STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056115	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Imperial Healthcare Center	11926 LA Mirada Blvd LA Mirada, CA 90638

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an informed consent for psychotropic medication (any drug that affects brain activities associated with mental processes and behavior) was obtained in accordance with the facility's policy and procedures for one of five sampled residents (Resident 4). This deficient practice placed Resident 4 at risk for experiencing unexpected and/or unwanted adverse effects or complications of the medication, including increased cognitive impairment (problems with a person's ability to think, learn, remember, use judgment, and make decisions), over sedation (excessive drowsiness, loss of response to verbal command, inappropriate movement, hearing abnormalities, visual disturbances, sweating, or nausea), and tardive dyskinesia (a chronic movement disorder that causes involuntary, repetitive movements in the body). Findings: During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 4's admitting diagnoses included dementia (a progressive state of decline in mental abilities), cognitive communication deficit (a disorder in which a person has difficulty communicating because of injury to the brain that controls the ability to think), generalized muscle weakness, and major depressive disorder (a mental health condition characterized by persistent sadness, a loss of interest or pleasure in activities, and a range of other symptoms). During a review of Resident 4's Minimum Data Set (MDS, a resident assessment tool), dated 4/23/2025, the MDS indicated Resident 4 had moderate cognitive impairment. The MDS indicated Resident 4 was independent with mobility while in and out of bed. During a review of Resident 4's History and Physical (H&P), dated 2/7/2024, the H&P indicated Resident 4 did not have the capacity to understand and make decisions. During a review of Resident 4's medical record titled Informed Consent - Informed Consent for Use of Psychotropic Medication, dated 1/17/2025, the record indicated Physician Assistant (PA) 1 signed the form to indicate he obtained an in-person informed consent for the administration of Lexapro 5 milligram (mg, a unit of dose measurement) every day for Resident 4, and indicated Licensed Vocational Nurse (LVN) 1 signed the document verifying in-person informed consent was obtained by PA 1. The record indicated Resident 4's Responsible Party (RP) 2 did not sign or date the document to indicate she provided informed consent for the administration of Lexapro. (continued on next page)

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 4's Medication Administration Record (MAR), dated 1/1/2025 to 1/31/2025, the MAR indicated Resident 4 received 31 doses of Lexapro. During a review of Resident 4's Medication Administration Record (MAR), dated 2/1/2025 to 2/28/2025, the MAR indicated Resident 4 received 28 doses of Lexapro. During a review of Resident 4's Medication Administration Record (MAR), dated 3/1/2025 to 3/31/2025, the MAR indicated Resident 4 received 31 doses of Lexapro. During a review of Resident 4's Medication Administration Record (MAR), dated 4/1/2025 to 4/30/2025, the MAR indicated Resident 4 received 30 doses of Lexapro. During an interview on 05/21/2025 at 9:58 a.m., with Resident 4's RP 2, RP 2 stated she made medical decisions for and provided consents on behalf of Resident 4. RP 2 stated an unidentified facility staff told her Lexapro (a medication used to treat depression) was ordered, and stated it was not a physician, nurse practitioner (NP), or PA that she spoke with. RP 2 stated, aside from the name of the medication and the indication for the medication, no one from the facility explained any potential side effects or potential complications of the Lexapro. RP 2 stated she had never talked to a physician, NP, or PA related to Resident 4's use of Lexapro. During a concurrent interview and record review on 5/21/2025 at 12:23 p.m., with LVN 1, Resident 4's record titled Informed Consent - Informed Consent for Use of Psychotropic Medication, dated 1/17/2025, was reviewed. LVN 1 stated the record did not indicate RP 2 provided informed consent for the administration of Lexapro. LVN 1 stated obtaining informed consent was important because psychotropic medications were high risk, especially for elderly residents (individuals over the age of 65). LVN 1 stated psychotropic medication, such as Lexapro, could cause sedation, falls, and accidents. During a concurrent interview and record review on 5/22/2025 at 10:30 a.m., with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled Verifications of Informed Consent for Psychotherapeutic Medications, revised 6/2024 was reviewed. The DON stated the P&P indicated each resident had the right to provide informed consent for treatment with psychotherapeutic drugs. The DON stated the P&P indicated staff were to obtain a written informed consent for treatment and a consent renewal every six (6) months, which would be recorded in the record. The DON stated it was important to get informed consent for the administration of the Lexapro to ensure RP 2 agreed with and was aware of the potential adverse effects of the ordered medication.

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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** Based on observation, interview, and record review, the facility failed to ensure call lights were kept within reach for two of 22 sampled residents (Resident 33 and Resident 75). This deficient practice removed Resident 33's and 75's ability to exercise their right to request assistance from staff and created the potential for accidents and/or delays in care. Findings: 1. During an observation on 5/20/2025 at 8:43 a.m., in Resident 33's doorway, Resident 33 was observed sitting up in a wheelchair in her room, at the foot of her bed. Resident 33's call light was in her bed and not within her reach. During a review of Resident 33's admission Record, the admission Record indicated Resident 33 was admitted on [DATE]. Resident 33's admitting diagnoses included generalized muscle weakness, abnormalities of gait and mobility, and history of falling. During a review of Resident 33's Minimum Data Set (MDS, a resident assessment tool), dated 5/4/2025, the MDS indicated Resident 33 had severe cognitive impairments (a decline in mental processes like memory, attention, language, and reasoning). The MDS indicated Resident 33 had lower extremity (hips, knees, ankles, feet) impairments on both sides of her body and required partial assistance from staff to complete activities. During a review of Resident 33's Fall Risk Assessment, dated 4/1/2025, the assessment indicated Resident 33 was at risk for falls. During a review of Resident 33's care plan titled At risk for falls secondary to recent fall prior to admission, dated 4/2/2025, the care plan indicated Resident 33 goals were to consistently use the call light for assistance. The care plan interventions indicated staff were to keep Resident 33's call light within easy reach. During a concurrent interview and record review on 5/21/2025 at 1:56 p.m., with Registered Nurse (RN) 1, a photo of Resident 33's wheelchair and call light placement, taken on 5/20/2025 at 8:43 a.m., was reviewed. RN 1 stated Resident 33's call light was not within reach. RN 1 stated the call light should always be within reach, and stated staff should ensure the call light was left within the resident's reach before leaving the room. 2. During an observation on 5/19/2025 at 10:23 a.m., at Resident 75's bedside, Resident 75 was observed sitting up in a wheelchair, on the left side of his bed. Resident 75's call light cord and call button were wrapped around the side rail of the bed, behind Resident 75. Resident 75 was heard yelling nurse! (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 Resident 75's admission Record, the admission Record indicated Resident 75 was admitted on [DATE] and readmitted on [DATE]. Resident 75's admitting diagnoses included generalized muscle weakness, reduced mobility, glaucoma (a group of eye diseases that can cause vision loss and blindness), and legal blindness (a status that government agencies can grant when you have severe vision loss). During a review of Resident 75's MDS, dated [DATE], the MDS indicated Resident 75 had moderate cognitive impairments and severely impaired vision. The MDS indicated Resident 75 had upper extremity (shoulder, elbow, wrist, and hand) and lower extremity impairments on both sides of his body requiring partial assistance from another person to complete activities. During a review of Resident 75's Fall Risk assessment dated [DATE], the assessment indicated Resident 75 was at high risk for falls. During a review of Resident 75's care plan titled The resident is at risk for recurrent falls & related injuries r/t: impaired vision, balance problem, gait abnormality, impaired cognition, weakness and history of fall, dated 5/1/2025, the care plan goals included Resident 75 having reduced risk for falls and injuries. The care plan interventions indicated staff were to keep Resident 75's call light within reach. During a concurrent observation and interview on 5/19/2025 at 10:37 a.m., at Resident 75's bedside, Licensed Vocational Nurse (LVN) 1 entered Resident 75's room and approached Resident 75. LVN 1 stated Resident 75 was legally blind. LVN 1 stated Resident 75's call light was stuck in the side rail and not within his reach. During an interview on 5/21/2025 at 2:02 p.m., with RN 1, RN 2 stated the call light should always be within the residents' reach to ensure staff can be made aware of and meet their needs. RN 1 also stated accidents could happen very quickly and stated that providing residents with a call light was important to prevent accidents. During a review of the facility's policy and procedure (P&P) titled Answering the Call Light, revised 3/2021, the P&P indicated the purpose of the policy was to ensure timely responses to the resident's requests and needs. The P&P indicated staff were to ensure the call light was within easy reach of the resident while they were in bed or confined to a chair.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide information related to Notice of Medicare Non-Coverage (NOMNC, a document that informs Medicare beneficiaries when their covered services are ending) and Skilled Nursing Facility Advance Beneficiary Notice (SNFABN, a document that informs beneficiaries about potential non-coverage for specific items or services and informs beneficiaries they may have to pay for the service out-of-pocket), to one of three sampled residents (Resident 98), who was self-responsible and had the capacity to understand and make decisions. This deficient practice removed Resident 98's right to file an appeal if he disagreed with the discontinued coverage, including rehabilitation services (i.e., physical therapy [the treatment of disease, injury, or deformity by physical methods rather than by drugs or surgery]). Findings: During a review of Resident 98's admission Record, the admission Record indicated Resident 98 was admitted on [DATE]. Resident 98's admitting diagnoses included generalized muscle weakness, abnormalities of gait (walking) and mobility, and lack of coordination. During a review of Resident 98's admission Minimum Data Set (MDS, a resident assessment tool), dated 3/12/2025, the MDS indicated Resident 98 did not have cognitive impairments (a decline in mental processes like memory, attention, language, and reasoning). The MDS indicated Resident 98 required supervision or touch assistance from staff to perform activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). During an interview on 5/22/2025 at 1:03 p.m. with the Business Office Manager (BOM), the BOM stated the purpose of the SNFABN and NOMNC were to notify the resident (or resident representative [RP]) that Medicare would no longer pay for services and allowed the resident or RP to file an appeal if they felt they still need skilled nursing services. The BOM stated that if the resident was alert and had decision making capacity, she provided the SNFABN and NOMNC notices directly to the resident, unless the resident preferred the notice to be provided to an alternative RP. During a concurrent interview and record review, on 5/22/2025 at 1:05 p.m., with the BOM, Resident 98's History and Physical (H&P) dated 3/10/2025, and SNAFBN and NOMNC dated 4/25/2025, were reviewed. The BOM stated the H&P indicated Resident 98 had the capacity to understand and make decisions. The BOM stated the SNAFBN and NOMNC indicated that the notices were explained to Resident 98's son who made the decision to forfeit the appeal process for continued Medicare coverage. The BOM stated this decision should have been made by Resident 98. The BOM stated forfeiture of the appeal meant Resident 98 would be under custodial care. The BOM stated this meant Resident 98's rehabilitative services were discontinued. The BOM stated rehabilitative services were important in facilitating the resident's safe discharge back into the community. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/22/2025 at 1:33 p.m., with Resident 98, Resident 98 stated his son was not involved in his medical care. Resident 98 stated he never asked the facility to involve his son in his care or allow his son to make any healthcare decisions on his behalf. Resident 98 stated he was not aware his son forfeited the appeal process for continued coverage, and stated he would have wanted to make the decision for himself. During a review of Resident 98's discontinued physician order, dated 4/9/2025, the order indicated Resident 98 received occupational therapy services (therapy aimed to improve one's ability to perform daily tasks, promote health and well-being, and maximize independence) five (5) times a week. The order indicated services were discontinued on 4/29/2025. During a review of Resident 98's discontinued physician order, dated 3/10/2025, the order indicated Resident 98 received physical therapy services five (5) times a week. The order indicated services were discontinued on 4/29/2025. During a review of Resident 98's active physician order, dated 4/24/2025, the order indicated Resident 98's was to transition to custodial care effective 4/29/2025. During a review of the facility's policy and procedure (P&P) titled Medicare Advance Beneficiary and Medicare Non-Coverage Notices, revised 9/2022, the P&P indicated residents were to be informed in advance when there would be changes to their bills, indicated the resident (or RP) was to be informed that they may choose to continue receiving the skilled services that may not be paid for by Medicare, and assume financial responsibility.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop a person-centered care plan (document that helps nurses and other team care members organize aspects of resident care) with interventions (actions a nurse takes to implement a care plan, intend to improve the resident's comfort and health) for two of two sampled residents' (Resident 10 and 68) use of side rails (short rails on one or both sides of the bed that can be used to assist in bed mobility). This deficient practice had the potential to result in Resident 10 and 68 not receiving the necessary care to safely utilize the side rails. Cross Reference F700. Findings: a. During a review of Resident 10's admission Record (Face Sheet), the Face Sheet indicated Resident 10 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included traumatic brain injury ([TBI], a disruption in the normal function of the brain that can be caused by a bump, blow, or jolt to the head) and functional quadriplegia (paralysis from the neck down, including legs, and arms, without any underlying injury or damage to the spinal cord). During a review of Resident 10's Minimum Data Set ([MDS], a resident assessment tool), dated 4/1/2025, the MDS indicated Resident 10's cognitive skills (process of thinking) for daily decision making was severely impaired. The MDS indicated Resident 10 had impairment on both sides of his upper (shoulder, elbow, wrist, and hand) and lower extremities (hip, knee, ankle, foot). The MDS indicated Resident 10 was dependent on staff's assistance with oral hygiene, toileting, bathing, dressing, personal hygiene, and rolling left and right. During a review of Resident 10's History and Physical (H&P), dated 8/19/2024, the H&P indicated Resident 10 did not have the capacity to understand and make decisions. During a review of Resident 10's Order Summary Report, dated 5/21/2025, the Order Summary Report indicated Resident 10 to utilize grab bars for self-turning and repositioning. The order date was 11/15/2024. During a review of Resident 10's Side Rail Assessment, dated 4/1/2025, the Side Rail Assessment recommended the use of bilateral grab bars as a mobility aid to assist in turning, repositioning, and transferring in bed. During an observation on 5/19/2025 at 10:55 a.m., in Resident 10's room, Resident 10 was laying in bed and had bilateral (both sides) half side rails (longer side rails attached to the side of the bed, covering about half the length of the bed) on the bed. During an interview on 5/21/2025 at 10:18 a.m., with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 10 utilized the side rail when turning. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 5/21/2025 at 1:15 p.m., with Registered Nurse (RN) 1, Resident 10 was observed lying in bed. RN 1 stated Resident 10 had bilateral half side rails installed on the bed. During a concurrent interview and record review on 5/21/2025 at 1:36 p.m. with RN 1, Resident 10's electronic health record (eHR) was reviewed. RN 1 stated Resident 10 did not have a care plan developed to address his use of side rails. RN 1 stated the purpose of the care plan was to guide the staff to properly care for Resident 10. RN 1 stated the care plan would indicate the staff's management and intervention to monitor and assess Resident 10's use of side rails. RN 1 stated, without the care plan, Resident 10 was at risk of not receiving the necessary care to safely utilize the side rails. b. During a review of Resident 68's admission Record (Face Sheet), the Face Sheet indicated Resident 68 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included generalized muscle weakness (lack of strength in many areas of the body), right and left hand contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion), and dementia (a progressive state of decline in mental abilities). During a review of Resident 68's MDS, dated [DATE], the MDS indicated Resident 68's cognition was moderately impaired. The MDS indicated Resident 68 required maximal assistance (helper does more than half the effort) with eating, oral hygiene, toileting, lower body dressing, and rolling left and right. During a review of Resident 68's H&P, dated 2/6/2025, the H&P indicated Resident 68 could make needs known but could not make medical decisions. During a review of Resident 68's Siderail Use Assessment, dated 2/3/2025, the Siderail Use Assessment indicated to use bilateral grab bars for space awareness and to increase sense of security and safety. During an observation on 5/19/2025 at 10:47 a.m., in Resident 68's room, Resident 68 was lying in bed. Resident 68 had bilateral grab bars installed to the bed. During an interview on 5/21/2025 at 10:35 a.m., with CNA 2, CNA 2 stated Resident 68 could use the grab bars to assist in turning in bed. During a concurrent observation and interview on 5/21/2025 at 1:12 p.m., with RN 1, in Resident 68's room, Resident 68 was observed lying in bed. RN 1 stated Resident 68 had bilateral grab bars on his bed. During a concurrent interview and record review on 5/21/2025 at 1:18 p.m., with RN 1, Resident 68's Orders, dated 5/21/2025 were reviewed. RN 1 stated Resident 21 had an order to utilize grab bars for self-turning and repositioning. RN 1 stated she inputted the order that day, 5/21/2025, because Resident 68 did not have an order for the grab bars previously. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/21/2025 at 1:54 p.m. with RN 1, Resident 68's eHR was reviewed. RN 1 stated Resident 68 did not have a care plan developed to address his use of grab bars. RN 1 stated a care plan should have been developed to ensure Resident 68 received the necessary care to safely utilize the side rails. During an interview on 5/22/2025 at 9:48 a.m., with the Director of Nursing (DON), the DON stated Residents 10 and 68 should have had care plans developed to address their use of side rails as a mobility aid. The DON stated individualized goals and interventions would be in place for the staff to follow in case any issues arose from the side rails. The DON stated without the care plan, the staff may not be able to provide the necessary care Residents 10 and 68 need. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, revised 3/2022, the P&P indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to conduct an interdisciplinary team (IDT) conference (a meeting to discuss the resident's plan of care, involving the IDT [physician, registered nurse, certified nursing assistant, dietary staff, the resident, and other pertinent staff]), and develop a care plan for one of two sampled residents (Resident 26) following a resident-to-resident altercation that occurred on 11/17/2024. These deficient practices had the potential for Resident 26 to be involved in another resident-to-resident altercation. Findings: During a review of Resident 26's admission Record, the admission Record indicated Resident 26 was originally admitted on [DATE] and readmitted on [DATE]. Resident 26's admitting diagnoses included dementia (a progressive state of decline in mental abilities), restlessness, agitation, Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), and a personal history of other mental and behavioral disorders. During a review of Resident 26's Minimum Data Set (MDS, a resident assessment tool), dated 9/26/2024, the MDS indicated Resident 26 had moderate cognitive impairments (a decline in mental processes like memory, attention, language, and reasoning). The MDS indicated Resident 26 did not have impairments to her lower extremities (hips, knees, ankles, feet) on either side of her body and could wheel herself in her wheelchair with supervision from staff. During a review of Resident 26's progress note, dated 11/17/2024, the progress note indicated Resident 26 was transferred to the hospital following an altercation with another resident. During a concurrent interview and record review on 5/22/2025 at 12:05 p.m., with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled Care Plans, Comprehensive Person Centered, revised 3/2022 was reviewed. The DON stated the P&P indicated the IDT was to review the care plans and update them when a change of conditioned occurred. The DON stated a resident-to-resident altercation was considered a change of condition. During a concurrent interview and record review on 5/22/2025 at 12:07 p.m., with the DON, Resident 26's IDT conference notes, dated 11/21/2024 were reviewed. The DON stated the IDT was conducted on 11/21/2024, when Resident 26 was re-admitted from the hospital following the resident-to-resident altercation. The DON stated the IDT conference notes did not indicate the resident-to-resident altercation was addressed or a care plan to address Resident 26's behavior of kicking others was developed. The DON stated it was important to have an IDT conference to address concerns and to identify staff interventions to prevent future incidents and altercations. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/22/2025 at 12:10 p.m., with the DON, the DON stated a care plan should have been developed following the resident-to-resident altercation to address Resident 26's behavior of kicking others, which is alleged to have started the altercation. The DON stated a care plan would outline interventions to prevent future altercations and ensure a safe environment for all facility residents. The DON stated Resident 26 did not have a current or discontinued care plan to address her behavior of kicking. During a review of the facility's P&P titled Safety and Supervision of Residents, dated 7/2017, the P&P indicated the interdisciplinary care team was to analyze information obtained from assessments and observations to identify any specific accident hazards or risks for individual residents. During a review of the facility's P&P titled Resident-to-Resident Altercations, dated 12/2016, the P&P indicated staff were to review the events with the nursing supervisor and Director of Nursing, and identify possible measures to try to prevent additional incidents. The P&P further indicated staff were to make any necessary changes in the care plan approaches to any or all of the involved individuals and document in the resident's clinical record all interventions and their effectiveness.

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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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure two out of five sampled residents (Resident 11 and Resident 72) were provided with communication tools. This deficient practice placed Residents 11 and 72 at risk of not having their needs met and potentially negatively affecting their psychosocial needs. Findings: 1. During a review of Resident 11's admission Record, the admission Record indicated Resident 11 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 11's diagnoses included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 11 's History and Physical (H&P) dated 1/19/2025, the H&P indicated Resident 11 could make needs known but could not make medical decisions. During a review of Resident 11's Minimum Data Set ([MDS] a resident assessment tool), dated 3/21/2025, the MDS indicated Resident 11's cognitive skills for daily decision making was intact (ability to think and reason). The MDS indicated Resident 11 required set up/clean up assistance for eating and oral hygiene. The MDS indicated Resident 11 required maximal assistance (helper does more than half the effort) for toileting hygiene, and shower/bathing, dressing and personal hygiene. The MDS indicated Resident 11's hearing was adequate. During a review of Resident 11's Activities Review assessment, dated 3/19/2025, the Activities Review assessment indicated Resident 11 had adequate hearing. During an interview on 5/19/2025 at 12:42 p.m. with Resident 11, in Resident 11's room, Resident 11 had difficulty answering questions. Resident 11 asked to be spoken to using her right ear because she recently lost her hearing from her left ear. Resident 11 stated she recently noticed her hearing impairment when she had staff repeat themselves when speaking to her. During an interview on 5/22/2025 at 11:12 a.m. with the Activity Director (AD), in Resident 11's room, the AD asked Resident 11 if she was hard of hearing. Resident 11 replied that she was hard of hearing from her left ear. The AD stated she was not aware that Resident 11 had a hearing impairment. The AD stated Resident 11 would benefit from a communication board. The AD asked Resident 11 if she would like a communication board and Resident 11 replied yes. The AD stated residents that have hearing impairment benefit from a communication board because it helps them communicate with staff by pointing to pictures. The AD stated it was important for residents to communicate with staff to make their needs known. The AD stated she completed an activity review assessment and did not document Resident 11 was hard of hearing. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/22/2025 at 2:03 p.m. with the Director of Nursing (DON), the DON stated she was not aware Resident 11 had a hearing impairment. The DON stated she noticed a small difference in Resident 11's hearing but not much. The DON stated Resident 11 needed a communication board to make her needs known. The DON stated it was important for Resident 11 to be able to communicate to prevent self-isolation. 2. During a review of Resident 72's admission Record, the admission Record indicated Resident 72 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 72's diagnoses included hepatomegaly (the liver is larger than its normal size) and dysphagia (difficulty or discomfort in swallowing). During a review of Resident 72's History and Physical (H&P) dated 4/13/2025, the H&P indicated Resident 72 had the capacity to understand and make decisions. During a review of Resident 72's MDS, dated [DATE], the MDS indicated Resident 72's cognitive skills for daily decision making was intact. The MDS indicated Resident 72 was independent for eating, oral hygiene, toileting hygiene, dressing, and personal hygiene. The MDS indicated Resident 72 required supervision for showering/bathing. The MDS indicated Resident 72 had difficulty in hearing (in some environments). During a review of Resident 72's Care Plan titled Hearing deficit, dated 2/15/2025, the care plan indicated the goal was that all of Resident 72's needs would be met by review date. The interventions indicated to use alternative communication tools as needed. During a review of Resident 72's Activities Review assessment, dated 5/1/2025, the Activities Review assessment indicated Resident 72 had adequate hearing. During a concurrent observation and interview on 5/20/2025 at 3:14 p.m. with Resident 72, in Resident 72's room, there was communication tools observed. When speaking, Resident 72 kept asking to repeat the questions. Resident 72 state he was hard of hearing from his left ear. Resident 72 stated he did not know what a communication board was. Resident 72 stated he would like a communication board and that it would be better to communicate with staff than to have staff repeat themselves when asking questions. During an interview on 5/22/2025 at 11:24 a.m. with the AD, in Resident 72's room, the AD asked Resident 72 if he was hard of hearing. Resident 72 replied he was hard of hearing from his left ear. The AD stated she was not aware that Resident 72 was hard of hearing. The AD stated Resident 72 needed a communication board due to his hearing impairment. The AD stated she completed an activity review assessment but did not document Resident 72 was hard of hearing. During an interview on 5/22/2025 at 1:58 p.m. with the Director of Nursing (DON), the DON stated she was not aware Resident 72 had a hearing impairment. The DON stated Resident 72 needed a communication board to express what he needs and what he wants. The DON stated if residents cannot communicate there was a potential risk for a decline in overall function. (continued on next page)

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F 0685 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 Care of Hearing-Impaired Resident dated 2001, the P&P indicated staff would assist hearing-impaired residents to maintain effective communication with clinicians, caregivers, other residents and visitors. The P&P indicated staff would evaluate and address avoidable obstacles to effective communication. The P&P indicated staff would evaluate resident's adaptive needs and progress at regular intervals.

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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** Based on observation, interview, and record review, the facility failed to ensure one of four sampled residents' (Resident 21) low air loss mattress ([LALM], a mattress designed to distribute body weight over a broad surface area to help prevent skin breakdown) was accurately set to Resident 21's weight. This deficient practice had the potential to result in the avoidable development of pressure ulcers ([PU], localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) and the complications associated with impaired skin integrity. Findings: During a review of Resident 21's admission Record (Face Sheet), the Face Sheet indicated Resident 21 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included metabolic encephalopathy (a change in how the brain works due to an underlying condition and could cause confusion and memory loss), cerebral infarction (a type of stroke that occurs when part of the brain does not get enough blood and oxygen), and dementia (a progressive state of decline in mental abilities). During a review of Resident 21's Minimum Data Set ([MDS], a resident assessment tool), dated 4/8/2025, the MDS indicated Resident 21's cognition (process of thinking) was severely impaired. The MDS indicated Resident 21 was dependent on staff's assistance with oral hygiene, toileting, bathing, dressing, and personal hygiene. The MDS indicated Resident 21 required maximal assistance (helper does more than half the effort) with rolling left and right in bed. The MDS indicated Resident 21 had a pressure-reducing device for the bed. During a review of Resident 21's History and Physical (H&P), dated 1/4/2025, the H&P indicated Resident 21 did not have the capacity to understand an make decisions. During a review of Resident 21's Order Summary Report, dated 5/21/2025, the Order Summary Report indicated Resident 21 to have a LALM for skin management. During a review of Resident 21's Care Plan titled, Potential impairment to Skin Integrity, dated 1/6/2025, the Care Plan indicated Resident 21's goal of maintaining intact skin. The Care Plan indicated staff interventions to have a LALM for skin management. During a review of Resident 21's Braden Scale for Predicting Pressure Sore Risk, dated 4/28/2025, the Braden Scale indicated Resident 21 was at risk for developing pressure sores. During an observation on 5/19/2025 at 11:12 a.m. and 2:25 p.m. and on 5/20/2025 at 12:15 p.m., in Resident 21's room, Resident 21 was observed lying in bed on a Drive brand LALM. The weight setting knob on the pump that inflated the LALM indicated the LALM was set for a resident that weighed approximately 200 pounds (lbs, a unit of measurement). The pump had a note with 100-150 taped on the front and an arrow pointed between 100 and 150lbs. (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 concurrent interview and record review on 5/21/2025 at 10:29 a.m., with Treatment Nurse (TN) 1, Resident 21's Weight, dated 5/2025, was reviewed. TN 1 stated Resident 21 weighed 104lbs and her LALM should be set according to the range on the pump. TN 1 stated the LALM set to 200lb was too high for Resident 21's weight because the LALM would be too firm. TN 1 stated Resident 21 had a LALM to prevent the development of PUs due to Resident 21's fragile skin and history of PUs that were already healed. TN 1 stated if the LALM was set outside of the appropriate weight range, the LALM would become too firm and could potentially cause Resident 21 to develop PUs. During an interview on 5/22/2025 at 9:20 a.m., with the Director of Nursing (DON), the DON stated LALM were utilized for wound prevention and management. The DON stated the LALM offloads pressure on the residents with fragile skin, those at risk for skin breakdown, and those with existing wounds. The DON stated when a LALM was used, a weight range was indicated on the pump to ensure the correct setting. The DON stated Resident 21's LALM setting should have been set between the indicated the setting on the pump to ensure the LALM was not too firm. The DON stated if the LALM setting was outside the indicate range, the pressure would be too high, causing the LALM to be too firm, which could cause Resident 21 to develop a PU. During a review of the facility's document titled, Med-Aire Assure 14530 Alternating Pressure and Low Air Loss Mattress System with Foam Base User Manual, undated, the document indicated to turn the Pressure Adjust Knob to set a comfortable pressure level according to the resident's weight.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain a hazard-free environment for two of 22 sampled residents (Resident 4 and Resident 87) by failing to ensure: 1. Staff responded timely to Resident 4's bed alarm. 2. Resident 4, who had a Wander Guard alarm (a security system designed to prevent residents from wandering outside of designated areas) did not exit the building unsupervised. 3. Resident 87 had a functioning bed alarm. These deficient practices placed Resident 4 and Resident 87 at risk for injuries related to unsafe wandering and/or falls. Findings: 1. During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was admitted to the facility on [DATE] and was most recently readmitted on [DATE]. Resident 4's admitting diagnoses included dementia (a progressive state of decline in mental abilities), generalized muscle weakness, lack of coordination, and abnormalities of gait (walking pattern) and mobility. During a review of Resident 4's History and Physical (H&P), dated 2/7/2024, the H&P indicated Resident 4 did not have the capacity to understand and make decisions. During a review of Resident 4's Minimum Data Set (MDS, a resident assessment tool), dated 4/23/2025, the MDS indicated Resident 4 had moderate cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS indicated Resident 4 required partial to moderate assistance from staff to walk ten (10) feet. a. During a review of Resident 4's Quarterly Risk Assessment, dated 4/23/2025, the assessment indicated Resident 4 was at high risk for falls. During a review of Resident 4's Change of Condition (COC) assessments dated 1/24/2025, 1/31/2025, and 2/23/2025, assessments indicated Resident 4 had two unwitnessed falls on 1/24/2025 and 2/23/2025, and a witnessed fall on 1/31/2025. During a review of Resident 4's physician order dated 2/3/2025, the order indicated staff were to apply bed and wheelchair pad alarms to remind Resident 4 to call for assistance and to alert staff when alarm goes off. During a review of Resident 4's care plan titled Resident 4 is at risk for falls & injuries ., dated 2/3/2025, the care plan indicated the purpose of the bed and wheelchair pad alarms was to prevent Resident 4 from having repeat incidents of falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/20/2025 at 8:23 a.m., with Resident 4, Resident 4 stated she knew that her strength was not good and stated she could fall if she tried to walk by herself. During an observation on 5/20/2025 at 9:36 a.m., in the doorway of Resident 4's room, observed Resident 4's bed alarm alarming. Resident 4 was observed standing up at bedside with bare feet and multiple staff walked past Resident 4's room, while alarm was audible from the hallway. During an observation on 5/20/2025 at 9:38 a.m., in the doorway of Resident 4's room, Resident 4 was observed putting on her own shoes and getting into her wheelchair. Resident 4 wheeled herself to the doorway of her room. The alarm on Resident 4's bed was still alarming, and multiple staff walked by without responding to the alarm. During an observation at 5/20/2025 at 9:39 a.m., in the hallway outside of Resident 4's room, Certified Nursing Assistant (CNA) 4 was observed approaching Resident 4 in the hallway, then entered Resident 4's room to respond to the alarm. During an observation on 5/20/2025 at 9:40 a.m., in the doorway of Resident 4's room, the Director of Nursing (DON) was observed entering Resident 4's room. Resident 4's bed alarm was still alarming. CNA 4 told the DON she did not know how to turn off the bed alarm in Resident 4's room. During an interview on 5/20/2025 at 9:46 a.m., with CNA 4, CNA 4 stated, when staff hear a bed or wheelchair alarm go off, they were to respond right away. During an interview on 5/21/2025 at 11:01 a.m. with Registered Nurse (RN) 1, RN 1 stated, when a bed alarm goes off, staff were to respond to the alarm right away. RN 1 stated any staff can respond to the bed alarm, not just nursing staff. RN 1 stated prompt response to bed or wheelchair alarms was important to prevent falls. RN 1 stated not responding to the bed alarm timely created the possibility for falls and injury. RN 1 stated staff should respond to bed and wheelchair alarm within seconds. RN 1 stated there should always be staff in the hallways to ensure someone was available to respond. During a review of the facility's policy and procedure (P&P) titled Falls and Fall Risk, Managing, revised 3/2020, the P&P indicated staff were to implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk for or with a history of falls. b. During an observation on 5/20/2025 at 8:35 a.m., in the hallway outside of room [ROOM NUMBER], Resident 4 was observed entering the building through a door indicated as an emergency exit only. The emergency exit alarm and Wander Guard alarm were both alarming. Staff did not directly observe Resident 4 enter the building, and no staff followed Resident 4 into the building to indicate she was supervised while outside. The MA turned off the alarms and walked away. During a review of Resident 4's physician order, dated 7/12/2024, the order indicated staff were to monitor Resident 4 for episodes of seeking exit door and attempts to leave premises without informing staff. The physician order indicated staff were to call Resident 4's physician if they observed the behavior for further orders. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 4's physician order, dated 5/7/2025, the order indicated staff were to apply a Wander Guard on Resident 4's wheelchair to alert staff when resident attempted to pass through an exit door. During a concurrent observation and interview, on 05/19/2025 at 11:36 a.m., in the hallway outside of room [ROOM NUMBER], Resident 4 was observed entering the building through a door indicated as an emergency exit only. The Wander Guard alarm sensor on the wall was alarming. Resident 4 stated she was outside and stated she goes outside often. Resident 4 was not accompanied by staff, and no staff responded to the alarm. Resident 4 wheeled herself down the hallway. During an interview on 5/19/2025 at 11:41 a.m., with Registered Nurse (RN) 1, RN 1 stated the doors next to room [ROOM NUMBER] were for employee use, or emergency evacuations only. RN 1 stated there was a gate outside of the doors that led out of the facility. During a concurrent observation and interview, on 5/19/2025 at 11:50 a.m., with the Maintenance Assistant (MA), the area outside of the exit doors by room [ROOM NUMBER] was observed. The MA stated there were no cameras monitoring the area. During an interview on 5/21/2025 at 11:07 a.m., with RN 1, RN 1 stated, when Resident 4 approached an exit door, the Wander Guard alarm should go off, prompting staff to stop her from exiting the building. RN 1 stated Resident 4 should be supervised when outside of the building due to the possibility of accidents outside, and staff not knowing Resident 4 was outside. RN 1 stated Resident 4 could end up behind the building and no one would know. RN 1 stated there was also the potential for Resident 4 to elope (a resident leaving the facility's premises without authorization or supervision). RN 1 stated Resident 4 should have supervision for her safety. During a review of the facility's P&P titled Wandering and Elopements, dated 2001, the P&P indicated staff were to identify residents who were at risk of unsafe wandering and strive to prevent harm through interventions to maintain the resident's safety. 2. During an observation on 5/19/2025 at 12:04 p.m., Resident 87 was observed lying in bed, with the bed alarm monitor hanging from Resident 87's left siderail. The bed alarm lights on the monitor were not flashing or lit up, indicating it was not on. During a review of Resident 87's admission Record, the admission Record indicated Resident 87 was admitted to the facility on [DATE]. Resident 87's admitting diagnoses included muscle contractures (stiffening/shortening at any joint, that reduces the joint's range of motion), dementia, and history of falling. During a review of Resident 87's MDS, dated [DATE], the MDS indicated Resident 87 had moderate cognitive impairment. The MDS indicated Resident 87 had impairments to his upper extremities (i.e., shoulder, elbow, wrist, hand) on one side of his body, and required partial to moderate assistance from staff for bed mobility. During a review of Resident 87's physician order, dated 8/19/2024, the order indicated staff were to place an alarm in Resident 87's bed for safety precaution every shift. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 87's Fall Risk Assessment, dated 11/21/2024, the assessment indicated Resident 87 was at high risk for falls. During a review of Resident 87's care plan titled The resident is at risk for further falls & related injuries created 8/21/2024 and revised on 11/22/2024, the care plan indicated the goal was to reduce Resident 87's risk for falls and injuries through implementation of safety devices and other interventions. The care plan interventions indicated staff were to place a bed pad alarm in Resident 87's bed for safety precaution and monitor for bed alarm placement and functioning every shift. During a concurrent observation and interview on 5/19/2025 at 12:07 p.m., with CNA 6 at Resident 87's bedside, Resident 87's bed alarm monitor was observed with no indicator lights on or flashing. CNA 6 stated she was not sure if the bed alarm was on or working. CNA 6 states she did not know how to check the functionality on the alarm monitor itself. During a concurrent observation and interview on 5/19/2025 at 12:13 p.m., with the Director of Nursing (DON) at Resident 87's bedside, Resident 87's bed alarm monitor was observed. The DON stated the bed alarm was not functioning and needed to be replaced. The DON stated the indicator lights on the monitor should blink to indicate the monitor is on. The DON stated that not having a functioning bed alarm was a fall risk. During a review of the facility's policy and procedure titled Falls and Fall Risk, Managing, revised 3/2020, the P&P indicated staff were to implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk for or with a history of falls.

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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** Based on observation, interview, and record review, the facility failed to ensure the proper use of side rails (short rails on one or both sides of the bed that can be used to assist in bed mobility) for two of two sampled residents (Residents 10 and 68) by failing to: 1. Ensure Resident 10 had grab bars (short side rails used to assist in bed mobility), instead of half side rails (longer side rails attached to the side of the bed, covering about half the length of the bed), were installed onto the bed. This deficient practice had the potential to result in Resident 10 unable to optimally utilize the half side rails in turning and repositioning in bed. 2. Ensure Resident 68 had an order for grab bars. 3. Obtain informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) from Responsible Party (RP) 1, for Resident 68's grab bars, immediately upon Resident 68's readmission to the facility. These deficient practices had the potential to result in the unsafe usage of grab bars and for RP 1 being unaware of the installment of grab bars and unable to make an informed decisions of its utilization. Findings: 1. During a review of Resident 10's admission Record (Face Sheet), the Face Sheet indicated Resident 10 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included traumatic brain injury ([TBI], a disruption in the normal function of the brain that can be caused by a bump, blow, or jolt to the head) and functional quadriplegia (paralysis from the neck down, including legs, and arms, without any underlying injury or damage to the spinal cord). During a review of Resident 10's Minimum Data Set ([MDS], a resident assessment tool), dated 4/1/2025, the MDS indicated Resident 10's cognitive skills (process of thinking) for daily decision making was severely impaired. The MDS indicated Resident 10 had impairment on both sides of his upper (shoulder, elbow, wrist, and hand) and lower extremities (hip, knee, ankle, foot). The MDS indicated Resident 10 was dependent on staff's assistance with oral hygiene, toileting, bathing, dressing, personal hygiene, and rolling left and right. During a review of Resident 10's History and Physical (H&P), dated 8/19/2024, the H&P indicated Resident 10 did not have the capacity to understand and make decisions. During an observation on 5/19/2025 at 10:55 a.m., in Resident 10's room, Resident 10 was lying in bed and had bilateral (both sides) half side rails on the bed. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/21/2025 at 10:18 a.m., with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 10 utilized the side rail when turning. CNA 1 stated Resident 10 could only grab the side rail on his left and sometimes had difficulty with holding onto the side rail. During a concurrent observation and interview on 5/21/2025 at 1:15 p.m., with Registered Nurse (RN) 1, Resident 10 was observed lying in bed. RN 1 stated Resident 10 had bilateral half side rails installed on the bed. During a concurrent interview and record review on 5/21/2025 at 1:44 p.m. with RN 1, Resident 10's Side Rail Assessment, dated 4/1/2025, was reviewed. RN 1 stated the Side Rail Assessment recommended the use of bilateral grab bars as a mobility aid to assist in turning, repositioning, and transferring in bed. RN 1 stated Resident 10 did not have bilateral grab bars installed on the bed and instead had bilateral half side rails. During a concurrent interview and record review on 5/21/2025 at 1:46 p.m. with RN 1, Resident 10's Orders, dated 11/15/2024, was reviewed. RN 1 stated the Orders indicated for Resident 10 to utilize grab bars for self-turning and repositioning. RN 1 stated Resident 10 had the incorrect side rails installed to his bed. RN 1 stated the grab bars were used for repositioning and turning compared to the half side rails which were used more for safety purposes. RN 1 stated installing the correct side rails was important to ensure Resident 10's safety and Resident 10's maximal utilization of the grab bars to assist in turning and repositioning. During an interview on 5/22/2025 at 9:35 a.m., with the Director of Nursing (DON), the DON stated according to Resident 10's orders and assessments, Resident 10 should have had grab bars on his bed instead of the half side rails. The DON stated the nurses were responsible for following Resident 10's orders. The DON stated half side rails were not appropriate for Resident 10 and were not practical for Resident 10 to grab while repositioning in bed. 2a. During a review of Resident 68's admission Record (Face Sheet), the Face Sheet indicated Resident 68 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included generalized muscle weakness (lack of strength in many areas of the body), right and left hand contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion), and dementia (a progressive state of decline in mental abilities). During a review of Resident 68's MDS, dated [DATE], the MDS indicated Resident 68's cognition was moderately impaired. The MDS indicated Resident 68 required maximal assistance (helper does more than half the effort) with eating, oral hygiene, toileting, lower body dressing, and rolling left and right. During a review of Resident 68's H&P, dated 2/6/2025, the H&P indicated Resident 68 could make needs known but could not make medical decisions. During a review of Resident 68's Siderail Use Assessment, dated 2/3/2025, the Siderail Use Assessment indicated to use bilateral grab bars for space awareness and to increase sense of security and safety. During an observation on 5/19/2025 at 10:47 a.m., in Resident 68's room, Resident 68 was lying in bed. Resident 68 had bilateral grab bars installed to the bed. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/21/2025 at 10:35 a.m., with CNA 2, CNA 2 stated Resident 68 could use the grab bars to assist in turning in bed. During a concurrent observation and interview on 5/21/2025 at 1:12 p.m., with RN 1, in Resident 68's room, Resident 68 was observed lying in bed. RN 1 stated Resident 68 had bilateral grab bars on his bed. During a concurrent interview and record review on 5/21/2025 at 1:18 p.m., with RN 1, Resident 68's Orders, dated 5/21/2025 were reviewed. RN 1 stated Resident 21 had an order to utilize grab bars for self-turning and repositioning. RN 1 stated she inputted the order that day, 5/21/2025, because Resident 68 did not have an order for the grab bars previously. RN 1 stated she was unsure how long Resident 68 had the bilateral grab bars on his bed for, but Resident 68 did not have any order for them since his readmission to the facility. RN 1 stated for a resident to appropriately have side rails, an assessment was completed and a physician's order had to be in place. During an interview on 5/22/2025 at 9:33 a.m., with the DON, the DON stated a physician's order for grab bars was necessary to ensure the physician deemed it necessary and safe to install onto the bed. The DON stated without an order for grab bars, Resident 68 was at risk of unsafe use of the grab bars. 2b. During a concurrent interview and record review on 5/22/2025 at 9:36 a.m., with the DON, Resident 68's Facility Verification of Resident Informed Consent for Use of a Device, dated 2/28/2025, was reviewed. The DON stated Resident 68 was readmitted to the facility and into his same room on 2/3/2025. The DON stated Resident 68 always had the grab bars on his bed. The DON stated when Resident 68 was readmitted to the facility, the informed consent should have been obtained the same day due to the grab bars being utilized. The DON stated the purpose of verifying informed consent was obtained from RP 1 was to ensure RP 1 agreed with the use of the grab bars were explained the risks and benefits. The DON stated with the delay in verifying informed consent, RP 1 may not have been aware of the use of the grab bars and could not make an informed decision to allow the continued use of them. During a review of the facility's policy and procedure (P&P) titled, Bed Safety and Bed Rails, undated, the P&P indicated, The use of bed rails or side rails is prohibited unless the criteria for use of bed rails have been met including attempts to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent. The P&P indicated, Before using bed rails for any reason, the staff shall inform the resident or representative about the benefits and potential hazards associated with bed rails and obtain informed consent.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure their medication error rate was less than five percent (%), when Licensed Vocational Nurse (LVN) 3 failed to administer two of five randomly selected residents' (Residents 28 and 66) medications in accordance with the physicians' orders. The outcome was two medication errors out of 30 opportunities for errors, which resulted in a Medication Administration Error Rate of 6.67%, based on the following: 1. LVN 3 did not administer Resident 28's metoprolol (medication to treat high blood pressure) with food. 2. LVN 3 did not administer Resident 66's aspirin (an antiplatelet medication used to prevent blood clots from forming) with food. This deficient practice had the potential to result in Residents 28 and 66 to experience stomach pain and discomfort. Findings: a. During a review of Resident 28's admission Record (Face Sheet), the Face Sheet indicated Resident 28 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included hypertensive heart disease with heart failure (long-term high blood pressure that weakened the heart, causing difficulty to pump blood efficiently) and paroxysmal atrial fibrillation (sudden episodes when the heart beats irregularly and rapidly). During a review of Resident 28's Minimum Data Set ([MDS], a resident assessment tool), dated 4/10/2025, the MDS indicated Resident 28's cognition (process of thinking) was severely impaired. The MDS indicated Resident 28 required maximal assistance (helper does more than half the effort) with toileting, dressing, and personal hygiene. During a review of Resident 28's History and Physical (H&P), dated 1/10/2025, the H&P indicated Resident 28 did not have the capacity to understand and make decisions. During a review of Resident 28's Order Summary Report, dated 5/20/2025, the Order Summary Report indicated to give metoprolol 50 milligrams (mg, unit of measurement), by mouth two times a day for hypertension. Hold the medication if the systolic blood pressure ([SBP], the top number in a blood pressure reading, representing the pressure in the arteries when the heart beats and pumps blood out) was less than 110 millimeters of mercury (mm Hg, unit of pressure measurement) or if the heart rate was less than 60 beats per minute (bpm). Give the medication with food or after meals. During an observation on 5/20/2025 at 8:25 a.m., in Resident 28's room, LVN 3 checked Resident 28's blood pressure, which was 140/60 mmHg, and heart rate which was 64 bpm. LVN 3 informed Resident 28 that he would prepare her medications. LVN 3 did not ask Resident 28 whether she ate breakfast or if she would like a snack. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 5/20/2025 at 8:30 a.m., outside of Resident 28's room, LVN 3 prepared a total of nine medications that consisted of nine tablets and one eye drop. LVN 3 entered Resident 28's room, explained the medications to Resident 28, and nine tablets were administered with water and LVN 3 administered the eye drop to Resident 28's left eye. LVN 3 expressed appreciation to Resident 28 and provided no other instruction. During a concurrent interview and record review on 5/20/2025 at 8:56 a.m., with LVN 3, Resident 28's Orders, dated 5/20/2025, was reviewed. LVN 3 stated Resident 28's order for metoprolol specified to give the medication with food. LVN 3 stated he did not ask Resident 28 whether she ate prior to taking the metoprolol nor offer Resident 28 a snack. LVN 3 stated food should be provided when administering metoprolol to prevent Resident 28 from experiencing stomach pains and discomfort. b. During a review of Resident 66's admission Record (Face Sheet), the Face Sheet indicated Resident 66 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (also known as stroke, a loss of blood flow to a part of the brain) affect the left non-dominant side, malignant neoplasm of the brain (a cancerous brain tumor), essential hypertension. During a review of Resident 66's MDS, dated [DATE], the MDS indicated Resident 66's cognition was moderately impaired. The MDS indicated Resident 66 required moderate assistance (helper does less than half the effort) with toileting, dressing, and personal hygiene. The MDS indicated Resident 66 took antiplatelet medication. During a review of Resident 66's H&P, dated 2/16/2025, the H&P indicated Resident 66 could make needs known but could not make medical decisions. During a review of Resident 66's Order Summary Report, dated 5/20/2025, the Order Summary Report indicated to give aspirin 81mg, by mouth one time a day, for stroke prophylaxis (prevention). Give the medication with food. During an observation on 5/20/2025 at 8:45 a.m., in Resident 66's room, LVN 3 informed Resident 66 that he would prepare her medications. LVN 3 did not ask Resident 66 whether she ate breakfast or if she would like a snack. During an observation on 5/20/2025 at 8:50 a.m., outside of Resident 28's room, LVN 3 prepared a total of six medications that consisted of seven tablets. LVN 3 entered Resident 66's room, explained the medications to Resident 66, and seven tablets were administered with water. LVN 3 expressed appreciation to Resident 66 and provided no other instruction. During a concurrent interview and record review on 5/20/2025 at 8:59 a.m., with LVN 3, Resident 66's Orders, dated 5/20/2025, was reviewed. LVN 3 stated Resident 66's order for aspirin specified to give the medication with food. LVN 3 stated he did not ask Resident 66 whether she ate breakfast prior to taking aspirin not offer Resident 66 a snack. LVN 3 stated food should be provided when administering aspirin to prevent Resident 66 from experiencing any kind of stomach discomfort. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/22/2025 at 9:11 a.m., with the Director of Nursing (DON), the DON stated prior to administering medication to a resident, the licensed nurse was responsible for reviewing the medication order. The DON stated all order instructions should be reviewed and carried out. The DON stated when a medication order specified to give with food, the licensed nurse should verify whether the resident ate a meal prior to administer the medication or should offer a small snack to the resident. The DON stated many medications could cause stomach discomfort if taken on an empty stomach, therefore the physician would order the medication to be taken with food. The DON stated Residents 28 and 66's medication orders specified to give with food, therefore the licensed nurse should have ensured they were given a snack if breakfast was not consumed. The DON stated Residents 28 and 66 were at risk of stomach pain and discomfort. During a review of the facility's policy and procedure (P&P) titled, Administering Medications, revised 4/2019, the P&P indicated, Medications are administered in accordance with the prescriber orders.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure one out of eight sampled residents (Resident 72) did not store medications at the bedside when: 1. Resident 72 had a medication bottle of Adderall (a stimulant that helps improve focus, attention, and impulse control in people with attention deficit hyperactivity disorder [ADHD, chronic condition including attention difficulty, hyperactivity, and impulsiveness]) at the bedside. 2. Resident 72 had a medication bottle of Atarax (medication for anxiety [a feeling of worriedness, dread, and uneasiness]) at the bedside. 3. Resident 72 had a medication bottle of Diovan (medication for high blood pressure [the force of blood pushing against the walls of the arteries is consistently too high]) at the bedside. These deficient practices placed Resident 72 at risk for potential medication error and potential adverse effects due to overdosing of medications. Findings: During a review of Resident 72's admission Record, the admission Record indicated Resident 72 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 72's diagnoses included ADHD, anxiety and hypertension (high blood pressure). During a review of Resident 72's History and Physical (H&P) dated 4/13/2025, the H&P indicated Resident 72 had the capacity to understand and make decisions. During a review of Resident 72's Minimum Data Set ([MDS] a resident assessment tool), dated 5/1/2025, the MDS indicated Resident 72's cognitive skills for daily decision making was intact (ability to think and reason). The MDS indicated Resident 72 was independent for eating, oral hygiene, toileting hygiene, dressing, and personal hygiene. The MDS indicated Resident 72 needed supervision for showering/bathing. During a review of Resident 72's Order Summary Report, dated 4/14/2025, the Order Summary Report indicated the following orders: 1. Adderall oral tablet 10 milligrams (mg, unit of measurement) give one tablet a day for ADHD. 2. Diovan 40 mg, give one tablet a day for high blood pressure. During a review of Resident 72's Medication Administration Record (MAR), dated 5/1/2025 - 5/21/2025, the MAR indicated Resident 72 received Adderall 10 mg, one tablet a day for ADHD, and Diovan 40 mg, one tablet a day for high blood pressure. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 5/20/2025 at 12:40 p.m. in Resident 72's room, there was a closed medication bottle at Resident 72's bedside. Resident 72 opened the dresser drawer, removed and opened a medication bottle. Resident 72 took one pill out and placed it in his mouth and swallowed it. Resident 72 stated he swallowed a pill for his anxiety. Resident 72 stated he took these pills all the time. Resident 72 stated it was safe for him to take this medication because his physician prescribed it. During an interview on 5/21/2025 at 12:13 p.m. with Resident 72, in Resident 72's room, Resident 72 stated he still had his medications in his dresser and he took his medications when he needed them. Resident 72 stated staff knew he had these medications because he was not hiding them, they were displayed on his dresser. During an interview on 5/21/2025 at 2:48 p.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated residents are not allowed to keep medications at their bedside, even over the counter medications (medications that can be purchased without a prescription) are not acceptable. LVN 2 stated it was unsafe for residents to keep medications at their bedside because they can overdose on those medications or their roommates can take the medication. LVN 2 stated nurses must be informed of all the medications residents take to prevent adverse effects. LVN 2 stated if a resident took medication without informing the licensed staff it could negatively interact with administered medication. LVN 2 stated it was unsafe practice to have residents with mediations at their bedside. During an interview on 5/21/2025 at 3:12 p.m. with Registered Nurse (RN) 2, RN 2 stated residents were not allowed to keep medications at their bedside. RN 2 stated if medications were discovered at a resident's bedside they must be removed immediately and inform the resident they could only take medication administered by a licensed nurse. RN 2 stated it was all of the staff's responsibility to make sure residents did not have medications at their bedside. During a concurrent observation and interview on 5/21/2025 at 3:36 p.m. with RN 2, in Resident 72's room, there was a medication bottle of Atarax and Diovan observed in the resident's dresser drawer and a medication bottle of Adderall on top of the dresser. RN 2 removed the bottles from the dresser and stated she did not know Resident 72 kept these medications at his bedside and it was an unsafe practice. RN 2 stated someone should have caught this and removed medications from Resident 72's bedside. RN 2 stated it was a possibility that Resident 72 took his medication and received the same medication from the licensed nurses which could have caused an overdose of the medication. During an interview on 5/22/2025 at 1:42 p.m. with the Director of Nursing (DON), the DON stated residents were not allowed to keep medications at their bedside because there was a risk of side effects, toxicity and a potential interaction with administered medication. The DON stated it was not safe for Resident 72 to self-administer his medication and he never requested to self-administer medications. The DON stated there was no reason why Resident 72 should have medications at his bedside. During a review of the facility's Policy and Procedure (P&P) titled Medication Storage in the Facility, undated, the P&P indicated medication supply was accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer mediations. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of facility's P&P titled Medication Administration, dated 4/2019, the P&P indicated resident may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, had determined resident had the decision-making capacity to do so safely.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to prepare and serve food to meet individual needs for one out of eight sampled residents (Resident 19) by: 1. Not ensuring Resident 19 received a regular diet during mealtime. This deficient practice did not meet Residents 19's individual needs and placed resident 19 to feel unsatisfied with the meal. Findings: During a review of Resident 19's admission Record, the admission Record indicated Resident 19 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 19's diagnoses included hypertensive heart disease (caused by persistently high blood pressure, causes chest pain, shortness of breath, fatigue, swelling in the legs or ankles, and palpitations) and malignant neoplasm (abnormal growth of cells that can spread to other parts of the body and cause harm) of the colon (longest part of the large intestine). During a review of Resident 19's History and Physical (H&P) dated 4/25/2025, the H&P indicated Resident 19 had the capacity to understand and make decisions. During a review of Resident 19's Minimum Data Set ([MDS] a resident assessment tool), dated 3/20/2025, the MDS indicated Resident 19's cognitive skills for daily decision making was intact (ability to think and reason). The MDS indicated Resident 19 required supervision for eating, oral hygiene, and personal hygiene. The MDS indicated Resident 19 required maximal assistance (helper does more than half the effort) for showering/bathing, lower body dressing and putting on and taking off shoes. During a review of Residents 19's Order Summary Report, dated 4/24/2025, the order summary report indicated Resident 19 had an order for regular diet (a balanced diet with no special restrictions or modifications) and regular texture (textures of foods commonly consumed by individuals with no increased risk of choking or swallowing difficulties, and who have no difficulty chewing). During a review of Resident 19's Nutritional Assessment, dated 4/29/2025, the assessment indicated Resident 19 was on a regular diet and regular texture. The Nutritional assessment indicated Resident 19's nutritional risks were altered nutrition and poor intake. During a concurrent observation and interview on 5/21/2025 at 1230 p.m., in Resident 19's room, Resident 19 received a food tray with ground meat. Resident 19 stated she did not know why she received her meat in that texture. Resident 19 stated she did not want to eat the meat that was served to her because she preferred regular texture food. Resident 19 questioned why she received ground meat and asked if this was a new diet change that she was not informed of. Resident 19 stated she had no problem chewing or swallowing and she did not want the ground meat because the ground meat was for residents that had issues with chewing and swallowing. Resident 19 stated she preferred to eat the big chunks of meat that was served for the regular texture diet. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 5/21/2025 at 12:37 p.m. with Certified Nursing Assistant (CNA) 5, in Resident 19's room, observed CNA 5 review Resident 19's dietary card (communication tool used to inform healthcare professionals, chefs, or food service staff about a person's specific dietary needs, restrictions, or allergies) and stated Resident 19's ordered diet was regular with regular texture. CNA 5 stated the meat that was on Resident 19's plate was for a mechanical soft diet (texture-modified diet, typically prescribed for individuals with difficulty chewing or swallowing) and not for a regular texture diet. CNA 5 stated the meat was for a mechanical soft diet because it was chopped up into small pieces. During a concurrent observation and interview on 5/21/2025 at 12:43 p.m. with the Dietary Supervisor (DS), in Resident 19's room, the DS observed Resident 19's food tray and stated Resident 19 had been served ground meat which was for a mechanical soft diet. The DS stated Resident 19 was ordered to receive a regular texture diet. The DS stated it was a mistake that Resident 19 received ground meat and Resident 19 should have received the cubed meat instead. The DS stated it was important to serve Resident 19 the correct food texture to provide her dignity during her mealtimes. The DS stated Resident 19 was able to chew and swallow and there was no reason to serve her ground meat. During an interview on 5/21/2025 at 3:02 p.m. with Licensed Vocational (LVN) 2, LVN 2 stated all food delivered to the residents was checked by the dietary department, licensed nurses, and CNAs. LVN 2 stated everyone was responsible for checking the residents' dietary cards and making sure it matched with the food residents received. LVN 2 stated staff must check if the resident received the correct diet, correct texture, correct liquid consistency and for allergies. During an interview on 5/21/2025 at 3:29 p.m. with Registered Nurse (RN) 2, RN stated all food delivered to residents must be checked because all residents have different diets and textures that potentially pose a safety concern. RN 2 stated a resident with a regular texture diet should not receive a mechanical soft diet because they do not need their food in smaller sizes to chew or swallow. RN 2 stated a resident on regular texture diet would feel degraded if they received food cut into small pieces. RN 2 stated it was important for all residents to receive the ordered diet for their dignity. During an interview on 5/22/2025 at 3:00 p.m. with the Director of Nursing (DON), the DON stated it was not acceptable to serve a resident a mechanical soft diet when they are ordered to receive a regular texture diet because it would affect their psychosocial needs. The DON stated Resident 19 could potentially think her health was deteriorating and that was the reason why her food was not regular texture. During a review of the facility's Policy and Procedure (P&P) titled Therapeutic Diets, dated 2001, the P&P indicated therapeutics diets are prescribed by the attending physician to support the resident's treatment and plan of care and in accordance with residents' goals and preferences.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Imperial Healthcare Center	11926 LA Mirada Blvd LA Mirada, CA 90638

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Arbitration Agreement (an agreement between the facility and the resident where they would resolve any disputes through a neutral person rather than going to court) was provided to and signed by an individual with decision making capacity for two of three sampled residents (Resident 104 and 105). This deficient practice resulted in Resident 104 and 105 being unaware that their right to resolve a dispute in court was waived after entering into the binding arbitration agreement. Findings: a. During a review of Resident 104's admission Record (Face Sheet), the Face Sheet indicated Resident 104 was admitted to the facility on [DATE] with diagnoses that included dementia (a progressive state of decline in mental abilities), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs). The Face Sheet indicated Resident 104 had two emergency contacts. During a review of Resident 104's Minimum Data Set ([MDS], a resident assessment tool), dated 5/14/2025, the MDS indicated Resident 104's cognition (process of thinking) was moderately impaired. The MDS indicated Resident 104 required supervision with eating, oral hygiene, upper body dressing, and personal hygiene. During a concurrent interview and record review on 5/22/2025 at 3:15 p.m., with Admissions Assistant (AA) 1, Resident 104's History and Physical (H&P), dated 5/11/2025, was reviewed. AA 1 stated Resident 104's H&P indicated Resident 104 did not have the mental capacity to understand and make decisions. AA 1 stated it was not part of her practice to check the H&P prior to reviewing the Arbitration Agreement with the resident. AA 1 stated to determine whether a resident was alert and capable of understanding the Arbitration Agreement, she would enter the room and just speak to the resident. AA 1 stated, If it is obvious [the resident] is not alert and is not able to sign, I would reach out to the resident's first emergency contact or responsible party (RP). During a concurrent interview and record review, on 5/22/2025 at 3:25 p.m., with AA 1, Resident 104's Arbitration Agreement, dated 5/13/2025, was reviewed. AA 1 stated on 5/13/2025, she entered Resident 104's room and when she spoke to Resident 104, Resident 104 appeared to be alert and understood what the Arbitration Agreement was prior to signing. AA 1 stated Resident 104 signed the Arbitration Agreement in English and Spanish. AA 1 stated due to Resident 104 assessed to not have the mental capacity to understand and make decisions, the Arbitration Agreement should not have been explained to nor signed by Resident 104. AA 1 stated the Arbitration Agreement should have been discussed with Resident 104's RP who had the capacity to understand and make an informed decision whether to enter the Arbitration Agreement or not. (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. During a review of Resident 105's admission Record (Face Sheet), the Face Sheet indicated Resident 105 was admitted to the facility on [DATE] with diagnoses that included metabolic encephalopathy (a change in how the brain works due to an underlying condition and could cause confusion and memory loss), cognitive communication deficit (having trouble communicating because of a problem with how the brain processes information), and dementia. The Face Sheet indicated Resident 105 had one emergency contact. During a review of Resident 105's MDS, dated [DATE], the MDS indicated Resident cognition was moderately impaired. The MDS indicated Resident 105 required maximal assistance (helper does more than half the effort) with toileting, bathing, and lower body dressing. During an interview on 5/22/2025 at 2:50 p.m. with Resident 105, Resident 105 stated she did not remember signing the Arbitration Agreement and did not remember what entering into the Arbitration Agreement meant. During a concurrent interview and record review on 5/22/2025 at 3:32 p.m., with AA 1, Resident 105 H&P, dated 5/15/2025, was reviewed. AA 1 stated Resident 105's H&P indicated Resident 105 could make needs known but could not make medical decisions. AA 1 stated based on Resident 105's H&P, any conversations or decisions regarding Resident 105's care should be dealt by Resident 105's RP. During a concurrent interview and record review on 5/22/2025 at 3:37 p.m., with AA 1, Resident 105's Arbitration Agreement, dated 5/16/2025, was reviewed. AA 1 stated on 5/16/2025, she entered Resident 105's room and explained to Resident 105 the process of entering the Arbitration Agreement. AA 1 stated Resident 105 appeared to understand the conversation and agreed to enter the Arbitration Agreement by signing the document. AA 1 stated due to Resident 105 assessed as not able to make medical decisions, she should not have allowed Resident 105 to sign the document. AA 1 stated the Arbitration Agreement should have been discussed with Resident 105's RP. During an interview on 5/22/2025 at 3:49 p.m., with the Administrator (ADM), the ADM stated prior to explaining the Arbitration Agreement to a resident, the resident's H&P should be reviewed to ensure they had the capacity to make medical decisions. The ADM stated Residents 104 and 105 were assessed to not have the capacity to make medical decisions, therefore, they should not have signed the Arbitration Agreement. During a review of the facility's policy and procedure (P&P) titled, Binding Arbitration Agreements, undated, the P&P indicated, Residents or representatives are informed of the nature and implications of any proposed binding arbitration agreements so as to make informed decisions on whether to enter into such agreements.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to place one of five sampled residents (Resident 253) on enhanced barrier precaution ([EBP], infection control intervention to reduce the transmission of multi-drug-resistant organisms [MDRO] from staff to patient). This deficient practice had the potential to result in staff members, who provided direct care to Resident 253, transmitting MDRO and other bacteria to Resident 253 and other residents. Findings: During a review of Resident 253's admission Record (Face Sheet), the Face Sheet indicated Resident 253 was admitted to the facility on [DATE] with diagnoses that included infection of right lower extremity amputation stump (residual limb leftover after the removal of the body part) and dehiscence of closure of surgical wound (a surgical incision that opens after it has been closed, usually due to a problem with healing). During a review of Resident 253's Minimum Data Set ([MDS], a resident assessment tool), dated 5/3/2025, the MDS indicated Resident 253's cognition (process of thinking) was intact. The MDS indicated Resident 253 required maximal assistance (helper does more than half the effort) with bathing, lower body dressing, and putting on and taking off footwear. The MDS indicated Resident 253 was on intravenous (IV) antibiotics (medications given directly into the blood stream to treat bacterial infections). During a review of Resident 253's History and Physical (H&P), dated 5/2/2025, the H&P indicated Resident 253 had a peripherally inserted central catheter ([PICC], a long, thin, flexible tube inserted into the vein in the arm that reaches a large vein near the heart) line on the left upper extremity for long-term antibiotic therapy. During a review of Resident 253's Skin Supplemental Assessment, dated 5/3/2025, the Assessment indicated Resident 253 had an infected wound with serous drainage (a clear to yellow fluid that leaks out of a wound) on his right above the knee amputation ([AKA], surgical removal of the portion of the leg above the knee) stump. During a concurrent observation and interview on 5/19/2025 at 10:43 a.m., outside Resident 253's room, Resident 253 was sitting in his wheelchair. Resident 253 was observed with a dressing over his right AKA stump and a PICC line on his left upper arm. Resident 253 stated he had an infection of his stump that required IV antibiotics. During a review of the facility's document titled, Door Sticker Identifiers, undated, the document indicated an orange sticker next to the resident's name indicated the resident was on EBP isolation precautions. During an observation on 5/19/2025 at 10:45 a.m. and 5/20/2025 at 8:16 a.m., outside of Resident 253's room, Resident 253's name was posted next to the door. Resident 253's name tag did not have an orange sticker next to his name. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/20/2025 at 9:29 a.m., with Resident 253, Resident 253 stated any time the staff entered his room and performed any kind of care, the staff member would not wear any gowns. During an interview on 5/21/2025 at 3:13 p.m., with the Infection Preventionist Nurse (IPN), the IPN stated to be placed on EBP, residents would have wounds, indwelling medical devices, presence of MDRO, and/or infected wound. The IPN stated residents on EBP should have a physician's order and to alert staff of the precautions, an orange sticker would be placed outside the resident's door, next to their name. The IPN stated Resident 253 should have been on EBP upon his admission to the facility due to the presence of a PICC line and his infected wound. The IPN stated Resident 253 slipped through the cracks and she did not realize he was not on EBP until 5/20/2025. The IPN stated Resident 253 was not on EBP for approximately 19 days. The IPN stated residents who required EBP, the staff were required to wear a gown and gloves when providing any direct care to the resident. The IPN stated not every staff member would be familiar with Resident 253 and the sticker was necessary to alert staff of Resident 253's isolation status. The IPN stated Resident 253 was at an increased risk for infection due to his PICC line and infected wound and without the proper EBP utilization, Resident 253 was at risk for worsening infection, During an interview on 5/22/2025 at 9:27 a.m., with the Director of Nursing (DON), the DON stated the purpose of EBP was to decrease and prevent the spread of bacteria and infection from the staff to residents and vice versa. The DON stated there were specific requirements for EBP, such as wounds with drainage and presence of a PICC line, which would require the staff to wear a gown and gloves during care. The DON stated Resident 253 should have been on EBP to ensure the staff took the necessary precautions. The DON stated Resident 253 was at risk for further infection if bacteria were to enter through his PICC line or his already infected wound. During a review of the facility's policy and procedure (P&P) titled, Standard Precautions, Enhanced Barrier Precautions, and Transmission Based Precautions, revised 8/7/2024, the P&P indicated for EBP, the use of gowns and gloves were primarily used during specific high contract care activities. The P&P indicated EBP was indicated for those with the presence of indwelling medical devices and chronic and open non-healing wounds.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the outside patio was safe and in functional condition when a nail stuck out from the water drain securement clip and the plastic tabletop was cracked and missing pieces. This deficient practice had the potential for residents to sustain injuries from the exposed nail and from the cracked plastic tabletop. Findings: During a review of Resident 32's admission Record (Face Sheet), the Face Sheet indicated Resident 32 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety disorder (persistent and excessive worry that interferes with daily activities), and transient cerebral ischemic attack (a temporary blockage of blood flow to the brain). During a review of Resident 32's History and Physical (H&P), dated 4/26/2025, the H&P indicated Resident 32 had the capacity to understand and make decisions. During a review of Resident 32's Minimum Data Set ([MDS], a resident assessment tool), dated 4/29/2025, the MDS indicated Resident 32's cognition (process of thinking) was intact. During a concurrent observation and interview on 5/20/2025 at 2:30 p.m. with Resident 32 in the outside patio, a nail was observed sticking out from the water drain securement clip and the point of the nail pointed towards the door. A table was observed with a crack on the plastic tabletop and the middle of the tabletop had jagged edges. Resident 32 stated the tabletop had been cracked for as long as he had been admitted to the facility. Resident 32 stated the water pipe was not properly secured to the wall and the nail was pointed towards the door where the residents would enter and exit through. Resident 32 stated the patio should be kept in safe conditions because any resident could accidentally injure themselves on the nail or table. During an interview on 5/20/2025 at 2:43 p.m., with the Maintenance Supervisor (MS), the MS stated every day he was responsible for cleaning the patio and ensuring the patio was in a clean, safe condition for the residents. The MS stated he was unsure how long the tabletop had been cracked and how long the nail had been sticking out from the water drain. The MS stated both issues should have been attended to immediately to ensure the safety of the residents who go out onto the patio. During an interview on 5/22/2025 at 10:34 a.m., with the Administrator (ADM), the ADM stated inside and outside the facility should be well-kept and all safety concerns should be addressed immediately. The ADM stated the water drain in the patio should have been fixed immediately after coming lose from the wall to ensure the nail did not stick out and pose a risk to the residents. During a review of the facility's policy and procedure (P&P) titled, Homelike Environment, revised 5/2017, the P&P indicated, Residents are provided with a safe, clean, comfortable, and homelike environment. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's job description titled, Director of Maintenance, revised 10/2020, the job description indicated the duties of the Director of Maintenance were to ensure the safe and proper functioning and equipment, maintain building and grounds throughout the year, and conduct ongoing inspections of the facility to identify areas and equipment requiring improvement or repairs.

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have policies on smoking. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility staff failed to ensure safe smoking practices were maintained for one of 10 sampled residents (Resident 79). This deficient practice placed Resident 79 at risk for burn injuries and accidents related to unsupervised cigarette smoking, and placed all facility residents at risk due to the fire hazard associated with unsafe smoking practices. Findings: During a review of Resident 79's admission Record, the admission Record indicated Resident 79 was originally admitted on [DATE] and was most recently readmitted on [DATE]. Resident 79's admitting diagnoses included generalized muscle weakness, lack of coordination, epilepsy (a brain condition characterized by recurrent, unprovoked seizures [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness]), and tobacco use. During a review of Resident 79's Minimum Data Set (MDS, a resident assessment tool), dated 3/21/2025, the MDS indicated Resident 79 had moderate cognitive impairments (a decline in mental processes like memory, attention, language, and reasoning). The MDS indicated Resident 79 required partial to moderate assist from staff with oral hygiene (ability to insert and remove dentures into and from the mouth and manage denture soaking and rinsing with use of equipment) and upper body dressing (the ability to dress and undress above the waist, including fasteners, if applicable). During a review of Resident 79's Smoking Assessment, dated 8/9/2024, the assessment indicated staff observed Resident 79 throwing cigarette butts (the part of a cigarette that is left after it has been smoked) over the wall that surrounded the facility, and into the yard of the house next to the facility. During a review of Resident 79's care plan titled The resident [has] history of tobacco use, previously a smoker ., created 3/29/2025, the care plan indicated the goal of care was Resident 79 being free from injury related to unsafe smoking practices. Care plan interventions indicated staff were to ensure Resident 79 smoked with staff supervision. During a review of the untitled facility document, dated 5/19/2025, the documented indicated the list of all residents who smoked in the facility and whether they required staff supervision while smoking. The documented indicated Resident 79 required supervision while smoking. During an observation on 5/21/2025 at 12:46 p.m., Resident 79 was observed sitting in his wheelchair on the walkway along the side of facility. Resident 79 was not in the designated smoking patio. Resident 79 was not visible from the smoking patio. Resident 79 lit and smoked a cigarette. Resident 79 was not accompanied or supervised by staff, and was observed wheeling himself back into the smoking patio where he was approached by Certified Nursing Assistant (CNA) 3 on the patio. CNA 3 brought him to his room. (continued on next page)

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/21/2025 at 12:53 p.m., with CNA 3, CNA 3 stated Resident 79 smoked. CNA 3 stated he required supervision while smoking and smoked at a designated time. CNA 3 stated she was not Resident 79's assigned CNA, and did not know he smoked a cigarette before she helped him back to his room. During a concurrent observation and interview, on 5/21/2025 at 12:56 p.m., at Resident 79's bedside, Resident 79 stated he kept his lighter at his bedside and would get cigarettes from other residents. Resident 79, who was sitting upright at the edge of his bed, lifted his wheelchair cushion, and a lighter was observed on the wheelchair seat. During an interview on 5/21/2025 at 1:01 p.m., with Registered Nurse (RN) 1, RN 1 stated Resident 79 required staff supervision while smoking. RN 1 stated staff supervision during smoking was for the safety of the resident. RN 1 stated unsupervised smoking created the risk for Resident 79 to sustain burns and other injuries. RN 1 stated residents were also forbidden from keeping lighters at their bedside. RN 1 stated keeping lighters at the bedside was a safety concern due to the potential for burn injuries and fires if there was oxygen therapy in use. During a concurrent observation and interview, on 5/21/2025 at 2:52 p.m., with Activity Staff (AS) 1, the AS stated the designated smoking patio was the area that was visible from the double door exiting from the facility onto the patio. AS 1 stated the side of the building where Resident 79 was observed smoking was not considered a part of the designated smoking area. During an observation on 5/21/2025 at 2:53 p.m., Resident 79 was observed sitting in his wheelchair on the walkway along the side of facility. Resident 79 was not in the designated smoking patio. Resident 79 was not visible from the smoking patio. Resident 79 lit a cigarette. Resident 79 was not accompanied or supervised by staff. Resident 79 was approached by AS 2 while smoking his cigarette. During an interview on 5/21/2025 at 2:56 p.m., with AS 2, AS 2 stated Resident 79 was smoking unsupervised. AS 2 stated Resident 79 required supervision while smoking. AS 2 stated he did not know where Resident 79 was getting cigarettes from. AS 2 stated staff supervision while smoking was to prevent accidents, and stated Resident 79 smoking without supervision was not safe. During a concurrent interview and record review, on 5/22/2025 at 10:43 a.m., with the Director of Nursing (DON), the untitled facility document indicating all residents in the facility who smoked, dated 5/19/25, was reviewed. The DON stated the document indicated staff were to be present to ensure safety while residents who required supervision smoked. The DON stated the documented indicated Resident 79 required supervised smoking privileges. During a concurrent interview and record review, on 5/22/2025 at 10:47 a.m., with the DON, the facility's policy and procedure (P&P) titled Smoking Policy - Residents, dated 2001, was reviewed. The DON stated the P&P indicated smoking was only permitted in designated resident smoking areas. The DON stated the side of the building, out of view of staff, was not considered a permitted designated smoking area. The DON stated the P&P indicated residents requiring supervised smoking privileges were not allowed to have or keep smoking items. The DON stated this was for resident safety, and stated possession of smoking items (i.e., lighters) created the potential for combustion, burns, and injuries.