STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056118	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gladstone Sub-Acute and Rehab Center	435 E. Gladstone St Glendora, CA 91740

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48729 Based on observation, interview, and record review, the facility failed to ensure the right to a dignified existence for one of one sampled resident (Resident 95) by failing to accommodate Resident 95's needs. On 6/10/2024, Resident 95 requested incontinence (having no voluntary control over urination or defecation [discharge of feces from the body]) care and Certified Nursing Assistant (CNA) 1 did not attend to Resident 95's needs timely due to Resident 95's roommate having a meal. This deficient practice resulted with Resident 95 feeling confused and uninformed and had the potential to result in Resident 95 feeling unsupported with Resident 95's care and had the potential to affect Resident 95's psychosocial well-being. Findings: During a review of Resident 95's Admission Record (AR), the AR, indicated Resident 95 was admitted to the facility on [DATE] with multiple diagnoses including heart failure (condition that develops when the heart doesn't pump enough blood for the body's needs), morbid obesity (body weight that is more than 80 to 100 pounds above a person's ideal body weight), and anxiety disorder (condition in which a person has excessive worry and feelings of fear, dread, and uneasiness). During a review of Resident 95's History and Physical, (H&P) dated 2/12/2024, the H&P indicated Resident 95 had the capacity to understand and make decisions. During a review of Resident 95's Minimum Data Set, (MDS - a standardized assessment and care planning tool) dated 5/23/2024, the MDS indicated Resident 95 was dependent (helper does all the effort to complete the activity) for toileting and bathing. The MDS indicated Resident 95 was always incontinent (having no voluntary control over urination) of urine. During a review of Resident 95's Care Plan, (CP) titled, Impaired functional abilities, dated 5/23/2024, the CP indicated Resident 95 required dependent assistance with toileting hygiene. Resident 95's CP indicated an intervention to explain all procedures and purpose before carrying out each one. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 95's CP, titled Bladder and Bowel Function: Incontinent, dated 5/23/2024, the CP indicated Resident 95 was at risk for bladder discomfort/ urinary tract infections (UTI, an infection in any part of the urinary system: kidneys, bladder, or urethra [tube through which the urine leaves the body]). The CP indicated an intervention to provide timely incontinent care as needed to keep the resident clean and dry at all times. The CPs goal indicated to keep resident, dry, clean, and odor free from incontinence daily. During an observation on 6/10/2024 at 1:12 PM in Resident 95's room, Certified Nursing Assistant (CNA) 1 was observed answering Resident 95's call light. Resident 95 requested to be changed (adult brief) in bed. CNA 1 stated CNA 1 would go get and gather supplies and return [to Resident 95's room]. Resident 95 specified that Resident 95 had only urinated on the adult brief and there were some supplies in Resident 95's room. CNA 1 left Resident 95's room. During an observation on 6/10/2024 at 1:30 PM in Resident 95's room, Resident 95 pressed the call light a second time and stated CNA 1 may have forgotten to return, and Resident 95 did not know why it took so long for CNA 1 to gather supplies. Licensed Vocational Nurse 2 (LVN 2) entered Resident 95's room to answer the call light and stated LVN 2 would call CNA 1 to Resident 95's room to provide incontinence care. During an interview on 6/10/2024 at 1:32 PM with CNA 1 in Resident 95's room, CNA 1 stated CNA 1 had not returned to Resident 95's room because CNA 1 were waiting for Resident 95's roommate to finish eating their meal before CNA 1 performed incontinence care to Resident 95. When asked, Resident 95 stated Resident 95 did not understand what the roommate had to do with Resident 95 getting changed and [CNA 1 did] not explain this because Resident 95 believed CNA 1 would get supplies and return [confused and uninformed]. CNA 1 stated to maintain infection control practices and to protect the dignity of the other residents in the shared room, CNA 1 was waiting until Resident 95's roommate was done with their meal before performing incontinence care. CNA 1 further stated CNA 1 should have explained to Resident 95 the reason for the delayed care. During an interview on 6/13/2024 at 12:01 PM with CNA 2, CNA 2 stated residents (in general) were usually not changed during mealtimes if the other residents (roommate) in the shared room were eating but if the resident was incontinent of urine, then it was possible to provide incontinence care sooner. CNA 2 further stated if a resident was not changed, or it was not explained to them why they were not getting changed right away, this could cause harm to the resident's dignity because the expectation of care was to have dignity and respect and the delay in care may make the residents feel unsupported. During an interview on 6/13/2024 at 1:26 PM with Director of Staff Development (DSD), the DSD stated the facility avoided changing soiled diapers (adult briefs) during mealtimes when there were multiple residents in one room. The DSD stated it was a courtesy to the residents who were still eating and for those residents not to lose their appetite. The DSD further stated urine incontinence care could be accommodated in this situation (urine incontinence) and it should be well communicated with the resident [explain] what is going on and give the resident an idea of how long it would take until the resident was changed. The DSD stated it was important to explain this for the resident to be aware they would be attended to, and staff was not ignoring their requests. The DSD stated the resident could feel bad that no one attended to them. (continued on next page)

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F 0550 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, Resident Rights - Quality of Life, dated 5/1/2023, the P&P indicated for the facility staff to explain procedures to the residents before they are performed. The P&P further indicated Demeaning practices and standards of care that compromise dignity are prohibited. Facility Staff will promote dignity and assist residents as needed by: B. Promptly responding to the resident's request for toileting assistance.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44027 Based on interview and record review, the facility failed to protect the rights of four of four sampled residents (Residents 18, 29, 36, and 49) or inform the resident's representatives (RPs), of their right to formulate an advanced directive (AD) when: a. For Resident 18, The Social Service Director (SSD) failed to provide information regarding AD to Resident 18's RP. b. For Resident 29, the SSD failed to document in Resident 29's medical record that the SSD discussed with Resident 29's RP about the right to formulate an AD for Resident 29. c. For Resident 36, the SSD failed to provide information regarding the right to formulate an AD to Resident 36's RP. d. Resident 49's AD was not kept in Resident 49's Medical Chart (medical record). These failures had the potential to result in lack of knowledge regarding decision making for care and treatment for Resident's 18, 29, 36, and 49 and for the resident's wishes regarding medical treatment to not be followed. Findings: a. During a review of Resident 18's Admission Record (AR), the AR indicated Resident 18 was admitted to the facility 10/18/2023 and readmitted on [DATE] with diagnoses including chronic respiratory failure (when the lungs can't get enough oxygen into the blood), type 2 diabetes mellitus (a chronic [long standing] condition that affects the way the body processes blood sugar), and dependence on respiratory ventilator (a type of breathing apparatus that moves air into and out of the lungs). The AR indicated Resident 18's niece was Resident 18's Responsible Party. During a review of Resident 18's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 4/26/2024, the MDS indicated Resident 18 was severely impaired (never/rarely made decisions) in cognitive skills (ability to make daily decisions). The MDS indicated Resident 18 was dependent (helper does all the effort) on staff for toileting, dressing, and bathing. During a concurrent interview and record review on 6/12/2024 at 10:13 PM with Social Service Director (SSD), Resident 18's Acknowledgement of Signatures (AOS), dated 10/25/2023, was reviewed. The AOS indicated Resident 18 had not executed an AD. The AOS contained an unmarked box next to the statement, I have received information on my right to formulate an Advanced Directive. The SSD stated Resident 18's RP was attempting to get conservatorship for Resident 18. The SSD stated the SSD did not provide Resident 18's RP with information about making an AD. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. During a review of Resident 29's AR, the AR indicated Resident 29 was admitted to the facility on [DATE] with diagnoses including Parkinson's disease (a brain disorder, progressive disease of the nervous system, that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), and bipolar disorder (a mental illness that causes unusual shifts in a person's mood). The AR indicated Resident 29's daughter was Resident 29's Responsible Party. During a review of Resident 29's MDS, dated [DATE], the MDS indicated Resident 29 had no impaired in cognitive skills. The MDS indicated Resident 29 required supervision from staff for toileting, dressing, and personal hygiene. During a concurrent interview and record review on 6/12/2024 at 10:43 PM with the SSD, Resident 29's AOS, dated 9/11/2023, was reviewed. The AOS contained an unmarked box next to the statement, I have received information on my right to formulate an Advanced Directive. The SSD stated the SSD did not document in Resident 29's medical record the discussion the SSD had with Resident 29's RP regarding information about making an AD. c. During a review of Resident 36's AR, the AR indicated Resident 36 was admitted to the facility on [DATE] with diagnoses including Chronic Respiratory failure, dependence on respiratory ventilator, and Parkinson's disease. The AR indicated Resident 36's Conservator (a court-appointed person responsible for managing the financial and personal affairs of a person who is incapacitated) was Resident 36's RP. During a review of Resident 36's MDS, dated [DATE], the MDS indicated Resident 36 was severely impaired in cognitive skills. The MDS indicated Resident 36 was dependent on staff for toileting, dressing, and bathing. During a concurrent interview and record review on 6/12/2024 at 10:29 AM with the SSD, Resident 36's AOS, dated 5/24/2024, was reviewed. The AOS indicated Resident 36 had not executed an AD. The AOS contained an unmarked box next to the statement, I have received information on my right to formulate an Advanced Directive. The SSD stated the SSD did not provide information about formulating an AD to Resident 36's Conservator. The SSD stated the information pamphlet given to residents (in general) about ADs did not include information regarding the facility's policies on implementing ADs. d. During a review of Resident 49's AR, the AR indicated Resident 49 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Chronic Respiratory failure, chronic obstructive pulmonary disease (COPD, long standing group of diseases that cause airflow blockage and breathing-related problems, make it difficult to breathe), and heart failure (condition in which the heart cannot pump enough blood to all parts of the body). The AR indicated Resident 49 was self-responsible. During a review of Resident 49's MDS, dated [DATE], the MDS indicated Resident 49 was moderately impaired in cognitive skills. The MDS indicated Resident 49 required set up or clean-up assistance from staff for toileting, dressing, and personal hygiene. During a review of Resident 49's AOS, dated 1/11/2024, the AOS had unchecked boxes next to the statements, I have executed an Advanced Directive and I have not executed an Advanced Directive. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 6/11/2024 at 3:27 PM with the SSD, Resident 49's Medical Chart was reviewed. The Medical Chart did not include Resident 49's AD. The SSD stated Resident 49 had an AD. The SSD stated the SSD did not know why Resident 49's AD was not in Resident 49's Medical Chart. During an interview on 6/12/2024 at 10:45 AM, the SSD stated resident's (in general) ADs should be kept in the resident's Medical Charts. During a review of the facility's policy and procedure (P&P) titled, Advance Directives, revised 9/1/2023, the P&P indicated, A copy of the resident's advance directive will be included in the resident's medical record. The P&P indicated: A. Upon admission, the Admissions Staff or designee will provide written information to the resident concerning his or her right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate advance directives. B. Each resident will also be informed that completing an advance directive is not a condition of admission to the Facility. C. During the Social Services Assessment process, the Director of Social Services or designee will also ask the resident whether he or she has a written advance directive, including whether the resident has requested or is in possession of an aid-in-dying drug. E. If the resident does not have an advance directive, the Admissions Staff or designee will inform the resident that the Facility can provide the resident with a copy of the Advance Directive form.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48729 Based on interview and record review, the facility failed to ensure the physician was notified of a change in condition for two of two sampled residents (Resident 19 and 40) when: a. Resident 19 was noted to have mild work of breathing (working harder to breathe, the amount of energy required to overcome the elastic and resistive elements of the respiratory system and move gas into and out of the lungs during spontaneous breathing) on 2/24/2024 and Resident 19 was hospitalized the next day on 2/25/2024 for shortness of breath. b. For Resident 40, the facility failed to inform Resident 40's physician regarding Resident 40's significant weight loss of 12.06% within six months. These failures had the potential to result in physical declines for Residents 19 and Resident 40. Cross Reference F656 and F803 Findings: a.During a review of Resident 19's Admission Record (AR), the AR indicated Resident 19 was admitted on [DATE] and readmitted on [DATE] with multiple diagnoses including chronic respiratory failure with hypoxia (condition that results in the inability to adequately provide oxygen to the body and results in an inadequate amount of oxygen in the blood), tracheostomy (a surgically created hole in the windpipe that provides an alternate airway for breathing) and dependence on respiratory ventilator (a type of breathing apparatus that moves oxygen-rich air into and out of the lungs through a tube). During a review of Resident 19's History and Physical (H&P) dated 12/11/2023, the H&P indicated Resident 19 did not have the capacity to understand and make decisions. During a review of Resident 19's Minimum Data Set, (MDS - a standardized assessment and care planning tool) dated 4/23/2024, indicated Resident 19 was dependent (helper does all the effort to complete the activity) for toileting and bathing. During an interview on 6/13/2024 at 5:02 PM with the Assistant Director of Nursing (ADON), the ADON stated normal vital sign range included: oxygen saturation above 92%, respiratory rate between 12 and 20, and heart rate between 60 and 100 [beats per minute]. The ADON stated the physician should be notified immediately when a resident showed work of breathing. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 6/13/2024 at 5:28 PM with the Director of Nursing (DON), Resident 19's Progress Notes (PN) dated 2/1/2024 to 2/29/2024 were reviewed. The PN indicated on 2/24/2024 Resident 19 was given medication [to treat] mild work of breathing noted by the Respiratory Therapist (RT) and included Resident 19's vital signs (measured basic functions of the body including body temperature, blood pressure, pulse and respiratory [breathing] rate.) The PN indicated Resident 19's breathing rate was 22, heart rate was 105 and oxygen saturation (measurement that indicates what percentage of blood saturated with oxygen) was 89%. The DON stated the PN indicated a change of condition for Resident 19 and Resident 19's physician should have been notified of the change. The DON further stated the DON could not find documentation to indicate the physician was made aware of Resident 19's change of condition and stated if this wasn't documented then it wasn't done. The DON stated the physician was the one who directed care and Resident 19 could have experienced [greater] respiratory distress since the physician was not notified at the time of the change of condition. During a review of the facility's policy and procedure (P&P) titled, Change of Condition Notification, dated 11/1/2017, indicated under Procedure, I. The licensed nurse will notify the resident's Attending Physician when there is C. A significant change in the resident's physical, mental, or psychosocial status, e.g., deterioration in health, mental or psychosocial status, life-threatening conditions, or clinical complications. The P&P further indicated under III. Notifying the Attending Physician, The Attending Physician will be notified timely with a resident's change of condition. 38108 b.During a review of Resident 40's AR, the AR indicated Resident 40 was admitted to the facility on [DATE] with multiple diagnoses including type 2 diabetes mellitus (an adult-onset long-term condition in which the body has trouble controlling blood sugar) with diabetic neuropathy (a type of nerve damage that can occur when you have diabetes), unspecified, heart failure, unspecified and gastro-esophageal reflux disease (GERD, a digestive disorder that occurs when acidic stomach juices, or food and fluids back up from the stomach into the esophagus [muscular tube through which food passes from the throat to the stomach]). During a review of Resident 40's History and Physical Examination (H&P), dated 12/16/2023, the H&P indicated Resident 40 had the capacity to understand and make decisions. During a review of Resident 40's MDS, dated [DATE], the MDS indicated, Resident 40's cognitive (ability to think and process information) skills for daily decision making were intact. The MDS indicated, Resident 40 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.) with eating. During a review of Resident 40's Weights and Vitals Summary (WVS), effective date range 11/1/2023 to 6/30/2024, the WVS indicated Resident 40 weighed 141.2 pounds (lbs., unit of weight) on 12/5/2023 and 134. 4 lbs. on 1/2/2024; the WVS indicated a one-month weight loss of seven lbs. The WVS indicated Resident 40 weighed 142.6 lbs. on 11/8/2023 and 125.4 lbs. on 5/1/2024, a total of 17 lbs. in six months and 12.06% weight loss in six months. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 40's Progress Note (PN), dated 4/14/2024, titled Interdisciplinary Team [IDT] Monthly Weight Variance the IDT indicated Resident 40's current body weigh was 127.6 lbs., and Resident 40 had a weight loss trend in months and weight loss was anticipated related to inadequate energy intake. The IDT recommended for Resident 40's physician to review (order) pancreatic enzyme replacement therapy (replaces enzymes [proteins that help speed up chemical reactions in the body] that the pancreas [organ of the digestive system and of the endocrine system] normally makes, enzymes that come in a capsule and taken with food). During a review of Resident 40's PN, dated 5/19/2024, note text: consult + monthly weight review, indicated Resident 40 current body weight was 125.4 lbs. The PN recommended for a physician inquiry for pancreatic enzyme replacement therapy. During an interview with Resident 40, on 6/10/24 at 11:42 AM, Resident 40 stated Resident 40 had digestive (breakdown of food) issues and Resident 40 could not eat anything with butter or grease, or Resident 40 got diarrhea (frequent loose, water stools) or gas accumulated around Resident 40's crotch (between the legs). Resident 40 stated Resident 40 ate as much as Resident 40 could. Resident 40 stated, if I lose weight, I lose weight. During an interview and concurrent record review of Resident 40's electronic and paper medical record (chart) with the ADON, on 6/13/2024 at 3:06 PM. The ADON stated Resident 40's physician was informed of Resident 40's significant weigh loss yesterday, 6/12/2024, after the survey team brought it to the facility's attention. The ADON stated Resident 40's physician should have been informed of Resident 40's weight loss to provide recommendations and prevent further weight loss that could cause more damage to Resident 40. During a review of the facility's policy and procedure, dated 11/1/2017, titled Change of Condition Notification, the P&P indicated to ensure residents, family, legal representatives, and physicians are informed of changes in the resident's condition in a timely manner, change in weight of five pounds or more within a 30-day period . The attending physician will be notified timely when there is a resident's change in condition. During a review of the facility's P&P titled Assessment and Management of Resident Weights, dated 11/1/2017, the P&P indicated significant weight change will be reviewed by the DNS (Director of Nursing Services) or designated licensed nurse. The P&P indicated significant weight changes are: 10% in six (6) months and the licensed nurse will notify the physician of the dietician's recommendation and notify the family/heath care decision maker of the weight changes as indicated.

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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** 38108 Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 40) had a resident-centered comprehensive care plan (CP, provides direction on the type of nursing care an individual needs that include goals of treatment, specific nursing interventions [actions, treatments, procedures, or activities designed to meet an objective and an evaluation plan]) developed to address Resident 40's progressive weight loss in accordance with the facility's policy and procedure (P&P), titled, Care Planning. This deficient practice had the potential to result in Resident 40 not to receive the necessary care and services in accordance with Resident 40's specific needs and the potential for continued weight loss and a physical decline to Resident 40. Cross Reference F580 and F803 Findings: During a review of Resident 40's AR, the AR indicated Resident 40 was admitted to the facility on [DATE] with multiple diagnoses including type 2 diabetes mellitus (an adult-onset long-term condition in which the body has trouble controlling blood sugar) with diabetic neuropathy (a type of nerve damage that can occur when you have diabetes), unspecified, heart failure, unspecified and gastro-esophageal reflux disease (GERD, a digestive disorder that occurs when acidic stomach juices, or food and fluids back up from the stomach into the esophagus [muscular tube through which food passes from the throat to the stomach]). During a review of Resident 40's History and Physical Examination (H&P), dated 12/16/2023, the H&P indicated Resident 40 had the capacity to understand and make decisions. During a review of Resident 40's Minimum Data Set (MDS, an assessment and screening tool), dated 3/22/2024, the MDS indicated, Resident 40's cognitive (ability to think and process information) skills for daily decision making were intact. The MDS indicated, Resident 40 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.) with eating. During a review of Resident 40's Order Summary Report (OSR), active orders as of 6/11/2024, the OSR indicated, a physician's order dated 4/15/2024 for CCHO (consistent, constant, or controlled carbohydrate, diet to manage carbohydrate [basic food group broken into sugars in the body] consumption), NAS (no added salt) diet regular texture, regular consistency, Low Fat/Chol (cholesterol, type of fat), chopped meats (no milk), double protein with meals. The OSR indicated a physician's order, dated 12/17/2022 for Diuretics - monitor for the following: decreased po (oral) intake . every shift. (continued on next page)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 40's Medication Administration Record (MAR), dated June 2024, the MAR indicated, Diuretics - Monitor for the following: decreased po intake .and/or sunken eyes. The MAR indicated, staff documented 0 and indicated Resident 40 did no have decreased po intake or sunken eyes. During a review of Resident 40's Weights and Vitals Summary (WVS), effective date range 11/1/2023 to 6/30/2024, the WVS indicated, the following weights: 6/3/2024 123.8 lbs (pounds, a unit of weight) 5/1/2024 125.4 lbs 4/25/2024 127.6 lbs 3/4/2024 130.2 lbs 2/5/2024 133.6 lbs 1/2/2024 134.4 lbs 12/4/2023 138.6 lbs 11/8/2023 142.6 lbs The WVS indicated, Resident 40 progressively lost weight in the last six (6) months. During an interview on 6/10/2024 at 11:42 PM with Resident 40, Resident 40 stated, Resident 40 could have (eat) a hamburger but only a bite. Resident 40 stated, Resident 40 could eat anything but no fat, butter, or grease. Resident 40 stated, Resident 40 got diarrhea if Resident 40 ate [anything with] grease. Resident 40 stated, Resident 40 was blind and did not remember which staff Resident 40 had spoken to regarding food dislikes. Resident 40 stated Resident 40 was tired of arguing [regarding food preferences] Resident 40 felt like no [staff] were listening to Resident 40. During a concurrent observation and interview on 6/12/2024 at 12:43 PM with Resident 40, Resident 40 was sitting at the side of Resident 40's bed on a wheelchair, there was a lunch tray that had a hamburger with about 2 bites eaten from the patty, Resident 40 stated, I ate as much as I can. Resident 40 stated, Resident 40 ate the canned fruit and drank the juice, that's all I can eat. Resident 40 stated, the hamburger meat was oily. During an interview and concurrent record review on 6/13/2024 at 1:55 PM with the Assistant Director of Nursing (ADON), the ADON stated there was no completed CP that addressed weight loss for Resident 40. The ADON stated, Resident 40 should have had a weight loss CP for staff to know what interventions that were realistic for Resident 40 could be done. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Care Planning, date revised 10/24/2022, the P&P indicated, to ensure that a comprehensive person-centered CP was developed for each resident based on their individual assessed needs. The P&P indicated, the CP served as a course of action where the resident (resident's family and/or guardian or other legally authorized representative), resident's attending physician, and Interdisciplinary Team (IDT, a team of health care professions who work together to establish plans of care for residents) work [together] to help the resident move toward resident-specific goals that address the resident's medical, nursing, mental and psychosocial needs.

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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** 44027 Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Residents 17) was provided proper interventions for edema (swelling caused by too much fluid trapped in the body's tissues) when the facility failed to elevate Resident 17's upper extremities (shoulders, elbows, wrists, or hands) to decrease edema as indicated in Resident 17's care plan (CP), titled, [Resident 17] is at Risk for Impaired Skin Integrity as evidenced by edema . This failure had the potential to result in worsening or unresolved edema for Resident 17 and placed Resident 17 at an increased risk of developing blood clots and/or skin injuries, additionally, the failure had the potential to result in a physical decline to Resident 17. Findings: During a review of Resident 17's Admission Record (AR), the AR indicated Resident 22 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including chronic respiratory failure (when the lungs can't get enough oxygen into the blood), type 2 diabetes mellitus (a chronic, long standing, condition that affects the way the body processes blood sugar), and heart failure (condition in which the heart cannot pump enough blood to all parts of the body). During a review of Resident 17's CP titled, [Resident 17] is at Risk for Impaired Skin Integrity as evidenced by edema to: right and left upper extremities, initiated 5/11/2024, the care plan's interventions indicated to elevate (allows the blood to circulate back to the heart without fighting gravity) Resident 17's arms and legs. During a review of Resident 17's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 5/17/2024, the MDS indicated Resident 17 was severely impaired (never/rarely made decisions) in cognitive skills (ability to make daily decisions). The MDS indicated Resident 17 was dependent (helper does all the effort) on staff for toileting, dressing, and bathing. During an observation on 6/10/2024 at 10:55 AM, Resident 17 was asleep in bed, lying on Resident 17's back with the head of the bed (HOB) elevated. Resident 17's arms were at Resident 17's side and were flat on the mattress and not elevated on pillows. Resident 17's fingers and forearms were swollen. During an interview on 6/11/2024 at 2 PM with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 17 had edema. LVN 1 stated interventions to treat Resident 17's edema included keeping Resident 17's arms and legs elevated with pillows to lessen the edema on Resident 17's legs and arms. LVN 1 stated if the facility staff did not keep Resident 17's arms and legs elevated then Resident 17 would be at an increased risk of getting blood clots. During an interview on 6/11/2024 at 2:02 PM with Treatment Nurse (TN) 1, TN 1 stated if facility staff did not elevate Resident 17's arms then there was an increased risk for Resident 17 to develop blood clots in her arms and there was increased risk of skin breakdown. TN 1 stated Resident 17 should have a pillow under Resident 17's arms to keep Resident 17's arms elevated (facility practice to use pillows to elevate extremities). (continued on next page)

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F 0684 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 Standards, revised 11/1/2017, the P&P indicated, All residents shall receive necessary care and services to assist them in attaining or maintaining the highest practicable level of physical, mental, and psychosocial well-being in accordance with a comprehensive assessment and plan of care.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44027 Based on interviews and record review, the facility failed to ensure four of five sampled residents (Residents 90, 49, 84, & 69) did not receive unnecessary psychotropic medications (drugs used to treat mental health disorders that alter neurotransmitters [transmit messages from neurons to muscles] in the brain) by failing to: a. Limit Resident 90's as needed (PRN) Alprazolam (a psychotropic medication used for the treatment of anxiety [a feeling of fear, dread, and uneasiness]) order to 14 days as indicated the facility's policy and procedure (P&P) titled, Psychotherapeutic Drug Management. b. Ensure Resident 49's physician documented a rationale to indicate the reason why a Gradual Dose Reduction (GDR, the stepwise tapering [to reduce dose over time] of a dose to determine if symptoms, conditions, or risks can be managed by use of a lower dose or determination of whether the dose or medication can be discontinued) was not attempted for Resident 49's Trazodone (a psychotropic medication used to treat depression) was personalized to Resident 49. c. Attempt a GDR for Resident 84's Risperdal (a psychotropic medication used to treat certain mental/mood disorders). The facility also failed to attempt non-pharmacological interventions (non-chemical interventions, not primarily based on the use of medications, e.g., deep breathing, activities) to address Resident 84's behaviors of hallucinations (for which Risperdal was prescribed). d-e. Attempt GDRs for Resident 69's Depakote (medication used to treat seizure disorders [a sudden, uncontrolled burst of electrical activity in the brain] and Seroquel (medication used to treat several kinds of mental health conditions) medications. These failures had the potential to cause adverse effects (unwanted, uncomfortable, or dangerous effects that a resident may have due to medication use) to Residents 90, 49, 84, & 69 related to the possible administration of unnecessary psychotropic medications. Findings: a. During a review of Resident 90's Admission Record (AR), the AR indicated Resident 96 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including hemiplegia (paralysis of one side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body) following intracerebral hemorrhage (an emergency condition in which a ruptured blood vessel causes bleeding inside the brain), dysphagia (difficulty swallowing foods or liquids), and anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 90's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 6/4/2024, the MDS indicated Resident 90 was moderately impaired with cognitive skills (ability to make daily decisions) The MDS indicated Resident 90 was dependent (helper does all of the effort to complete the activity) on staff for toileting, bathing, and dressing. The MDS indicated Resident 90 received psychotropic medications while at the facility. During a concurrent interview and record review on 6/13/2024 at 9:18 AM with the Assistant Director of Nursing (ADON), Resident 90's Order Summary Report active orders dated 6/11/2024, was reviewed. The Order Summary Report indicated Resident 90 had a medication order for Alprazolam oral tablet 0.5 MG (milligrams, unit of measurement) via gastrostomy tube (G-tube, a tube inserted through the belly that brings nutrition directly to the stomach) every 8 hours PRN for anxiety manifested by (m/b) irritability. The medication was ordered on 5/24/2024 and had an end date of 6/23/2024 (longer than 14 days). The ADON stated Resident 90's doctor wanted Resident 90's order for PRN Alprazolam to last for 30 days. The ADON stated Resident 90's doctor did not document why Resident 90 needed the PRN Alprazolam for longer than 14 days. b. During a review of Resident 49's AR, the AR indicated Resident 49 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Chronic (long standing) Respiratory failure, chronic obstructive pulmonary disease (COPD, a group of diseases that cause airflow blockage and breathing-related problems), and heart failure (condition in which the heart cannot pump enough blood to all parts of the body). The AR indicated Resident 49 was self-responsible. During a review of Resident 49's MDS, dated [DATE], the MDS indicated Resident 49 was moderately impaired in cognitive skills. The MDS indicated Resident 49 required set up or clean-up assistance from staff for toileting, dressing, and personal hygiene. The MDS indicated Resident 49 took psychotropic medications while at the facility. During a review of Resident 49's Order Summary Report active orders dated 6/13/2024, the Order Summary Report indicated Resident 49 had a medication order for Trazodone HCl oral tablet 50 MG taken by mouth (PO) at bedtime for depression manifested by (m/b) inability to sleep at night. During a concurrent interview and record review on 6/13/2024 at 2:58 PM with the ADON, Resident 49's Note to Attending Physician/Prescriber signed 4/4/2024, was reviewed. The Note to Attending Physician/Prescriber indicated the pharmacist recommended a GDR attempt for Resident 49's prescribed Trazadone. The Note to Attending Physician/Prescriber indicated the prescriber disagreed with the pharmacist's recommendation and indicated as one of the reasons to not attempt a GDR was, The behavioral symptoms present a danger to the resident or others. The ADON stated the reason documented for not attempting the GDR was not personalized to Resident 49. The ADON stated Resident 49 was never a danger to himself or others. c. During a review of Resident 84's AR, the AR indicated Resident 84 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including acute kidney failure (a condition in which the kidneys suddenly cannot filter waste from the blood), anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and impulse disorder (a group of behavioral conditions that make it difficult to control your actions or reactions). (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 84's MDS, dated [DATE], the MDS indicated Resident 84 was moderately impaired in cognitive skills. The MDS indicated Resident 84 was dependent on staff for toileting, dressing, and bathing. The MDS indicated Resident 84 took psychotropic medications while at the facility. During a concurrent interview and record review on 6/13/2024 at 3:21 PM with the ADON, Resident 84's Note to Attending Physician/Prescriber signed 4/8/2024, was reviewed. The Note to Attending Physician/Prescriber indicated the pharmacist recommended a GDR attempt for Resident 84's prescribed Risperdal. The Note to Attending Physician/Prescriber indicated Resident 84's physician disagreed with the Pharmacist's recommendation. The Note to Attending Physician/Prescriber did not indicate why a GDR attempt was likely to impair the resident's function or cause Resident 84's psychiatric disorder to worsen. The ADON stated a GDR was never attempted for Resident 84's Risperdal. The ADON stated the facility had recently changed Physiatrists services because the facility was not satisfied with how many GDR recommendations were not being attempted. The ADON stated it was important to attempt GDRs because of the risks associated with long term use of psychotropic medications. The ADON stated the facility did not attempt nonpharmacological interventions for Resident 84's hallucinations (the reason Risperdal was ordered for Resident 84). The ADON stated the facility should have attempted nonpharmacological interventions to see if the interventions were an effective treatment instead of Resident 84 needing to take psychotropic medications. During a review of the facility's P&P, titled, Psychotherapeutic Drug Management, revised 5/17/2024, the P&P indicated, PRN orders for psychotropic drugs are limited to 14 days. If the Attending Physician/LHP believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. The P&P indicated, During the first year of receiving an anti-psychotic or other psychopharmacologic medication, at least one attempt at GDR or dose tapering is attempted . A second attempt, in a subsequent quarter the same year (12-month period) unless the first attempt demonstrated that GDR or tapering was clinically contraindicated. The attempts should be at least a month apart .After the first year, GDR or tapering should be attempted once a year .GDR or tapering may be considered clinically contraindicated if the resident's targeted symptoms worsened or returned during the reduction . If this occurs, the Attending Physician/LHP must document the clinical rationale why further GDR attempts should not be done (further attempts may cause impairment of resident function, increase distressed behavior(s), cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder. 48729 d. During a review of Resident 69's AR, the AR indicated Resident 69 was admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including dementia with psychotic disturbance (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), psychosis (abnormal behaviors that can be seen as symptoms of dementia that can include delusions, hallucinations, aggression and paranoia), and impulse disorder. During a review of Resident 69's History and Physical, (H&P) dated 9/4/2023, the H&P indicated Resident 69 did not have the capacity to understand or make decisions. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 69's MDS, dated [DATE], the MDS indicated Resident 69 had behavior symptoms not directed towards others (physical symptoms such as hitting or scratching self, pacing, or verbal/ vocal symptoms like screaming, disruptive sounds) and behavior of this type occurred one to three days. The MDS indicated Resident 69 was dependent for toileting and bathing. During a review of Resident 69's Order Summary Report, (OSR), active orders dated as of 6/1/2024, the OSR indicated a physician's order for Depakote 500 MG delayed release oral tablet taken by mouth every 12 hours for impulse control disorder manifested by screaming and yelling. The order had a start date of 8/28/2023. During a review of Resident 69's Note to Attending Physician/Prescriber ([NAME]) dated 4/11/2024, the [NAME] indicated, the pharmacist recommended a GDR attempt for Resident 69's prescribed Depakote. The [NAME] indicated the prescriber disagreed with the pharmacist's recommendation and indicated No change to current order, risk less than benefits of continued use. During a review of Resident 69's Psychotherapeutic Drug Summary Sheet, (PDSS) last dated 4/30/2024, the PDSS for Depakote, indicated a summary of behavioral manifestation: screaming and yelling for Resident 69 from 8/27/2023 to 4/30/2024. The PDSS indicated Resident 69 had two documented behaviors during this time frame. During a concurrent interview and record review on 6/13/2024 at 4 PM with the ADON, Resident 69's IDT Other Notes - V2 (IDTN) dated 4/23/2024 were reviewed. The IDTN, electronically signed by Resident 69's psychiatrist indicated Resident 69 was not a candidate for GDR at the time due to behaviors including outbursts of yelling and screaming and periods of hitting self on the head when agitated. The ADON was asked why a GDR was not clinically indicated since Resident 69 did not have any documented behaviors since 9/2023, the ADON stated the facility was transitioning to another psychiatrist and the new psychiatrist wanted to get to know the residents more before changing the medications. The facility's policy and procedure (P&P) titled Psychotherapeutic Drug Management dated 5/17/2024 was reviewed. The P&P indicated under Guidelines for gradual dose reduction: A. During the first year of receiving antipsychotic medication or other psychopharmacologic medication, at least one attempt at GDR or dose tampering is attempted. The ADON stated per facility policy, a GDR should have been attempted. e. During a review of Resident 69's Order Summary Report, (OSR), active orders dated as of 6/1/2024, the OSR indicated a physician's order for Seroquel 100 MG oral tablet taken by mouth two times a day for dementia with behavioral disturbances manifested by self-injurious behavior of hitting self on the head several times repeatedly. The order indicated a start date of 8/28/2023. During a review of Resident 69's PDSS, last dated 3/1/2024, the PDSS, for Seroquel, indicated a summary of behavioral manifestation from 10/1/2023 to 2/29/2024. The PDSS indicated Resident 69 had two documented behaviors during this time frame. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 6/13/2024 at 4 PM with the ADON, Resident 69's IDTN dated 4/23/2024 and the facility's P&P titled Psychotherapeutic Drug Management dated 5/17/2024 were reviewed. The IDTN, electronically signed by Resident 69's psychiatrist indicated Resident 69 was not a candidate for GDR at the time due to behaviors including outbursts of yelling and screaming and periods of hitting self on the head when agitated. The ADON was asked why a GDR was not clinically indicated since Resident 69 did not have any documented behaviors since 10/2023, the ADON stated the facility was transitioning to another psychiatrist and the new psychiatrist wanted to get to know residents (in general) more before changing the medications. The ADON stated per facility policy, a GDR should have been attempted [for Resident 69]. During a review of the facility's P&P, dated 5/17/2024, the P&P indicated under Guidelines for gradual dose reduction: A. During the first year of receiving antipsychotic medication or other psychopharmacologic medication, at least one attempt at GDR or dose tampering is attempted. The P&P also indicated under Tapering and Gradual Dose Reduction: A. Gradual dose reduction is indicated when the resident's clinical condition has improved or stabilized, or the underlying causes of symptoms have resolved, and the type of medication requires gradual dose reduction of the dosage in order to avoid adverse consequences that could occur if the medication is stopped abruptly.

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38108 Based on observation, interview, and record review, the facility failed to ensure food preferences, such as nuts and foods that did not contain oil, were served and followed for one of one sampled resident (Resident 40) as indicated in the facility's policy and procedures (P&P). This failure resulted in further weight loss to Resident 40 and had the potential to result in a physical decline to Resident 40. Cross Reference F656 and F580 Findings: During a review of Resident 40's Admission Record (AR), the AR indicated Resident 40 was admitted to the facility on [DATE] with multiple diagnoses including type 2 diabetes mellitus (an adult-onset long-term condition in which the body has trouble controlling blood sugar) with diabetic neuropathy (a type of nerve damage that can occur when you have diabetes), unspecified, heart failure, unspecified and gastro-esophageal reflux disease (GERD, a digestive disorder that occurs when acidic stomach juices, or food and fluids back up from the stomach into the esophagus [muscular tube through which food passes from the throat to the stomach]). During a review of Resident 40's Dietary Nutritional Assessment/Progress Note (DNAPN), dated 6/23/2023, the DNAPN indicated Resident 40 requested to have a hamburger for lunch and no grease on Resident 40's food. During a review of Resident 40's History and Physical Examination (H&P), dated 12/16/2023, the H&P indicated Resident 40 had the capacity to understand and make decisions. During a review of Resident 40's Minimum Data Set (MDS, an assessment and screening tool), dated 3/22/2024, the MDS indicated, Resident 40's cognitive (ability to think and process information) skills for daily decision making were intact. The MDS indicated, Resident 40 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.) with eating. During a review of Resident 40's untitled and undated food preference ticket (FPT), the FPT indicated Resident 40 disliked milk, mild products, gravy, fried foods, mayonnaise, tuna sandwich and orange juice and liked hamburgers, peanut butter, apple slices, and small salads. During a review of Resident 40's DNAPN, dated 3/22/2024, the DNAPN indicated Resident 40 requested to have burgers for lunch and dinner, no mayonnaise, and requested to have fried eggs for breakfast cooked on a non-stick pan (no grease). The DNAPN indicated Resident 40 had stomach issues and could not have any kind of grease. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 40's Progress Note (PN), dated 3/24/2024, titled Interdisciplinary Team [IDT] Monthly Weight Variance [MWV] the notes indicated Resident 40 weight 130.2 lbs. The notes indicated; the RD met with Resident 40 who reported did not want to lose further weight. The notes indicated Resident 40 was a very selective eater and wanted foods with little to no oil due to Resident 40 experiencing diarrhea. During a review of Resident 40's PN-IDTMWV, dated 4/14/2024, the notes indicated Resident 40's current body weight was 127.6 lbs., and Resident 40 was below Resident 40's goal weight of 130 to 140 lbs. The notes indicated Resident 40 declined nutritional alternative options (unspecified), wanted fried eggs cooked without cooking spray or oil, and reported having episodes of diarrhea when eating fats due to Resident 40 missing Resident 40's gallbladder (body organ that breakdown oil or fat). During a review of Resident 40's PN, dated 5/19/2024, note text: consult + monthly weight review, the notes indicated Resident 40's current body weight was 125.4 lbs. and was below Resident 40's goal weight. The notes indicated Resident 40 wanted nuts, the RD explained to Resident 40 that the facility did not carry nuts and Resident 40 confirmed Resident 40 was not interested in buying his own nuts. During a review of Resident 40's Order Summary Report (OSR), active orders as of 6/11/2024, the OSR indicated, a physician's order dated 4/15/2024 for CCHO (consistent, constant, or controlled carbohydrate, diet to manage carbohydrate [basic food group broken into sugars in the body] consumption), NAS (no added salt) diet regular texture, regular consistency, Low Fat/Chol (cholesterol, type of fat), chopped meats (no milk), double protein with meals. During a review of Resident 40's Weights and Vitals Summary (WVS), effective date range 11/1/2023 to 6/30/2024, the WVS indicated, the following weights: 5/1/2024 125.4 lbs (pounds, a unit of weight) 4/25/2024 127.6 lbs 3/4/2024 130.2 lbs 2/5/2024 133.6 lbs 1/2/2024 134.4 lbs 12/4/2023 138.6 lbs 11/8/2023 142.6 lbs The WVS indicated, Resident 40 progressively lost weight in the last six (6) months. (continued on next page)

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	056118	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gladstone Sub-Acute and Rehab Center	435 E. Gladstone St Glendora, CA 91740

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/10/2024 at 11:42 PM with Resident 40, Resident 40 stated, Resident 40 could have [eat] a hamburger but only a bite. Resident 40 stated, Resident 40 could eat anything but no fat, butter, or grease. Resident 40 stated, Resident 40 got diarrhea if Resident 40 ate [anything with] grease and gas accumulated around Resident 40's crotch (between the legs). Resident 40 stated Resident 40 was tired of arguing [regarding food preferences] Resident 40 felt like no [staff] were listening to Resident 40. Resident 40 stated, I eat as much as I could and if I lose weight, I lose weight. During a concurrent observation and interview on 6/12/2024 at 12:43 PM with Resident 40, Resident 40 was sitting at the side of Resident 40's bed on a wheelchair, there was a lunch tray that had a hamburger with about 2 bites eaten from the patty, an empty fruit bowl, and an empty glass of juice. Resident 40 stated, I ate as much as I can, I cannot eat anything on here [pointing to the lunch tray]. Resident 40 stated, Resident 40 ate the canned fruit and drank the juice, that's all I can eat. Resident 40 stated, the hamburger meat was oily and stated he liked the hamburger patty well done without any oil. Resident 40 stated Resident 40 did not have a gallbladder and anything Resident 40 ate that had oil went right through Resident 40. Resident 40 stated, I shit oil and it stinks. Resident 40 stated, I am blind, and I don't have a leg, so I need someone to clean me. Resident 40 stated Resident 40 got pain in Resident 40's stomach because the gas [due to greasy food] went up Resident 40's stomach and Resident 40 felt so uncomfortable. Resident 40 stated he avoided the whole thing [eating greasy foods] and stated Resident 40 ate what Resident 40 could from served meals or, I just don't eat. Resident 40 stated Resident 40 has told them (unidentified staff members) so many times and stated he talked to everyone here [at the facility] that would listen - but you know what?, I'm tired of arguing, I just don't have the strength to argue anymore [and] I just eat what is given to me. During an interview and concurrent record review of Resident 40's Dietary Nutritional Screening Assessment (DNSA) and chart, dated 12/21/2023, with the Registered Dietician (RD), on 6/12/2024 at 12:57 PM, the DNSA indicated Resident 40 disliked greasy foods, liked fried eggs (no oil or butter) for breakfast, and burgers for lunch and dinner. The RD stated Resident 40 experienced a weigh loss of 12.6% in six months. The RD stated Resident 40 was offered nutritional alternative options, however, the RD could not remember the kinds of alternative foods offered to Resident 40. The RD was unable to provide or locate documentation that indicated the types of food alternatives offered to Resident 40. The RD stated food alternative options and accommodating residents was important to help them be happy with what they were eating and to stay in compliance with the ordered diet. During an observation and concurrent interview with the cook (CK), on 6/12/2024 at 1:15 PM, the CK stated Resident 40 was the only resident at the facility who received a fried hamburger for lunch and dinner. The CK stated the CK fried [with oil] Resident 40's hamburger patty in a regular pan. A regular pan was observed with grease on the base of the pan. A non-stick pan was observed on top of the preparation table, clean, and unused. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Dietary Supervisor (DS), on 6/12/2024 at 1:19 PM, the Dietary Services Supervisor (DSS) stated Resident 40 had requested (date unidentified) a fried egg to be cooked in a non-stick-pan without oil or fat. The DSS stated the DSS informed Resident 40 that even on non-stick pans, oil was needed to cook eggs. The DSS stated I cannot cook eggs without oil. The DSS stated the DSS gave Resident 40 a food alternative [well-done patty] and Resident 40 received a fried hamburger every day for lunch and dinner. The DSS stated Resident 40 had requested a well-done hamburger patty to minimize oil content. The DSS stated there were other ways to cook a hamburger patty such as grilling or steaming the patty. The DSS stated it was important for the facility to respect the dietary preferences of the residents because that was a resident's right as long as it was compliant with the doctor's order. During an interview with the Assistant Director of Nursing (ADON) and Resident 40 at Resident 40's bedside, on 6/12/2024 at 4:09 PM, Resident 40 stated, I wanted nuts such as cashews or almonds. They [the facility] no longer provided meals that I wanted, like big salads and fresh fruits. I love fruits and salads! I don't want anything fried or sauces on my food. During an interview with the ADON on 6/12/2024 at 4:20 PM, the ADON stated Resident 40 was awake, alert, and oriented. The ADON stated Resident 40's food wishes were ordinary, manageable, and could easily be provided by the facility. The ADON stated food preferences were not followed [for Resident 40] by the kitchen [staff] and stated this was a factor that could contribute to [further] weight loss and unwanted weight loss could affect Resident 40's health due to the lack of nutrition for Resident 40's body. During an interview and concurrent record review of Resident 40's FPT with the DSS, on 6/12/2024 at 4:36 pm, the DSS stated the FPT did not indicate Resident 40 could not tolerate oil, preferred the hamburger patties well done, and liked fried eggs [cooked on a non-stick pan]. The DSS stated specifics indicated in the FPT were important because the kitchen cooks based [meal preparation] on resident likes and dislikes indicated on the FPT. During a review of the facility's P&P titled, Unplanned Weight Loss,' release date 4/2018, indicated the purpose of the procedure is to provide appropriate interventions for any unplanned weight loss. The P&P included fundamental information that indicated, 6 months - 10% weight loss is significant; greater than 10% is severe weight loss. During a review of the facility's P&P titled, Nutrition & Weight Variance Committee), dated 11/1/2017, the P&P indicated to ensure that each resident maintains acceptable parameters of weight and nutritional status, such as body weight and protein levels . Objectives of the P&P may include but not limited to assessing changes in diet, food preferences and increased caloric intake. During a review of the facility's policy titled Resident Rights - Accommodation of Needs, dated 5/1/2023, the P&P indicated to ensure that the facility provides an environment and services that meet the resident's individual needs. The P&P indicated residents' individual needs and preferences are accommodated to the extent possible . and to accommodate a resident's individual needs and preferences, facility staff will assist the resident in maintaining independence, dignity, and well-being to the extent possible according to their wishes. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's undated document titled, Department of Food and Nutrition Services Consultant (Consultant Dietician) Job Description, indicated the registered dietician (RD) provides consultation to the facility for the purpose of providing nutrition care and oversight of the operations of the Department of Food and Nutrition Services, which will result in optimal health of the resident/patient. The RD evaluates the nutritional needs of resident/patients and documents in the nutritional record, evaluates and monitors the food service department to assure that the department is providing adequate acceptable quality food. During a review of a facility undated document titled, Dietary Manager [DM] Job Description, the document indicated the DM's principal responsibilities were to ensure the meals were served according to expressed resident preferences, implements and revises menus to meet resident's needs.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48729 Based on observation, interview, and record review, the facility failed to remove one unopened expired milk carton and 22 apples, received [DATE], from one of one walk-in refrigerator (Refrigerator 1). This failure had the potential to result in food poisoning (illness caused by food contaminated with bacteria [living organism that can cause an infection]) from serving spoiled foods to the residents who were able to consume the food items. Findings: During a concurrent observation and interview on [DATE] at 9:45 AM with the Dietary Services Supervisor (DSS) in the facility's Refrigerator 1, there was a clear plastic bin that contained 22 red apples labeled received on [DATE] and opened on [DATE]. The DSS stated the label was correct and the fruit was received on [DATE]. During a concurrent interview and record review on [DATE] at 9:49 AM with the DSS, the facility's Suggested Refrigerated Storage Guideline, dated 2018, was reviewed. The Suggested Refrigerated Storage Guideline, indicated to store apples for one month. The DSS stated the DSS would throw out the apples because even though they looked good, the apples could be bad on the inside. The DSS further stated the DSS would not serve the apples to the residents (in general) because it could make them sick. During a concurrent observation and interview on [DATE] at 9:53 AM with the DSS in the facility's Refrigerator 1, there was one of three unopened 1-gallon whole milk containers dated [DATE]. The DSS stated the unopened milk dated [DATE] expired [DATE] and should not be in Refrigerator 1. The DSS further stated the milk would be thrown out immediately so it was not accidentally served to the residents because the residents could get sick if the milk was consumed. During a review of the facility's policy and procedure (P&P) titled, Food Receiving and Storage of Cold Foods, dated 2018, the P&P indicated older perishable foods should be rotated to use the first in-first out method.