Resident 17) splints (a medical device used to gradually stretch and prevent further tightening of a muscle or joint to improve range of motion) were placed on by the Restorative Nurse Assistant (RNA) as scheduled. This deficient practice of not placing splints on Resident 17 as scheduled had the potential to cause contractures (a permanent tightening of the muscles tenon, ligaments, or skin that limits normal movement of a body part). Findings: During a review of Resident 17's Admission Record (Face Sheet- front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 17 was initially admitted to the facility on [DATE] and readmitted on [DATE]. The face sheet indicated, Resident 17's diagnoses included dementia (a progressive state of decline in mental abilities), major depressive disorder (a mental health condition that causes a persistently low mood and a loss of interest in activities), and muscle weakness (a patient has a reduced ability to move their muscles). During a review of Resident 17's History and Physical (H&P), dated 12/4/2024, the H&P indicated Resident 17's can make needs known but cannot make medical decisions. During a review of Resident 17's Minimum Data Set ([MDS]- a federally mandated assessment tool), dated 10/23/2024 the MDS indicated, Resident 17's cognition (ability to learn, reason, remember, understand, and make decisions) was usually understands and understood. The MDS indicated Resident 17 was substantial assistance on staff for personal hygiene, showering, and dressing. The MDS indicated resident prefers family involved in care discussions. During an observation on 12/3/2024 in Resident 17's room, there were no splints placed on Resident 17 during the hours of 10:00 a.m. to 4:00 p.m. During an observation on 12/4/2024 in Resident 17's room, there were no splints placed on Resident 17 during the hours on 8:00 a.m. to 4:00 p.m. During a review of Resident 17's physician orders, titled Order Summary Report, dated 12/1/2024, the Order Summary Report indicated the RNA were to apply air pump hand splint (used for stiffness and shortening of the muscles of the arm) to the left and right upper extremities for four to six hours for three times a week. The Order Summary Report indicated the RNA were to apply ankle-foot orthosis ([AFO]- a brace that's fitted to the ankle, foot, and lower leg to stabilize the joint and improve alignment) to the left and right ankle for four to six hours three times a week. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 12/4/2024 at 3:18 p.m. with RNA 1, Resident 17's Order Summary Report, dated 12/1/2024 was reviewed. The Order Summary Report indicated the RNA were to apply air pump hand splint to the left and right upper extremities for four to six hours for three times a week. The Order Summary Report indicated the RNA were to apply AFOs to the left and right ankle for four to six hours three times a week. RNA 1 stated Resident 17 was scheduled to have the splints placed on Tuesday, Thursday, and Saturdays. RNA 1 stated there was no documentation that the splints were placed on Resident 17 on Tuesday or Wednesday. RNA 1 stated it was important to place the splints as scheduled to prevent contractures. RNA 1 stated when the splints were not placed it can cause contractures or worsening of contractures. During an interview on 12/5/2024 at 10:59 a.m. with Physical Therapist (PT) 1, PT 1 stated Resident 17 had impaired range of motion and was not able to fully open his arms and shoulders. PT 1 stated Resident 17 was no longer on physical therapy and was currently on the RNA program (a training program that teaches Certified Nurse Assistants how to care for patients with limited mobility). PT 1 stated the recommendation was for Resident 17 to wear the splints three times a week to prevent worsening of the contractures. During a review of facility's policy and procedure (P&P) titled, Restorative Nursing Program Guidelines, dated 9/2019, the P&P indicated the RNA provides nursing interventions that promote the resident's ability to adapt and adjust to living as independently as possible. The P&P indicated the Director of Nursing, or the licensed nurse designee, manages, supervise the activities, and directs in the Restorative Nursing Program and directs. The P&P indicated the RNAs were to document the frequency, amount of time, and the tolerance of the activities.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 49906 Based on observation, interview, and record review, the facility failed to provide supervision to Resident 89 when she wandered into Resident 34's room and was pushed by him after facility's knowledge of her wandering behavior. This failure had the potential for Resident 89 to be injured. Findings: A review of Resident 89's Order Summary Report indicated on June 18, 2024, an order to monitor Resident 89's behavior every shift bipolar disorder manifested by mood swing as evidenced by angry outbursts. A review of Resident 89's care plan initiated on November 13, 2024, indicated the resident wanders aimlessly and significantly intrudes on others privacy or activities. Interventions indicated to distract resident from wandering. A review of the Incident Intake Report, intake number CA00933127, the report indicated on November 30, 2024, at 9:45 am, Resident 89 entered Resident 34's room. Resident 34 yelled at Resident 89 to get out of his room hitting on her shoulder causing Resident 89 to stumble out of the room. A review of Resident 89's Order Summary Report dated December 1, 2024, indicated a physicians' order for 1:1 sitter (one staff member assigned to care for one resident) every shift for safety. During observations on December 3, 2024, Resident 89 walked through the facility hallways stopping at several doors and looking into other residents' rooms constantly redirected by same staff member. During a concurrent observation and interview on December 3, 2024, at 11:43 am with Resident 34, Resident 34 stated Resident 89 comes into his room often and no one stops her. Resident 34 was approached by two transporters and moved to a gurney for transport out of the facility before finishing the interview. During an interview on December 4, 2024, at 2:09 pm with LVN 2, LVN 2 stated she was in the hall and heard Resident 34 yell at, hit, and push Resident 89 in the door of his room. She asked Resident 34 if he pushed Resident 89 and he stated yes, she is not supposed to be in here. He is verbally aggressive even toward nurses. Resident stumbled after being pushed and could have hit her face on the floor.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 43419 Based on interview and record review the facility failed to secure a gastrostomy tube (G-tube-a plastic tube inserted into the stomach to provide nutrition) to prevent dislodgement for one of one sampled resident (Resident 90). This failure resulted in Resident 90's G-tube being dislodged three times. Findings: During a review of Resident 90's admission record dated 8/2023, it indicated Resident 90 had the following diagnosis but not limited to a having a G-tube. During a review of Resident 90's MDS (a standardized assessment tool) record dated 8/16/2023, it indicated the resident has a G-tube. During a record review of Resident 90's nursing progress notes dated 7/25/2024 through 8/18/2024, the nursing progress notes indicated Resident 90's G-tube was dislodged on 7/25/2024, 7/30/2024, and 8/17/2024. The nursing notes also did not indicate Resident 90 used an abdominal binder (a device placed around the abdomen to keep the G-tube in place). During an interview on 12/5/2024 at 8:17 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 90 should have had an abdominal binder to prevent G-tube dislodgement. During a concurrent interview and record review on 12/5/2024 at 11:00 a.m. with Charge Nurse (CN) 1, Resident 90's physician orders dated 6/2/2024 through 9/2/2024 were reviewed. The physician orders did not indicate an abdominal binder was ordered for Resident 90. CN 1 stated Resident 90 was a candidate for an abdominal binder to protect his G-tube from being pulled out or dislodged. CN 1 also stated a G-tube dislodged three times is not in accordance with nursing standards of care and preventive measures should have been ordered and implemented. During a review of the facility ' s policy and procedure (P&P) titled, Enteral Tube Management: nasogastric Tube, Gastrostomy tube and Jejunostomy Tube, dated 9/2023, the P&P indicated, its the responsibility of the facility to maintain safety of enteral tubes (a flexible tube into the stomach for nutrition) before initiating enteral feeding.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46832 Based on observation, interview and record review, the facility failed to: 1. Ensure oxygen tubing was dated for one of five sampled residents (Resident 63). This deficient practice had the potential for the resident to develop a Respiratory Infection. Findings: During a review of Resident 63's face sheet (front page of the chart that contains a summary of basic information about the resident), the face sheet indicated Resident 63 was admitted on [DATE]. The face sheet indicated Resident 63's diagnoses included Chronic Obstructive Pulmonary Disease (COPD- a chronic lung disease causing difficulty in breathing), chronic respiratory failure (a long-term condition that makes it difficult for the body to exchange oxygen and carbon dioxide), Type 2 Diabetes Mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing) and anemia (a condition where the body does not have enough healthy red blood cells). During a review of Resident 63's Minimum Data Set (MDS- a federally mandated resident assessment tool), the MDS indicated Resident 63's cognitive skills was intact. The MDS also indicated Resident 63 was dependent on staff with toileting needs, showering, and upper/lower body dressing. During an observation, on 12/3/2024, at 1:51 p.m., in Resident 63's room, Resident 63 was observed receiving 2.5 liters of oxygen via nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) with no date labeled on the tubing. Resident 63 stated she couldn't remember when the oxygen tubing was last changed but stated staff changed the tubing sometime last week. During a concurrent observation and interview, on 12/5/2024, at 8:22 a.m., with the Director of Nursing (DON), the DON stated the protocol for oxygen tubing was to change the tubing every 7 days and label the tubing with a date. The DON stated Resident 63's oxygen tubing was not labeled with the date and should had been labeled when it was last changed. The DON stated the risk of not labeling oxygen tubing could result in staff not knowing if or when the tubing was last changed. The DON stated, It is an infection control issue. During a review of the facility's policy and procedures, titled Oxygen Therapy, dated 11/2017, indicated, Oxygen tubing, mask, and cannulas will be changed no more than every seven (7) days and as needed. The supplies will be dated each time they are changed.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46144 Based on observation, interview, and record review the facility failed to: 1. Ensure one out of six residents (Resident 72) had a consent (the process in which a health care professional educates a patient about the risk, benefits, and alternatives of a given procedure or intervention) for bedrails (bars attached to the side of a bed to help patients move and reduce the risk of falling out of the bed). This deficient practice of not having a consent for the risk and benefits for bedrails use placed Resident 72 at risk for entrapment. Findings: During a review of Resident 72's Admission Record (Face Sheet- front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 72 was initially admitted to the facility on [DATE] and readmitted on [DATE]. The face sheet indicated, Resident 72's diagnoses included metabolic encephalopathy (a brain dysfunction caused by a chemical imbalance in the blood that affects the brain), major depressive disorder (a mental health condition that causes a persistently low mood and a loss of interest in activities), and spinal stenosis (a narrowing of the spinal canal that compresses the spinal cord, nerves, and resulting in pain in the back and legs). During a review of Resident 72's History and Physical (H&P), dated 9/18/2024, the H&P indicated Resident 72 can make needs known but cannot make medical decisions. During a review of Resident 72's Minimum Data Set ([MDS] a federally mandated assessment tool), dated 11/15/2024 the MDS indicated, Resident 72's cognition (ability to learn, reason, remember, understand, and make decisions) was able to understand and be understood. The MDS indicated Resident 72 was dependent on staff for personal hygiene, showering, and dressing. The MDS indicated bed rail restraints were not being used for Resident 72. During an observation on 12/3/2024 at 10:52 a.m. Resident 72 had bilateral bedrails. Resident 72 was not able to easily release the bedrails from the bed. During an interview on 12/4/2024 at 8:54 a.m. with Resident 72. Resident 72 stated the staff did not discuss with him about having the bedrails. Resident 72 stated he did not give consent for the bed rails. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 12/4/2024 at 1:06 p.m. with Registered Nurse (RN) 1, RN 1 stated there was no consent for bedrails for Resident 72. RN 1 stated anything that is blocking the resident from freely moving there should have a consent. RN 1 stated bedrail consent would describe the risk and benefits of having the bedrails. RN 1 stated it was important to discuss the risk and benefits with the resident. RN 1 stated if something was to happen to the resident such as getting trapped in the bedrails, he would not be aware of the risk and benefits. During a concurrent observation and interview on 12/5/2024 at 11:29 a.m. with Director of Nursing (DON), the DON stated there were bilateral bedrails attached to the bed. The DON stated there should be a consent for bedrails. The DON stated it was important to have the consent if something was to happen to the resident they consented for the bedrail. The DON stated without the consent the resident would not know the risk and benefit of its use. The DON stated Resident 72 could hurt himself trying to get out the bed and the worst-case scenario would be strangulation (applying pressure to the neck or throat to restrict breathing or blood circulation). During a review of the facility's policy and procedure (P&P) titled, Bed Rails, dated 6/2024, the P&P indicated to evaluate the resident's need for bed rails the licensed nurse will complete the bed rail evaluation prior to the use and installation of any bed rail. The P&P indicated the licensed nurse will discuss the risk involved with the use of bed [NAME] with the resident. The P&P indicated ordering physician will obtain informed consent from the resident prior to the use of bed rails.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46144 Based on observation, interview, and record review the facility failed to: 1. Ensure one out of six residents (Resident 72) had a physician order for bedrails. This deficient practice of not having a physician order for bedrails for Resident 72 placed the resident at risk for entrapment (when a patient gets trapped in a hospital bed, usually in the side rails). Findings: During a review of Resident 72's Admission Record (Face Sheet- front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 72 was initially admitted to the facility on [DATE] and readmitted on [DATE]. The face sheet indicated, Resident 72's diagnoses included metabolic encephalopathy (a brain dysfunction caused by a chemical imbalance in the blood that affects the brain), major depressive disorder (a mental health condition that causes a persistently low mood and a loss of interest in activities), and spinal stenosis (a narrowing of the spinal canal that compresses the spinal cord, nerves, and resulting in pain in the back and legs). During a review of Resident 72's History and Physical (H&P), dated 9/18/2024, the H&P indicated Resident 72 can make needs known but cannot make medical decisions. During a review of Resident 72's Minimum Data Set ([MDS] a federally mandated assessment tool), dated 11/15/2024 the MDS indicated, Resident 72's cognition (ability to learn, reason, remember, understand, and make decisions) was able to understand and be understood. The MDS indicated Resident 72 was dependent on staff for personal hygiene, showering, and dressing. The MDS indicated bed rail restraints were not being used for Resident 72. During a concurrent interview and record review on 12/4/2024 at 12:52 p.m. with Registered Nurse (RN) 1, there were no physician orders for bedrails. RN 1 stated there were no current physician orders. RN 1 stated physician orders are required for bedrails usage. RN 1 stated it was important to have the physician orders if something was to happen to Resident 72 there would be a legal order. RN 1 stated what could happen with having the bedrails; the resident legs could get trapped or other parts of his body. RN 1 stated the entrapment could cause harm. During a review of the facility policy and procedure (P&P), titled Physician Orders, dated 8/2020, the P&P indicated to have a process to verify that all physician orders are complete and accurate. The P&P indicated treatments orders will include the description, frequency, and the condition for which the treatment is ordered. The P&P indicated the licensed nurse will be responsible for documenting and carrying out the order. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Bed Rails, dated 6/2024, the P&P indicated to evaluate the resident's need for bed rails the licensed nurse will complete the bed rail evaluation prior to the use and installation of any bed rail. The P&P indicated the licensed nurse will discuss the risk involved with the use of bed [NAME] with the resident. The P&P indicated ordering physician will obtain informed consent from the resident prior to the use of bed rails.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43419 Based on observation, interview, and record review the facility failed to ensure: 1. Food in the kitchen was not stored in the kitchen past the used by date. 2. Food was labeled with the dates it was opened and to be used by. The failure had the potential to result in a foodborne illness (an illness that comes from eating contaminated food) in the residents. Findings: During a concurrent observation and interview on 12/3/2024 at 9:03 a.m. with Dietary Manager (DM), in the kitchen, two bowls of ice cream were kept inside the freezer past the indicated use by date of 12/2/2024. DM stated the bowls of ice cream should be thrown away because one day has passed since the ice cream's use by date of 12/2/2024. DM stated this can prevent foodborne illness. During a concurrent observation and interview on 12/3/2024 at 9:09 a.m. with DM, in the kitchen, an opened package of tapioca pudding mix was not labeled with the date it was opened and to be used by. DM stated all food items should be labeled with date opened and date to be used by to prevent foodborne illness. During a review of the facility's policy and procedure (P&P) titled, P-DS52 Food Storage and Handling, dated 6/4/2024, the P&P indicated, all storage products should be labeled and dated. During a review of the facility's P&P titled, DS52 Food Storage and Handling, dated 6/4/2024, the P&P indicated all items will be labeled and dated to avoid foodborne illnesses.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 43419 Based on observation, interview, and record review, the facility failed to ensure for one of four trash dumpsters had their lid closed completely. This failure had the potential to attract pests (like flies and rodents) that could spread diseases and bacteria to the residents. Findings: During a concurrent observation and interview on 12/3/2024 at 9:25 a.m. with Dietary Manager (DM), the lid of one trash dumpster was open and not closed completely flat. DM stated trash container lids should be closed completely to prevent pests from getting inside the container and creating an infestation. During a review of the facility's policies and procedures (P&P) titled, Waste Management Administrative Manual, dated 4/21/2022, the P&P indicated waste container must be closable.